IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

GEORGIA COLLEGE OF EMERGENCY PHYSICIANS and BRETT CANNON, M.D., Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEPARTMENT OF LABOR, DEPARTMENT OF THE TREASURY, OFFICE OF PERSONNEL MANAGEMENT, and the CURRENT HEADS OF THOSE AGENCIES IN THEIR OFFICIAL CAPACITIES, Defendants.	)	CIVIL ACTION NO. 1:21-cv-05267-MHC

BRIEF *AMICUS CURIAE* OF THE EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOCIATION IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION, OR IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

SCHIFF HARDIN LLP
Jack R. Bierig (*Pro Hac Vice pending*)
Illinois Bar No. 0207039
233 South Wacker Drive
Suite 7100
Chicago, Illinois 60606

PARKER HUDSON RAINER & DOBBS, LLP
Robert M. Brennan
Georgia Bar No. 079798
Tracy M. Field
Georgia Bar No. 259341
303 Peachtree Street, N.E.
Suite 3600
Atlanta, Georgia 30308

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Statutes

Other Authorities

Regulations

Legislative Materials

EXHIBITS

1. *The Evolving Role of Emergency Departments in the United States* (RAND Corp. 2013) (excerpt).
   Full report available at https://www.rand.org/pubs/research_reports/RR280.html.

2. "Nevada Jury: Health Insurers Owe ER doctors $60M in Damages," Wash. Post. (Dec. 7, 2021), available at https://www.washingtonpost.com/business/nevada-jury-health-insurers-owe-er-doctors-60m-in-damages/2021/12/07/62b99f54-57c8-11ec-8396-5552bef55c3c_story.html

3. Letter from 152 Members of Congress to Defendant Departments (Nov. 5, 2021), available at https://wenstrup.house.gov/uploadedfiles/2021.11.05_no_surprises_act_letter.pdf.

4. Letter from House Ways and Means Committee Chairman Neal and Ranking Member Brady to Defendant Departments (Oct. 4, 2021), available at https://www.mcdermottplus.com/wp-content/uploads/2021/10/surprise-billing-regs-Neal-Brady-letter.pdf

5. "Neal Opening Statement at Markup of Surprise Medical Billing, Hospice, and Health Care Investment *Transparency* Legislation" (Feb. 12, 2020) (as prepared for delivery), available at https://waysandmeans.house.gov/media-center/press-releases/neal-opening-statement-markup-surprise-medical-billing-hospice-and

6. Joint Statement of the Committees on Ways and Means, Energy and Commerce, and Education and Labor, "Protecting Patients from Surprise Medical Bills" (Dec. 21, 2020) (pdf version). Native-format version available at https://gop-waysandmeans.house.gov/protecting-patients-from-surprise-medical-bills/.

7. Letter from Members of Congress with Health Care Expertise to Defendant Departments (Nov. 5, 2021), available at https://burgess.house.gov/uploadedfiles/2021.11.02_doc_caucus_surprise_billing_letter.pdf

8. "Physicians Decry Unintended Consequences of California's Surprise

INTRODUCTION AND INTERESTS OF *AMICUS CURIAE*

The Emergency Department Practice Management Association ("EDPMA") is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. The Interim Final Rule ("Rule") is contrary to the language and legislative history of the No Surprises Act, Pub. L. 116-260, div. BB, tit. I, 134 Stat. 1182, 2757-890 (2020) ("NSA"), and was published without the notice and comment required by the Administrative Procedure Act, 5 U.S.C. § 553(b). *See* 42 U.S.C. § 300gg-111(c); 45 C.F.R. § 149.510 (2021); 86 Fed. Reg. 55,980 (Oct. 7, 2021). The Rule will severely undermine the quality and availability of emergency care in this country.

The EDPMA strongly supports the NSA's goal of protecting patients from "surprise" healthcare bills. The NSA accomplishes this goal by prohibiting insurers and out-of-network providers from charging patients more than what they would have paid had those services been furnished by an in-network provider. At the same time, the NSA seeks to ensure fair compensation for healthcare providers.

