Multiple Documents

Part	Description
1	17 pages
2	Exhibit Exhibit A
3	Exhibit Exhibit B
4	Text of Proposed Order

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS

LIFENET, INC., Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	Civil Action No. 22-cv-00162-JDK

DEFENDANTS' MOTION TO TRANSFER AND SUPPORTING MEMORANDUM

INTRODUCTION

Plaintiff urges the Court to decide—on an emergency basis—claims that are virtually identical to those in a suit that has been pending in the U.S. District Court for the District of Columbia for nearly six months. The plaintiff in the earlier-filed case is a trade association that brought suit on behalf of 93% of the U.S. air ambulance industry—including a company that is not only business partners with Plaintiff here, but that may well have the principal financial stake in this case. Indeed, that company has submitted declarations in support of both summary judgment in the earlier-filed case and Plaintiff's motion for expedition here. And the parties in both cases seek the same relief: vacatur of the challenged regulation. To prevent the unnecessary expenditure of judicial resources, avoid wasteful and duplicative litigation, and avert the possibility of inconsistent judgments, Defendants respectfully move the Court, under the first-to-file rule, to transfer this case to the U.S. District Court for the District of Columbia.

At issue in both cases is an interim final rule that implements the arbitration provisions of the No Surprises Act of 2020 as they pertain to air ambulance service providers. Pub. L. No. 116-

260, div. BB, tit. I (Dec. 27, 2020). The Act contains one set of statutory provisions governing the arbitration of payment disputes between physicians or other health care providers and group health plans or health insurance issuers, *see* 42 U.S.C. § 300gg-111, and a second set of statutory provisions addressing the arbitration of payment disputes between air ambulance service providers and plans or issuers, *see id.* § 300gg-112. Defendants have implemented these statutory provisions by issuing separate regulations in October 2021 that address each type of payment dispute. *See* 45 C.F.R. § 149.510, 149.520.[1]

In November 2021, the Association of Air Medical Services—an international trade association that represents over 93% of air ambulance service providers in the United States, including Plaintiff's partner and affiliate, Air Methods Corporation—brought suit in the U.S. District Court for the District of Columbia on behalf of its members, challenging the regulations promulgated under the No Surprises Act that relate to the arbitration of payment disputes involving air ambulance service providers. *See Ass'n of Air Med. Servs. v. U.S. Dep't of Health & Human Servs.*, No. 1:21-cv-03031-RJL (D.D.C.). In that case, the parties have fully briefed cross-motions for summary judgment, and the Honorable Richard J. Leon heard argument on March 21, 2022.

On April 27, 2022, over a month after oral argument in *Association of Air Medical Services*, Plaintiff filed this essentially duplicative case. The claims in the two cases challenging the air-ambulance regulations are virtually identical. The Plaintiff here, LifeNet, Inc., is business partners with Air Methods, one of the companies on whose behalf the plaintiff in *Association of Air Medical*

[1] The statute sets forth parallel amendments to the Public Health Service Act (PHSA), the Employee Retirement Income Security Act, and the Internal Revenue Code, and the interim final rules set forth parallel regulations implemented by HHS, the Department of Labor, and the Department of the Treasury. For ease of reference, except where otherwise noted, this brief cites only to the PHSA and to the HHS regulations.

Services is suing.[2] Air Methods has submitted declarations in both cases. And the administrative record in the earlier suit is fully developed and includes all the relevant material that pertains to the air ambulance regulations that Plaintiff challenges here.

"'Considerations of comity and orderly administration of justice dictate that two courts of equal authority should not hear the same case simultaneously.'" *West Gulf Maritime Ass'n v. Int'l Longshoremen's Ass'n*, 751 F.2d 721, 729 (5th Cir. 1985) (citation omitted). Thus, under the "first-to-file" rule, when a subsequent suit raises issues that are "substantially similar" to those raised by an earlier one, the second suit may be "dismissed, stayed, or transferred and consolidated" with the first. *Sutter Corp. v. P&P Indus., Inc.*, 125 F.3d 914, 920 (5th Cir. 1997). Which course is appropriate is generally for "the court initially seized of a controversy . . . to decide." *Mann Mfrg. Inc. v. Hortex*, 439 F.2d 403, 407 (5th Cir. 1971). Accordingly, the role of the court hearing a later-filed case, such as this one, is limited to weighing whether there is a "likelihood of substantial overlap" with the earlier-filed one and, if so, transferring the later-filed case to the court where the earlier-filed one is being heard. *Id*. at 408 & n.6.

The issues in this case are, at a minimum, "substantially similar" to those in *Association of Air Medical Services*. Considerations of comity and the orderly administration of justice thus counsel in favor of a transfer of this action to the U.S. District Court for the District of Columbia, so that that court may determine whether this case should be consolidated with its predecessor.

[2] Defendants do not yet know, at the outset of this litigation, whether Plaintiff is itself a member of the association.

RELEVANT BACKGROUND

A. The No Surprises Act

This case is about an interim final rule promulgated to implement portions of the No Surprises Act (NSA or the Act) by Defendants—the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (together, the Departments), along with the Office of Personnel Management (OPM). The principal aim of the NSA, enacted in late December 2020, is to address the phenomenon of surprise medical bills that result when a patient (particularly in an emergency) is unable to choose to receive care from an in-network provider. The NSA limits a patient's share of the cost of emergency services delivered by out-of-network providers, including air ambulance providers, and prohibits the practice of "balance billing." *See* 42 U.S.C. § 300gg-112(a)(2). The Act also addresses how a payment dispute in these situations between an out-of-network health care provider and a group health plan or health insurance issuer will be resolved. *See id*. § 300gg-112(b)(1)(A)-(B). The Act creates an arbitration mechanism ("independent dispute resolution" or "IDR" process) whereby each party will submit its proposed payment amount and an independent, private arbitrator, known as a "certified IDR entity," will select between the two offers. *Id*. § 300gg-112(b)(5)(A)(i). Congress also directed the Departments to create rules to establish this arbitration process, and to do so within one year of the NSA's enactment. *Id*. § 300gg-112(b)(2)(A).