Accordingly, the NSA establishes a process whereby patients are removed from billing disputes, and providers and payors negotiate among themselves to arrive at a reasonable payment for the unreimbursed amounts. Should those negotiations fail, the parties may invoke an arbitration process called Independent Dispute

Resolution ("IDR"). The IDR entity *must* consider each of the statutory factors and examine the particular facts of the claim to determine the reimbursement. The NSA does not constrain the discretion of the IDR entity in weighing the required statutory factors, or assign primacy to, or create a presumption in favor of, any of the factors.

The Rule is directly contrary to the NSA's unambiguous language. Under the Rule, one of the many statutory factors is given primacy in determining the out-of-network rate: the "qualifying payment amount" ("QPA"). The QPA is the insurer's median contracted (*i.e.*, *in*-network) amount for the service. It is calculated exclusively by the insurer and is not subject to review by the IDR entity. 86 Fed. Reg. at 55,996. The IDR entity is *required* to choose the offer closer to the QPA absent exceptional circumstances. Contrary to the NSA, which requires the IDR entity to consider all statutory factors, under the Rule the IDR entity is *precluded* from considering any factor other than the QPA unless the provider "clearly demonstrates" that the QPA is "materially different from the appropriate out-of-network rate." *Id.* at 55,984. And if the IDR entity believes that the offer farther from the QPA better reflects the actual value of the services, it must provide a "detailed explanation" justifying the departure from the QPA. *Id.* at 56,000.

The Rule's one-sided procedure tilts the IDR process decidedly in favor of insurers and, necessarily, toward reimbursement rates that are inadequate and below

market. All healthcare providers will be materially and adversely affected by the Rule, but *Amicus Curiae* and its emergency physician members particularly so. Under the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, emergency physicians and facilities are required to treat and stabilize all emergency room patients, regardless of insurance status or ability to pay. Indeed, more than two-thirds of uncompensated medical care is provided in emergency rooms, and insurers consistently underpay emergency providers. (Ex. 1 at 2; Ex. 2.) The situation has long since passed a crisis point. The burden of uncompensated care is growing, closing many emergency departments and hospitals, and threatening the ability of emergency departments to care for patients, including the indigent and rural populations, who rely on emergency departments as an important safety net.

The Rule will serve only to exacerbate this already bleak picture. Fair reimbursement of providers is critical to the viability of our healthcare system. But implementation of the Rule will drive reimbursement down to artificially low, below-market rates—not only for out-of-network services, but ultimately for in-network services as well—all to the detriment of patients.

Key congressional architects of the NSA have warned that the Rule "could incentivize insurance companies to set artificially low payment rates, which could narrow provider networks and jeopardize patient access to care—the exact opposite

of the goal of the law. It could also have a broad impact on reimbursement for in-network services, which could exacerbate existing health disparities and patient access issues in rural and urban underserved communities." (Ex. 3 at 2.)[1] Indeed, Defendants themselves recognized that "undercompensation could threaten the viability of these providers [and] facilities . . . . This, in turn, could lead to participants, beneficiaries and enrollees not receiving needed medical care, undermining the goals of the No Surprises Act." 86 Fed. Reg. at 56,044.

What members of Congress feared has already come true. The EDPMA's members have received notices from insurers threatening to terminate their contracts (and in some cases terminating their contracts) unless they agree to substantial discounts to their contracted rates. Those notices specifically cite the primacy the Rule accords to QPAs as the legal justification for their actions.

ARGUMENT

I. The Rule Directly Conflicts with the NSA's Clear Language.

A. The NSA Requires That the IDR Entity Consider All Statutory Factors in Determining the Out-of-Network Rate.

Given the NSA's prohibition against balance-billing patients, out-of-network

[1]More than 70 rural hospitals have ended all services since 2011. *See* https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

providers must turn to the patient's insurer for payment of unreimbursed amounts. Under the NSA, insurers must pay providers the "out-of-network rate," which, as relevant here, is the amount determined through a 30-day open negotiation process culminating, if necessary, in IDR. 42 U.S.C. §§ 300gg-111 (a)(3)(K). Each party submits an offer for a payment amount, and the IDR entity must choose one as the "out-of-network rate." *Id.* §§ 300gg-111(c)(1)(A), (c)(1)(B), (c)(5)(B), (c)(5)(A).

The NSA does not set a benchmark for determining the out-of-network rate—a concept Congress squarely rejected. *See infra* pp. 8-12. Instead, the NSA provides a detailed list of factors that the IDR entity "*shall* consider" in its determination:

1. The QPA for comparable services furnished in the same geographic area. *See* 42 U.S.C. § 300gg-111(c)(5)(C)(i)(I).
2. Five "additional circumstances":
   - The "level of training, experience, and quality and outcomes measurements" of the provider. *Id.* § 300gg-111(c)(5)(C)(ii)(I).
   - The "market share" of the provider or payor in the relevant geographic area. *Id.* § 300gg-111(c)(5)(C)(ii)(II).
   - The "acuity of the individual receiving such item or service" or the "complexity of furnishing such item or service to such individual." *Id.* § 300gg-111(c)(5)(C)(ii)(III).
   - The "teaching status, case mix, and scope of services" of the facility. *Id.* § 300gg-111(c)(5)(C)(ii)(IV).
   - "Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or . . . the plan . . . to enter into network agreements and, if applicable, contracted rates between [those entities] during the previous 4 plan years." *Id.* § 300gg-111(c)(5)(C)(ii)(V).
3. Any information the IDR requests from the parties. *Id.* § 300gg-111(c)(5)(C)(i)(II).

4. Any additional information submitted by the parties. *Id.*

The IDR entity "*shall not* consider" (i) usual and customary charges; (ii) amounts the provider would have billed absent the NSA's ban against balance-billing; and (iii) reimbursement rates by a public payor. *Id.* § 300gg-111(c)(5)(D).

Thus, Congress identified with precision the factors that IDR entities "shall" and "shall not" consider in determining the out-of-network reimbursement rate. Congress left to the discretion of the IDR entity how to balance each of those factors to arrive at the appropriate reimbursement. The NSA does not instruct IDR entities how to weigh the statutory factors, give primacy to the QPA, or create a "presumption" that the QPA is the proper reimbursement. Nor does the NSA place the burden on providers to "clearly demonstrate" that the QPA is "materially different from the appropriate out-of-network rate." The NSA did not make QPA the proxy for, or even the predominant factor in calculating, the out-of-network rate.

B. The Rule Rewrites the NSA Under the Guise of "Interpretation."

The Rule proceeds from the assumption that the "best interpretation" of the NSA is that the IDR entity *must* accept the offer closer to the QPA, unless the provider satisfies the burden of "clearly demonstrat[ing]" that the QPA is "materially different from the appropriate out-of-network rate." 86 Fed. Reg. at 55,984, 55,996. The Rule does not "interpret" the NSA. It materially alters the statute.

Rather than a robust arbitration process in which the IDR entity is *required* to evaluate *all* the factors Congress believed were relevant to determining a proper reimbursement rate, the Rule turns the IDR into a truncated, meaningless exercise—one in which the IDR entity is prohibited from considering the required statutory factors absent special circumstances, and in which the foregone conclusion is that the QPA will be selected as the reimbursement amount. The NSA's detailed and comprehensive requirements for the IDR further demonstrate that Congress did not intend additional "interpretation" of the NSA through administrative action or "gap-filling." Indeed, while the NSA specifies numerous instances requiring action by an administrative agency (Cmplt. ¶ 46 & n.9), the statute did not do so with respect to the IDR entity's discretion to determine a fair out-of-network reimbursement rate.

Finally, there is no support for the Departments' conclusion that "the statute contemplates that typically the QPA will be a reasonable out-of-network rate." 86 Fed. Reg. at 55,996. Had Congress believed that the QPA—the *in*-network rate calculated solely by the payor—would "typically" be the appropriate amount for *out*-of-network reimbursements, it would have said so. The fact that Congress specified many factors—*in addition* to the QPA—that the IDR entity must consider shows that Congress did not believe that the QPA would "typically" be adequate. Indeed, the QPA will be lower than the reasonable market rate. *See infra* pp. 12-14.