Congress was particularly concerned with the problem of surprise billing in the air ambulance industry, and so the NSA contained several provisions specifically addressing the problem of surprise billing from air ambulance services. *See* 42 U.S.C. § 300gg-112 ("Ending surprise air ambulance bills"). The Act includes one set of statutory provisions addressing the arbitration of payment disputes involving physicians or other health care providers, *see id.*

§ 300gg-111, and a separate set of provisions addressing payment disputes involving air ambulance service providers, *see id.* § 300gg-112. The air ambulance provisions lay out factors unique to that industry for arbitrators to consider when deciding on a payment amount. *Id*. § 300gg-112(b)(5)(C)(ii).

Defendants issued interim final rules addressing both sets of statutory provisions. In one set of rules, Defendants established regulations governing the arbitration of payment disputes between physicians and other health care providers and plans or issuers. *See* 45 C.F.R. § 149.510. This Court vacated certain provisions of those regulations in a decision issued earlier this year. *Tex. Med. Ass'n v. HHS*, 6:21-cv-00425, 2022 WL 542879 (E.D. Tex. Feb. 23, 2022). Defendants also established a second set of regulations governing payment disputes involving air ambulance service providers. *See* 45 C.F.R. § 149.520. Those regulations were not at issue in *Texas Medical Association*, as no plaintiff in that action was an air ambulance service provider.

Defendants are preparing a set of final rules that they anticipate will supersede the portions of 45 C.F.R. § 149.510 that this Court has vacated, as well as portions of the separate regulation under 45 C.F.R. § 149.520 involving the arbitration of air ambulance payment disputes. Defendants anticipate that these rules will be published by early summer. Defendants have filed a notice of appeal to the Fifth Circuit of the judgment in *Texas Medical Association*. In light of the forthcoming rulemaking, Defendants filed an unopposed motion to hold that appeal in abeyance, and the Fifth Circuit granted that motion on May 3, 2022.

B. Proceedings in *Association of Air Medical Services*

In November 2021, the Association of Air Medical Services filed a two-count complaint in the U.S. District Court for the District of Columbia challenging the regulations concerning air ambulance service providers. Compl., *Ass'n of Air Med. Servs. v. HHS.*, No. 1:21-cv-03031

(D.D.C.), ECF No. 1 (attached as Exhibit A), *consolidated with Am. Med. Ass'n v. HHS*, No. 1:21-cv-03231 (D.D.C). There, the Association of Air Medical Services described itself as the international trade association that represents over 93% of air ambulance providers in the United States. Compl. ¶ 20 *Ass'n of Air Med. Servs*., No. 1:21-cv-03031 (D.D.C.), ECF No. 1. The Association supported its claim to standing in that action by alleging that its members, Air Methods Corporation, PHI Health, LLC, and Global Medical Response, Inc., would suffer a loss of revenue under the rule. *Id.* ¶ 123; *see also Ass'n of Air Med. Servs.*, No. 1:21-cv-03031 (D.D.C.), ECF 1-5 (Decl. of Grayson Michael Foster, Chief Financial Officer of PHI Health, LLC), ECF No. 1-6 (Decl. of Michael Preissler, Chief Financial Officer of Global Medical Response, Inc.), ECF No. 1-7 (Decl. of David Portugal, Chief Financial Officer of Air Methods Corporation).

The parties in *Association of Air Medical Services* have fully briefed cross-motions for summary judgment, based on an administrative record that spans more than 6,000 pages and that includes a broader range of supporting materials and comments from stakeholders than what was included in the administrative record in the *Texas Medical Association* action. *See Ass'n of Air Med. Servs.*, No. 1:21-cv-03031 (D.D.C.), ECF Nos. 5, 10, 11, 31, 44 (parties' briefs); *id*., ECF No. 12-1 (index to administrative record). Numerous amici have filed briefs in the *Association of Air Medical Services* action, including amici asserting interests unique to the context of surprise billing by air ambulance service providers. *Id.,* ECF Nos. 17, 20, 21, 24, 27, 33, 34, 35, 36, 37 (amicus briefs). Judge Richard J. Leon held oral argument on March 21, 2022, and the summary judgment motions remain pending. *See id.*, (minute entry Mar. 21, 2022); *id.*, ECF No. 57 (transcript of proceedings).

C. This Case

On April 27, 2022—over five months after the complaint in *Association of Air Medical Services* was filed, and over a month after oral argument was held in that case—Plaintiff filed a two-count complaint in this Court challenging the same regulatory provisions that are at issue in the action pending before Judge Leon. ECF No. 1.

Plaintiff is business partners with Air Methods Corporation, which—as noted above—is a member of the Association of Air Medical Services. *See, e.g.*, LifeNet, About LifeNet: The LifeNet Story, https://www.lifenetems.org/ ("Through a partnership with Air Methods, LifeNet has helicopters at both the Texarkana and Hot Springs Regional Airports."). Air Methods, for its part, describes its business relationship with LifeNet as one following its "alternative delivery model." *See* Air Methods, Explore Our Healthcare Partners: LifeNet EMS, https://www.airmethods.com/air-medical/healthcare-partners/. As Air Methods has explained, under the "alternative delivery model," it provides aviation, fuel, maintenance, licensure, and assumes the responsibility for billing for air ambulance services. *See* Air Methods, No Surprises Act: Implementation of Air Ambulance Services: Meeting with Air Methods (Apr. 27, 2021) (page 5,817 of the administrative record in the District of Columbia action) (attached as Exhibit B).