II. The Legislative History Confirms that the Rule Is Contrary to the NSA.

The conclusion that the Rule is contrary to the intent of Congress is confirmed by a review of the NSA's legislative history. Congress rejected all attempts to do what the Rule does: create a benchmark for provider reimbursement, limit the discretion of the IDR entity in applying the statutorily mandated factors, and otherwise skew the IDR process heavily in favor of insurers, granting them a material advantage that they were unable to obtain during the legislative process.

The NSA was the product of more than two years of intense legislative activity. Insurers lobbied Congress to make median in-network rates the benchmark. Other proposals included arbitration, but because the in-network rate would have been the benchmark, arbitration would have been merely "a backstop [that], at most, [would] result in a mere adjustment to the benchmark rate." (Ex. 4 at 2.)

For example, on July 9, 2019, House Energy and Commerce Committee Chairman Pallone and Ranking Member Walden introduced H.R. 3630, which would have set the reimbursement rate at the insurer's median contracted rate. H.R. 3630, 116th Cong. § 2 (2019). This "benchmark" generated stiff opposition. An amendment provided for an IDR-like process for services above $1,250. H.R. 2328, 116th Cong. tit. IV, § 402(b) (2019). Likewise, in July 2019, Senator Lamar Alexander introduced S. 1895 (Senate Health, Education, Labor and Pensions

Committee). That bill would have set a "benchmark for payment" for out-of-network services at "the median in-network rate for such services provided to [health plan] enrollees." S. 1895, 116th Cong. tit. I, §103 (2019).

In February 2020, two pieces of legislation reflected the two major competing approaches to provider reimbursement: H.R. 5800 (House Education and Labor Committee) and H.R. 5826 (Ways and Means). H.R. 5800 would have required insurers to make a minimum payment of the median contracted rate, with an IDR process if that rate was at least $750. H.R. 5800, 116th Cong. § 2 (2020). H.R. 5826 did not establish a payment standard, but provided for a negotiation process, with a dispute-resolution process if negotiations failed. H.R. 5826, 116th Cong. § 7 (2020).

Chairman Neal noted that the sponsors of H.R. 5826 had "worked to craft a process where the provider's offer and the plan's offer receive equal weight"; the IDR entity "considers, but isn't bound by, the plan's median in-network rate"; and "the provider is not left in a position to disprove the adequacy of such a rate." He noted his concern with "giving too much weight to such a benchmark rate" (Ex.5):

> [W]e already know insurers are looking for any way they can pay the least amount possible. They will work to push those rates down, regardless of what it means for community providers like physicians, hospitals, and our constituents who they employ. With no federal network adequacy standards, plans can push rates down and drop providers from networks with no consequences, leaving patients holding the bag. . . . Surprise bills would be much less common if insurer networks were more robust.

Congress ultimately adopted the Ways and Means approach to determining reimbursement rates. Congress considered, but rejected, the approach embodied in the Rule, which effectively sets the QPA as the presumptive reimbursement amount and constrains the IDR process so that it decidedly favors insurers over providers. Indeed, on the day the NSA was passed, the three major House Committees addressing these issues issued a Joint Statement noting what the NSA "does not do": "This text includes NO benchmarking or rate-setting." (Ex. 6.) The Joint Statement emphasizes that the IDR entity "must equally consider" the many statutory factors:

- This independent dispute resolution process fairly decides an appropriate payment for services based on the facts and relevant data of each case. This results in savings by stopping bad actors from driving up costs across the health care system . . . .
- The arbitrator must equally consider many factors, including:
  - Median contracted rates;
  - Education and experience of providers and severity of individual cases;
  - Previously contracted rates going back four years;
  - Good faith efforts to negotiate–bad actors will be held accountable;
  - Market share of both parties–this will help prevent any stakeholder that dominates a region from trying to set rates at an untenable level; and
  - Any other factors brought forward by providers and plans, except for billed charges or government-set rates.