The "alternative delivery model" is a term of art in the air ambulance industry. Under the "alternative delivery model," a national entity such as Air Methods handles the billing and realizes all profits or losses from medical billing, while a local partner is paid a fixed fee; in contrast, under the "traditional model," the local partner handles billing, and retains both the risk and the potential profit from billing for air ambulance services, while the national entity is instead paid a fixed fee. *See* Air Medical Insights, *Choosing an Air Medical Delivery Model* (Jan. 20, 2020), http://airmedicalinsights.com/2020/01/air-medical-transport-delivery-model/; see also Air

Medical Insights, *Making the Switch: from ADM to Traditional*, at 4 http://airmedicalinsights.com/adm-to-traditional-lp/ (explaining that under the alternate delivery model, the local partner "no longer exercise[s] control over pricing, billing or collections practices associated with its air ambulance program."). In other words, under the partnership between LifeNet and Air Methods, LifeNet is paid a flat fee for its services, but Air Methods apparently retains all interest in patient billing, meaning that it has a clear financial interest—and perhaps the primary (or even the only) stake—in the resolution of payment disputes involving air ambulance transports performed under the LifeNet-Air Methods partnership.[3]

In this action, Plaintiff seeks the same relief that the national association and Air Methods have sought in the *Association of Air Medical Services* action, namely, the vacatur of portions of the regulation addressing the arbitration of air ambulance payment disputes. What is more, Plaintiff here seeks unjustifiably expedited briefing in support of a summary judgment motion with respect to these claims, even though the rule Plaintiff challenges was issued in October 2021, over six months ago, and briefing in the related case concluded several months ago. Indeed, it is telling that, in support of its motion for expedited briefing, Plaintiff submits declarations from other air ambulance service providers that are members of the Association of Air Medical Services, ECF Nos. 19-1, 19-2, 19-3, as those companies have been active participants in *Association of Air Medical Services* from the outset of that litigation. *See Ass'n of Air Med. Servs.*, No. 1:21-cv-03031 (D.D.C.), ECF No. 1-7 (Decl. of David Portugal, Chief Financial Officer of Air Methods), ECF

[3] The precise nature of the partnership between LifeNet, Inc. and Air Methods is unclear to Defendants at this early stage of the litigation. If information is developed in this litigation that reveals that Air Methods alone retains a financial interest in billing for air medical services, this would call into question LifeNet's standing to bring this action.

No. 1-5 (Decl. of Grayson Michael Foster, Jr., Chief Financial Officer of PHI Health, LLC), ECF No. 1-6 (Decl. of Michael Preissler, Chief Financial Officer of Global Medical Response, Inc.).[4]

Despite the overlap of affiliated parties and claims between this case and *Association of Air Medical Services*, Plaintiffs have not filed a notice of related case. *See* ECF No. 1-1 (civil cover sheet); E.D. Tex. Local R. CV-42(a) ("Duty to Notify Court of Collateral Proceedings and Re-filed Cases. Whenever a civil matter commenced in or removed to the court involves subject matter that either comprises all or a material part of the subject matter or operative facts of another action, whether civil or criminal, then pending before this or another court or administrative agency, or previously dismissed or decided by this court, counsel for the filing party shall identify the collateral proceedings and/or re-filed case(s) on the civil cover sheet filed in this court."). Instead, they cite only *Texas Medical Association* case as a related case, even though that case does not involve the portions of the statute or regulations that specifically apply to air ambulance services. Because the *Texas Medical Association* case did not involve the statutory or regulatory provisions that apply to air ambulance services, this Court has not received full briefing or the full administrative record on the rulemaking process for the air ambulance regulations, as Judge Leon has in the *Association of Air Medical Services* case.

[4] Counsel for Plaintiff in this case also represents PHI Health, LLC in an action filed two days after this one in the Eastern District of Kentucky bringing similar challenges to the regulations promulgated under the No Surprises Act. *See* Compl. *PHI Health, LLC and Empact Midwest, LLC v. HHS*, No. 6:22-cv-00095-REW (E.D. Ky. Apr. 29, 2022), ECF No. 1.

ARGUMENT

This Case Should Be Transferred to the U.S. District Court for the District of Columbia under the First-to-File Rule

The issues in this case are, at a bare minimum, substantially similar to the issues that have been fully briefed and argued in *Association of Air Medical Services*, and Plaintiff here seeks the same relief sought in that case.[5] The Court should therefore transfer this action to the U.S. District Court for the District of Columbia under the first-to-file rule, so that that court may determine whether this case should be consolidated with its predecessor. And Defendants respectfully submit that the Court should resolve this motion before embarking on the precipitous summary judgment proceedings that Plaintiff requests. "Although district courts have discretion as to how to handle their dockets, once a party files a transfer motion, disposing of that motion should unquestionably take top priority." *In re Apple Inc.*, 979 F.3d 1332, 1337 (Fed. Cir. 2020). *Accord, In re Horseshoe Ent.*, 337 F.3d 429, 433 (5th Cir. 2003) ("disposition of that [transfer] motion should have taken a top priority"); *E. Texas Boot Co., LLC v. Nike, Inc.*, No. 2:16-CV-0290-JRG-RSP, 2017 WL 2859065, at *2 (E.D. Tex. Feb. 15, 2017) (same). "Judicial economy requires that another district court should not burden itself with the merits of the action until it is decided [whether] a transfer should be effected." *In re Apple Inc.*, 979 F.3d at 1337 (quoting *McDonnell Douglas Corp. v. Polin*, 429 F.2d 30, 30 (3d Cir. 1970)).[6]

The "first-to-file rule is grounded in principles of comity and sound judicial administration." *Save Power Ltd. v. Syntek Fin. Corp.*, 121 F.3d 947, 950 (5th Cir. 1997). As the

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[5] The Departments have explained that, even if the national association were to prevail in the *Association of Air Medical Services* action, any relief should be limited to the national association, or its identified association members. *Ass'n of Air Med. Servs.*, No. 1:21-cv-03031, ECF No. 44, at 27. For similar reasons, if Plaintiff were to prevail here, any relief should be appropriately limited.

Fifth Circuit has emphasized, the "federal courts long have recognized that the principle of comity requires federal district courts—courts of coordinate jurisdiction and equal rank—to exercise care to avoid interference with each other's affairs." *Id*. (citation omitted). "The concern manifestly is to avoid the waste of duplication, to avoid rulings which may trench upon the authority of sister courts, and to avoid piecemeal resolution of issues that call for a uniform result." *Id*. "This concern applies where related cases are pending between two judges in the same district . . . as well as where related cases have been filed in different districts." *Id*.

Under the first-to-file rule, when a subsequent suit raises issues that are "substantially similar" to those raised by an earlier one, the second suit may be "dismissed, stayed, or transferred and consolidated" with the first. *Sutter Corp.*, 125 F.3d at 920. As a procedural matter, the "Fifth Circuit adheres to the general rule that the court in which an action is first filed is the appropriate court to determine whether subsequently filed cases involving substantially similar issues should proceed." *Save Power*, 121 F.3d at 950. Thus, "[o]nce the *likelihood* of substantial overlap between the two suits ha[s] been demonstrated, it [i]s no longer up to the [second-filed court] to resolve the question of whether both should be allowed to proceed." *Mann*, 439 F.2d at 408 (emphasis added). Rather, "the ultimate determination of whether there *actually* [i]s a substantial overlap . . . belong[s] to the [first-filed court]," *id*., which "may decide whether the second suit filed must be dismissed, stayed, or transferred and consolidated," *Sutter Corp.*, 125 F.3d at 920.[7]

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[6] Defendants requested Plaintiff's position on this motion via email on May 5. Plaintiff did not respond. Instead, on May 11, Plaintiff moved for expedition of this case, stating in its brief that it does not believe that transfer was appropriate.

[7] Earlier Fifth Circuit cases suggest that the second-filed court also has the discretion, in appropriate circumstances, to dismiss or stay the second-filed action. *See, e.g.*, *West Gulf*, 751 F.2d at 729 & n.1 (while "a district court may dismiss an action where the issues presented can be resolved in an earlier-filed action pending in another district court," in "addition to outright

Thus, a "second-filed court plays a limited role when presented with a motion to transfer or stay based on the first-to-file rule." *Platt v. Nash*, No. 16-294, 2016 WL 6037856, at *1 (E.D. Tex. Oct. 14, 2016). That role is to decide whether the movant has shown a "*likelihood* of substantial overlap" between the two suits. *Mann*, 439 F.2d at 408 (emphasis added); *accord Cadle Co. v. Whataburger of Alice, Inc.*, 174 F.3d 599, 606 (5th Cir. 1999) (second-filed court should determine only whether "the issues *might* substantially overlap") (emphasis added). If the movant makes this showing, then "the second-filed court allows the first-filed court to 'resolve the question of whether both [cases] should be allowed to proceed.'" *Platt*, 2016 WL 6037856, at *1 (citation omitted). The factors relevant to the substantial overlap inquiry "include whether 'the core issue' in each case is the same and whether 'much of the proof adduced . . . would likely be identical.'" *Marshall v. Chevron U.S.A. Inc.*, No. MO:19-cv-00273-DC-RCG, 2020 WL 9813023, at *2 (W.D. Tex. Dec. 10, 2020), *report and recommendation adopted*, No. MO:19-cv-273-DC, 2021 WL 2181148 (W.D. Tex. Jan. 6, 2021) (citation omitted).

This case has a "likelihood of substantial overlap" with the *Association of Air Medical Services* case already pending in the U.S. District Court for the District of Columbia. *Mann*, 439 F.2d at 408. As noted, Plaintiff here is business partners with Air Methods, which is a member of the Association of Air Medical Services, the plaintiff in the District of Columbia action, and Air Methods holds (at a minimum) a substantial financial interest in the billing for air medical services

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dismissal, it sometimes may be appropriate to transfer the action or to stay it"); *id*. at 730 ("Our holding and discussion in *Mann* make plain that in this [second-filed] case the district court should have stayed, dismissed, or transferred [the plaintiff's] action."). Although those cases do not appear to have been overturned, later Fifth Circuit cases indicate that "once the [second-filed] court f[i]nd[s] that the issues might substantially overlap, the proper course of action [i]s for the court to transfer the case to the [first-filed] court to determine which case should, in the interests of sound judicial administration and economy, proceed." *Cadle Co. v. Whataburger of Alice, Inc*., 174 F.3d 599, 606 (5th Cir. 1999).

performed under the Air Methods-LifeNet partnership. *See supra* at 6-7. Plaintiff's claims are substantially similar to those raised in *Association of Air Medical Services*, and unlike in *Texas Medical Association*, the claims specifically relate to the regulation governing air ambulance services. *See supra* at 8. And this suit was filed just a month after a hearing on the merits in *Association of Air Medical Services*. *See supra* at 8. The Association of Air Medical Services represents 93% of air ambulance providers, and complying with inconsistent judgments in that case (which could impact 93% of the industry) and this one (impacting a single plaintiff) could be particularly burdensome on both the air ambulance and health insurance industries. If ever there were a need "to avoid the waste of duplication" and "to avoid rulings which may trench on the authority of other courts," *Save Power*, 121 F.3d at 950, it is here.

That the parties here are not formally identical to those in *Association of Air Medical Services* is no barrier to transfer. Under the first-to-file rule, "[c]omplete identity of parties is not required for dismissal or transfer of a case filed subsequently to a substantially related action." *Id.* at 951. The Fifth Circuit has explained that an "incomplete identity of parties does not mandate that two 'essentially identical' actions remain pending simultaneously where," as here, any "missing parties probably could be made parties" to the first-filed case. *Id*. (citing *West Gulf*, 751 F.2d at 731 n.5). Further, the Fifth Circuit has repeatedly noted that the first-to-file rule may be applied to "dismiss[] a second-filed action without prejudice even though it involved different plaintiffs than the first-filed action." *Id*. (citation omitted); *accord West Gulf*, 751 F.2d at 731 n.5.