Since promulgation of the Rule, congressional leaders have made clear that it violates the NSA. For example, the principal architects of the legislation expressed their concern that the Rule "do[es] not reflect the law that Congress passed":

> Congress sought to promote fairness in payment disputes between insurers and providers--carefully specifying all the various factors that should be

> considered during the independent dispute resolution (IDR) process. . . .
> . . . Despite the careful balance that Congress designed for the independent dispute resolution process, the [Rule] strays from the No Surprises Act in favor of an approach that Congress did *not* enact in the final law and does so in a very concerning manner.

(Ex. 4 at 2.) Contrary to the NSA, the Rule "crafts a process that essentially tips the scale for the median contracted rate being the default appropriate payment amount" (*id.*). "Such a standard affronts the provisions enacted into law, and we are concerned that this approach biases the IDR entity toward one factor (a median rate) as opposed to evaluating all factors equally as Congress intended." *Id.*

Many congressional members with healthcare expertise objected that the Rule "does not reflect legislation that could have passed Congress or the law as written. . . . [T]he [Rule] places a disproportionate emphasis on the QPA, which necessarily undervalues other factors brought to the arbiter, including quality and outcomes data. (Ex. 7.) Thus, the QPA "is unlikely to reflect actual market-based payment rates for all circumstances," which will adversely affect the availability of healthcare, particularly in underserved areas:

> By instructing the IDR entity to rely upon the QPA as the primary factor in determining payment rates, the [Rule] will limit providers' ability to utilize other statutorily required and relevant factors when negotiating with the payor. Under this [Rule], we are concerned that the IDR process will lead to narrower networks and decreased access to medical care for millions of American patients, which would have a disproportionate impact on access to care in rural and underserved areas. If this [Rule] is finalized as written, providers may no longer be able to afford to serve these communities given

> the downward pressure on commercial rates coupled with the already delicate payor mix.

A letter from 152 members of Congress expressed these same concerns, emphasizing that "Congress rejected a benchmark rate and determined the best path forward for patients was to authorize an open negotiation period coupled with a balanced IDR process." (Ex.3.) The Rule, on the other hand, "do[es] not reflect the way the law was written, do[es] not reflect a policy that could have passed Congress, and do[es] not create a balanced process to settle payment disputes." (*Id.*) By making the median in-network rate "the default factor considered in the IDR process," the Rule threatens grave consequences for patients, including jeopardizing access to care and exacerbating health disparities in underserved communities. (*Id.*)

III. The Rule Will Have Serious Adverse Consequences for Patients.

If upheld, the Rule will result in a host of serious adverse consequences for healthcare providers and their patients.

First, there is no basis for the Departments' assumption that the QPA/*in*-network rate will "typically" be a reasonable *out*-of-network rate. By requiring the IDR entity to consider a number of factors *in addition to* the QPA, the NSA makes clear that the QPA alone does not accurately represent prevailing market rates. The real world of health insurance markets bears this out. Market rates are fairly represented by *actual payments* to providers for actual services rendered, not by a

median of *contracted* rates irrespective of the actual utilization of those contracts in the marketplace. Contracted rates are affected by any number of factors, including the market share of the plan and provider, the unique economic and clinical environment in the communities, and penalty and bonus structures. In some contracts, risk-sharing amounts can total 10-15%; the contracted rates are adjusted *downward* to reflect the potential for earning such an incentive. Providers often agree to lower contracted rates in exchange for reimbursement certainty and administrative efficiencies. In fact, when insurers calculate median contracted rates, they must exclude risk sharing, bonuses, or penalties, and other real-world incentive-based payments. 86 Fed. Reg. 36,872, 36,894 (July 13, 2021). In short, using contracted rates as the QPA, and the QPA as a proxy for out-of-network rates, will deviate drastically from any representation of the actual prevailing market rate.