The Seventh Circuit's decision in *National Health Federation v. Weinberger*, 518 F.2d 711 (7th Cir. 1975)—which the Fifth Circuit cited with approval in *Save Power* and *West Gulf*—is instructive. There, much like here, after one organization challenged a pair of regulations in the Southern District of New York, another organization challenged the same regulations in the

Northern District of Illinois. *Id*. at 712. The Seventh Circuit held that the district court should have dismissed the second-filed suit because the two cases raised the same issues—an outcome that was "particularly appropriate" given that the first-filed suit was at a more "advanced stage" and involved review of a "voluminous" administrative record. *Id*. at 712-13 & n.2. That the plaintiffs in the second-filed case differed from those in the first worked no inequity, the court explained, since the "dismissal would operate without prejudice." *Id*. at 713-14. Moreover, observing that "counsel for plaintiffs, prior to filing the [second] suit here, were aware of the [first-filed] suit" in the Southern District of New York, and "could have . . . as easily brought" their claims "in that district, which might then have led to a consolidation of the suits," the court suggested that "the filing of the [second] complaint here smacks of gamesmanship." *Id*. at 714.

Such concerns are even more pronounced in this case, given that Plaintiff here, as a business partner of a member of the Association of Air Medical Services, would presumably argue that it should benefit from a judgment in *Association of Air Medical Services* in its favor, *see* Compl. ¶ 20, *Ass'n of Air Med. Servs.* (invoking the interests of Association of Air Medical Services members, who make up "93% of air ambulance providers in the United States" and who represent "every emergency air ambulance care model"), a prospect that would pose a particularly acute risk of inconsistent judgments were this suit, concerning identical issues, to proceed in a separate forum. *Cf. West Gulf*, 731 F.2d at 731 n.5 (noting that the "local union defendants are in privity with the ILA and working in concert with the ILA and could be bound by any injunction the [first-filed] court . . . might issue"). Indeed, while the first-to-file rule does not require analysis of the potential res judicata effect of an earlier suit on a later one, *see Cadle*, 174 F.3d at 603-05, it is well established that a final judgment in a suit brought by an organization on behalf of its members can bind the members. *See, e.g.*, *Tahoe-Sierra Pres. Council, Inc. v. Tahoe Reg'l*

Planning Agency, 322 F.3d 1064, 1083-84 (9th Cir. 2003) (plaintiffs' "membership in and close relationship with the Association is sufficient to bind them as parties in privity for res judicata purposes"). Given that a judgment in the *Association of Air Medical Services* suit could potentially bind up to 93% of the air ambulance service providers, the practical effects of navigating inconsistent judgments could be particularly burdensome for all involved.

Regardless, even if the potential res judicata effect of a judgment in *Association of Air Medical Services* were less clear, an in-depth analysis of this issue goes well beyond the "limited role" that the "second-filed court plays . . . when presented with a motion to transfer or stay based on the first-to-file rule." *Platt*, 2016 WL 6037856, at *1. Here, given the similarity of parties and claims, there is at least a "*likelihood* of substantial overlap" between this case and *Association of Air Medical Services*, *Mann*, 439 F.2d at 408 (emphasis added), and this Court need go no further to resolve this motion.

CONCLUSION

For the foregoing reasons, the Court should transfer this case to the U.S. District Court for the District of Columbia so that that court may determine whether it should be consolidated with *Association of Air Medical Services*.

Dated: May 12, 2022

Respectfully submitted,

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Counsel for Defendants

CERTIFICATE OF CONFERENCE

I hereby certify that counsel for the Defendants has complied with the meet and confer requirements of Local Rule CV-7. On May 5, 2022, counsel for the Defendants emailed counsel for the Plaintiff to state that the Defendants intended to file this motion to transfer, and asked counsel for the Plaintiff to state their position with respect to a transfer. Counsel for the Plaintiff did not respond to that email, but instead filed a motion for expedited summary judgment briefing which states the Plaintiff's opposition to a transfer.

/s/ Anna Deffebach
ANNA DEFFEBACH

CERTIFICATE OF SERVICE

I hereby certify on this 12th day of May, 2022, a true and correct copy of this document was served electronically by the Court's CM/ECF system to all counsel of record.

/s/ Anna Deffebach
ANNA DFFFEBACH

EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION OF AIR MEDICAL SERVICES,
909 N. Washington Street, Suite 410
Alexandria, VA 22314,

Plaintiff,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES,
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LAURIE BODENHEIMER, in her official capacity as Associate Director, Healthcare and Insurance, in the U.S. Office of Personnel Management,
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Civil. No. 1:21-cv-3031

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Washington, DC 20224,

CHARLES RETTIG, in his official capacity as Commissioner of the Internal Revenue Service,
1111 Constitution Avenue NW,
Washington, DC 20224,

and

DOUGLAS W. O'DONNELL, in his official capacity as Deputy Commissioner for Services and Enforcement in the Internal Revenue Service,
1111 Constitution Avenue NW
Washington, DC, 20224,

Defendants.

COMPLAINT

Plaintiff the Association of Air Medical Services (AAMS) brings this complaint against the U.S. Department of Health and Human Services; Xavier Becerra, in his official capacity as Secretary of Health and Human Services; the U.S. Office of Personnel Management; Kiran Ahuja, in her official capacity as Director of the U.S. Office of Personnel Management; Laurie Bodenheimer, in her official capacity as Associate Director, Healthcare and Insurance, in the U.S. Office of Personnel Management; the U.S. Department of Labor; Martin J. Walsh, in his official capacity as Secretary of Labor; the U.S. Employee Benefits Security Administration; Ali Khawar, in his official capacity as the Acting Assistant Secretary for the Employee Benefits Security Administration; the U.S. Department of the Treasury; Janet Yellen, in her official capacity as Secretary of the Treasury; Lily L. Batchelder, in her official capacity as Assistant Secretary of the Treasury (Tax Policy); the Internal Revenue Service; Charles Rettig, in his official capacity as Commissioner of the Internal Revenue Service; and Douglas W. O'Donnell, in his official capacity as Deputy Commissioner for Services and Enforcement in the Internal Revenue Service (collectively, Defendants), and alleges as follows:

INTRODUCTION

1. This is an action under the Administrative Procedure Act to set aside interim final rules (the Rules or IFRs) issued by the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, and the Office of Personnel Management (collectively, the Departments) to implement the No Surprises Act, Pub. L. No. 116-260, 134 Stat. 1182, div. BB, tit. I (2020). The Rules are inconsistent with the statute's text and purpose and impose through administrative fiat policies that Congress expressly considered and rejected.

2. Indeed, the Chairman and the Ranking Member of the House Ways and Means Committee recently described the Rules as reflecting "an approach that Congress did not enact in the final law" and "in a very concerning manner." *See, e.g.*, Exhibit 1 (Oct. 4, 2021 letter). More

than 150 additional members of Congress from both parties have similarly stated that the Departments' approach is "contrary to the statute" and could "narrow provider networks and jeopardize access to patient care" and "exacerbate existing health disparities and patient access issues in rural and urban underserved communities." Exhibit 2 (Nov. 5, 2021 letter).

3. The administrative overreach in the IFRs promises to impact one segment of the healthcare sector differently from all others: the air ambulance industry. The air ambulance industry fills a critical need in the American healthcare system because the faster a person who suffers a traumatic injury or other medical emergency reaches a hospital, the better the overall outcome.[1] Yet more than 85 million Americans—greater than one quarter of the Nation's population—live further than a one-hour drive from the nearest Level 1 or Level 2 trauma center.[2] For those Americans, lifesaving emergency medical care is not a guarantee. Nor is the situation improving. Nineteen rural hospitals closed in the United States in 2020, and more than 180 rural hospitals have closed since 2005—about a 10% decrease.[3] The sad reality is that access to hospitals is decreasing for most Americans living, visiting, or traveling through rural areas at great distances from trauma

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[1] Hannah Pham et al., *Faster On-Scene Times Associated with Decreased Mortality in Helicopter Emergency Medical Services (HEMS) Transported Trauma Patients*, 2 Trauma Surgery & Acute Care Open 1, 4 (2017) ("It is imperative that trauma victims receive care as soon as possible, whether it be prehospital or definitive care. From our observations, we have identified that faster time of arrival on-scene and departure from scene are directly related to decreased mortality."); Patrick Schoettker et al., *Reduction of Time to Definitive Care in Trauma Patients: Effectiveness of a New Checklist System*, 34 Injury 187, 187 (2003) ("[P]rolonged time to definitive care has been identified as an issue preventing optimal care of injured patients. Early transfer of severely injured patients to a major trauma centre has been shown to be associated with better survival.").

[2] Am. Med. Ass'n, *Air Ambulance Regulations and Payments* (2018), perma.cc/2WR8-D747.

[3] *Rural Hospital Closures*, Cecil G. Sheps Ctr. for Health Servs. Rsch., (visited Nov. 15, 2021), perma.cc/LE9K-U3QX.

centers. If air ambulances stopped operating, many patients could not receive emergency or definitive care within the time required to ensure an optimal outcome.[4]

4. Air ambulances are on standby 24 hours a day, seven days a week, and they respond when they are called. They play no role in deciding which patients to transport. First responders (such as police and firefighters) and physicians (typically at community hospitals) decide when patients should be airlifted to a facility, and it is they who call air ambulances when necessary. Air ambulances respond to these time-sensitive emergency calls and carry out the transport so long as conditions are safe for air travel. And they do so without regard to a patient's ability to pay, insurance coverage, or insurance-network status.

5. While air ambulances are essential and life-saving tools, their use also comes at a cost. To provide these services, air ambulance providers must make substantial investments in aircraft, air bases, medical personnel, medical products and equipment, and regulatory compliance measures. These fixed costs are unavoidable and incurred regardless of whether an air ambulance completes zero transports in a day or several of them. Because air ambulances are typically responding on-demand to unplanned medical emergencies, they cannot schedule or predict the timing of specific transports. For similar reasons, it can be challenging for an air ambulance provider to reliably project its future volume of transports over time.

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[4] David Michaels, et al., *Helicopter Versus Ground Ambulance: Review of National Database for Outcomes in Survival in Transferred Trauma Patients in the USA*, 4 Trauma Surgery and Acute Care Open 1, 3 (2019) ("After adjusted analysis, we found that helicopter use is associated with decreased mortality in trauma patients. The higher level of care provided by helicopter medical personnel and the faster on-scene arrival of air transport is still associated with better outcomes compared with ground transportation."); Pham, *supra*, at 3 ("The faster the [helicopter EMS] is able to reach the scene, the faster critically injured patients will receive medical care. It is evident that trauma is time sensitive, especially in its earliest moments, and [helicopter EMS] provides a faster method of reaching and caring for severely injured patients.").

6. These unique characteristics of air ambulance operations deter group health plans and issuers from entering into network contracts with independent air ambulance providers, notwithstanding the providers' best efforts to negotiate such contracts. Under ordinary circumstances, group health plans and issuers steer increased patient volume to "in-network" providers in exchange for the network providers accepting discounted rates. But this network contracting model is a poor fit for the air ambulance industry; air ambulance providers deliver emergency transports on call, and they cannot pick and choose their patients. Group health plans and issuers, in turn, have no ability to steer increased patient volumes in return for discounts. Despite air ambulance providers' good-faith attempts to negotiate network contracts with group health plans and issuers, payers often refuse to offer rates sufficient to offset the significant fixed costs of air ambulance operations. As a result, air ambulance companies are often forced to stay "out of network." And out-of-network air ambulance providers must then negotiate billing arrangements with issuers on a case-by-case basis.