Second, there is no serious dispute that "benchmarks" result in underpayments and, in turn, contraction of provider networks and narrowing of healthcare choices. The California experience is illustrative. California enacted a benchmark rate, but that benchmark became the default rate for out-of-network and even some in-network services. Insurers recognized that they could force providers out of network by paying the artificially low benchmark rate and then offering take-it-or-leave it contracts. These narrowed networks jeopardized patient access to care. Small,

independent providers could not remain financially viable and were forced to consolidate with larger systems to continue to care for their patients. This consolidation substantially increased healthcare costs. (Ex. 8.) For emergency physicians, the problem is even more acute. EMTALA causes insurers to be even less inclined to keep emergency providers in-network, because their policyholders must receive emergency care regardless of insurance status. Insurers have no incentive to enter into fair contracted rates with emergency physicians.

Third, the experience in California and elsewhere is already starting to play out nationwide as a result of the Rule. The Rule has had the effect of narrowing provider networks and thereby reducing the availability of healthcare to patients. Since publication of the Rule, numerous physician practices have received termination notices of longstanding network agreements (including those that protect patients in rural and underserved communities), or threats to terminate existing agreements unless providers agree to substantial discounts from their contracted rates. Some of those letters cite the Rule as justification. (Exs. 9-10.)

Finally, the Departments' assumption that lower reimbursement rates will translate into lower costs to patients is without any basis. The Departments state that the Rule will "help limit the indirect impact on patients that would occur from higher out-of-network rates if plans and issuers were to pass higher costs on to individuals

in the form of increases in premiums." 86 Fed. Reg. at 55,996. There is no evidence that insurers pass their savings onto insureds. In fact, when states provide for fair reimbursement (like New York and Connecticut), the resulting premiums are actually *lower* than the national average. One study examined premiums in New York, Connecticut, and nationwide from 2015-2019. In 2019, the percentage growth in premiums was 73% nationwide, but only 50% in New York and 35% in Connecticut. (Ex. 11.) There is no evidence of a relationship between higher premiums and laws that improve emergency physician reimbursement. In short, the Rule will result in a host of negative consequences for providers and patients, without any of the hoped-for positives in the form of lower insurance premiums.

CONCLUSION

The EDPMA respectfully requests that the Court grant Plaintiffs' Motion.

Respectfully submitted this 4th day of February, 2022.

SCHIFF HARDIN, LLP
By: */s/ Jack R. Bierig*
Jack R. Bierig (*Pro Hac Vice pending*)
Illinois Bar No. 0207039
233 South Wacker Drive
Suite 7100
Chicago, Illinois 60606
Telephone: (312) 258-5511
Facsimile: (312) 258-5600
jbierig@schiffhardin.com

PARKER HUDSON RAINER & DOBBS, LLP
By: */s/ Robert M. Brennan*
Robert M. Brennan
Georgia Bar No. 079798
Tracy M. Field
Georgia Bar No. 259341
303 Peachtree Street, N.E.
Suite 3600
Atlanta, Georgia 30308
Telephone: (404) 523-5300
Facsimile: (404) 522-8409
bbrennan@phrd.com
tfield@phrd.com

CERTIFICATE OF COMPLIANCE

In compliance with N.D. Ga. R. 7.1D, I certify that the foregoing **BRIEF *AMICUS CURIAE* OF THE EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOCIATION IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION, OR IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT** has been prepared in conformity with N.D. Ga. R. 5.1. This brief was prepared with Times New Roman (14 point) type, with a top margin of one and one-half (1½) inches and a left margin of one (1) inch. This brief is proportionately spaced and is no longer than twenty-five (25) pages.

/s/ Robert M. Brennan
Robert M. Brennan

CERTIFICATE OF SERVICE

I hereby certify that I have this day served a copy of the within and foregoing **BRIEF *AMICUS CURIAE* OF THE EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOCIATION IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION, OR IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT** with the Clerk of Court using the CM/ECF system which will automatically send email notification of such filing to the attorneys of record in this action.

This 4th day of February, 2022

/s/ Robert M. Brennan
Robert M. Brennan