7. This case concerns the No Surprises Act, through which Congress sought to restructure this inefficient process that effectively placed patients in the middle of payment disputes between health plans or issuers and air ambulance providers. Prior to the Act, when a plan or issuer failed to negotiate or adequately reimburse a provider, the patient would receive a bill for the unpaid balance of the invoice not covered by her insurance—a so-called balance bill.

8. Through the Act, Congress required plans and issuers to come to the negotiating table with air ambulance providers to reach a fair and reasonable rate for these critical services. Barring that, Congress provided that the dispute would be resolved through an efficient independent dispute resolution (IDR) process in which an independent entity would consider the information enumerated in the statute and then select the appropriate rate from one of the offers submitted by the parties. Through this design, Congress strongly incentivized providers and payers to resolve disputes amongst themselves or to submit the most reasonable offer.

9. Congress's design, however, was swiftly undone by the Departments through the IFRs. In July 2021, the Departments issued Interim Final Rule Part I without notice and comment. *Requirements Related to Surprise Billing; Part I*, 86 Fed. Reg. 36,872 (July 13, 2021) (attached as Exhibit 3). In October 2021, they followed up with Interim Final Rule Part II, again without notice and comment. *Requirements Related to Surprise Billing; Part II*, 86 Fed. Reg. 55,980 (Oct. 7, 2021) (attached as Exhibit 4). Critical elements of the IFRs diverge wildly from the structure Congress created with the Act and must be vacated in part.

10. *First*, IFR Part II deems the "qualifying payment amount" (QPA) (which is determined by plans and issuers) presumptively dispositive of the payment dispute and *requires* the IDR entity to select the offer that is closest to that amount. 86 Fed. Reg. at 56,104. It does so notwithstanding the statute's enumerated list of circumstances that the IDR entity "shall consider," only one of which is the QPA. Public Health Service Act (PHSA) § 2799A-2(b)(5)(C). To overcome the IFR's presumption, a provider must offer information that "clearly demonstrates" that the QPA is "materially different" from the "appropriate out-of-network rate." 86 Fed. Reg. at 55,984. In this way, the Departments have adopted an IDR process that is not actually "independent" and flouts the process that Congress enacted; indeed, it is not a meaningful dispute resolution process at all.

11. The Departments are transparent on that point too, explaining that they wanted to "allow for predictability" and "certainty" by "encourag[ing] plans, issuers, providers, and facilities to make offers that are closer to the QPA" and to "avoid the Federal IDR process altogether." 86 Fed. Reg. at 56,061. But an IDR process rigged simply to reaffirm the QPA is neither an independent process nor faithful to Congress's directive to consider multiple enumerated factors in making a decision.

12. *Second*, Part I compounds this error by intentionally depressing the QPA for air ambulance services in a manner contrary to the statutory language and wholly divorced from

market realities. Under the statute, the QPA is supposed to reflect the median of the "contracted rates recognized by the plan" offering the "same or similar" service provided by a provider in the "same or similar specialty" and "geographic region." PHSA § 2799A-1(a)(3)(E)(i)(I). IFR Part I defies this language in three interrelated ways: (1) it excludes most categories of agreed-upon payments between air ambulance providers and health plans; (2) it fails to distinguish between hospital-based air ambulance services and independent air ambulance services; and (3) it relies on overbroad geographic regions.

13. First, while IFR Part I defines a "contracted rate" as the amount "a group health plan has contractually agreed to pay," it specifies arbitrarily that a contract between an air ambulance provider and a plan "for a specific participant . . . does not constitute a contract." 86 Fed. Reg. at 36,953. This exception conflicts with the statute, which reaches *all* "contracted rates," and it arbitrarily excludes from calculation of the QPA the single-case rates for air ambulance services that are actually negotiated "under such plans or coverage." PHSA § 2799A-1(a)(3)(E)(i)(I).

14. Excluding single-case agreements and other types of historical payments results in intentional QPA deflation. Single-case rates are, by definition, contracted rates. The single case rate represents what the group health plan or issuer actually will pay and the provider will accept. The circumstances under which they are negotiated make them a market rate, particularly given the limited history of network contracting in the air ambulance industry.

15. Second, IFR Part I fails to distinguish between hospital-based air ambulance providers and independent air ambulance providers for purposes of calculating the QPA. Eliminating single-case agreements and treating these different providers the same will further deflate the QPA. That is because hospital-based air ambulance providers' rates comprise a larger number of the contracted rates in the QPA analysis. In-network agreements with payers are, in general, reached more often for hospital-based air ambulance providers because the hospitals enter into global agreements for all of their service lines (including air ambulance) which can cross-subsidize the

cost of the air ambulance services. Hospitals can also negotiate volume discounts across the full suite of hospital services that independent air ambulance providers simply do not offer. Indeed, sometimes the negotiated in-network rates are altogether illusory, negotiated by hospitals that do not even conduct air ambulance transports. In-network rates negotiated for hospital-based air ambulance services, such as they are, therefore do not cover "similar" specialty services (*id.*) or reflect market conditions for independent air ambulance providers. The Departments accounted for this distinction for other types of providers, for example, by treating hospital-based and freestanding emergency departments separately. 86 Fed. Reg. at 36,892. But when it came to the air ambulance industry, the Departments arbitrarily chose to depress air ambulances' QPAs by treating all providers the same.

16. Third, the Departments exacerbated these distortions by arbitrarily defining "geographic region" to mean Census-defined metropolitan statistical areas (which are derived without any consideration of the factors that actually affect air ambulance services or pricing), extending the relevant geographic regions for determining region-specific QPAs by hundreds of miles, far beyond what common sense and experience support.

17. The Departments' arbitrary approach to defining the QPA reflects an arbitrary, counter-textual decision to depress the QPA for air ambulance services, in contravention of the regime that Congress adopted. Indeed, the Departments readily concede in IFR Part I that they have purposefully adopted standards designed to deflate the QPA below actual "contracted rates recognized by the plan or issuer" for air ambulance services reimbursed "under such plans or coverage" (PHSA § 2799A-1(a)(3)(E)(i)(I)). *See* 86 Fed. Reg. at 36,891. That approach is inconsistent with both the statutory text and purpose, and if not vacated, will diminish the availability of air ambulance services, with devastating consequences for individuals in need of those services.

18. In sum, the Departments tasked with implementing the Act have turned the statutory text on its head. They adopted a policy that was rejected by Congress in the Act itself to

administratively deflate the amount an out-of-network provider can hope to get from a group health plan or issuer by excluding ubiquitous types of "contracted rates" from consideration in the QPA. And they have dictated the outcome of the IDR process by making the QPA presumptively dispositive, forcing the provider to take that purposefully deflated rate. In so doing, the Departments have gutted the IDR process that Congress created and jeopardized the ongoing viability of air ambulance providers generally. Without adequate payments to cover their fixed costs, air ambulance providers will be driven out of the market. These harms are imminently approaching, with the IFRs' requirements set to apply to plan years beginning January 1, 2022.

19. Congress did not intend to cripple the air ambulance industry like this. The Act was supposed to remove patients from the payment disputes between group health plans or issuers and providers and to give both sides the necessary tools to reach prompt and reasonable resolutions of those disputes. The IFRs twist Congress's balanced design into an indefensibly one-sided scheme that disfavors air ambulance providers. They are arbitrary and contrary to law and should be swiftly set aside in part.

PARTIES

20. Plaintiff the Association of Air Medical Services is the international trade association that represents over 93% of air ambulance providers in the United States. Together, AAMS's 300 members operate more than 1,000 helicopter air ambulances and 200 fixed wing air ambulance services across the United States. AAMS represents every emergency air ambulance care model, including hospital-based aircraft, independent aircraft at bases in rural areas far from hospitals, and many hybrid variations. AAMS represents and advocates on behalf of its members in a variety of forums. As part of that mission, AAMS brings litigation, including the instant action, on behalf of its members to challenge government action that will harm them.

21. Defendant U.S. Department of Health and Human Services is the federal department charged with substantial responsibility for public health.

22. Defendant Xavier Becerra is the Secretary of Health and Human Services. The Secretary of Health and Human Services is the official charged by law with administering the Public Health Service Act. He is sued in his official capacity only.

23. Defendant U.S. Office of Personnel Management is the federal agency charged with administering the Federal Employees Health Benefit Program.

24. Defendant Kiran Ahuja is the Director of the U.S. Office of Personnel Management. She is sued in her official capacity only.

25. Defendant Laurie Bodenheimer is the Associate Director, Healthcare and Insurance, in the Office of Personnel Management. She is sued in her official capacity only.

26. Defendant U.S. Department of Labor is the federal department with substantial responsibility for labor issues.

27. Defendant Martin J. Walsh is the Secretary of Labor. The Secretary of Labor is an official charged by law with administering the Employee Retirement Income Security Act of 1974 (ERISA). He is sued in his official capacity only.

28. Defendant U.S. Employee Benefits Security Administration (EBSA) is an agency within the U.S. Department of Labor. The EBSA has delegated authority for administering ERISA.

29. Defendant Ali Khawar is the Acting Assistant Secretary for the Employee Benefits Security Administration. He is sued in his official capacity only.

30. Defendant U.S. Department of the Treasury is the federal department with substantial responsibility for managing federal finances and for enforcing finance and tax laws.

31. Defendant Janet Yellen is the Secretary of the Treasury. The Secretary of the Treasury is the official charged by law with administering the Internal Revenue Code. She is sued in her official capacity only.

32. Defendant Lily L. Batchelder is Assistant Secretary of the Treasury (Tax Policy). She is sued in her official capacity only.

33. Defendant Internal Revenue Service (IRS) is a federal agency within the Department of the Treasury. The IRS has delegated authority for administering the Internal Revenue Code.

34. Defendant Charles Rettig is the Commissioner of the Internal Revenue Service. He is sued in his official capacity only.

35. Defendant Douglas W. O'Donnell is the Deputy Commissioner for Services and Enforcement in the Internal Revenue Service. He is sued in his official capacity only.

JURISDICTION AND VENUE

36. AAMS brings this suit under the Administrative Procedure Act, 5 U.S.C. §§ 551 *et seq.*, and the Declaratory Judgment Act, 28 U.S.C. § 2201.

37. The court's jurisdiction is invoked under 28 U.S.C. § 1331.

38. Venue is proper in this district under 28 U.S.C. § 1391(e) because at least one defendant resides in this district and a substantial part of the events or omissions giving rise to the claim occurred in this district.

FACTUAL ALLEGATIONS

A. The air ambulance industry

39. The air ambulance industry is an integral part of the emergency medical system. Air medical services are often the only lifeline that critically ill and injured patients have to definitive care, especially in rural areas.

40. Traumas, stroke, heart attacks, burns, and high-risk neonatal or pediatric cases account for 90 percent of all helicopter air ambulance transports. Without helicopter air ambulances, more than 85 million Americans would not be able to reach a Level 1 or 2 trauma center within an hour when these emergent circumstances arise.

41. Air ambulance providers play no role in determining whether or when to transport a patient. Instead, first responders, like local police and fire departments, or treating physicians, decide when a patient needs to be transported.

42. Air ambulance providers do not question a first responder's or physician's request for services; indeed, in many states, emergency medical services providers have a duty to respond imposed as a condition of licensure. Thus, air ambulance providers determine only whether aviation conditions are safe to fly the patient.

43. At the outset, air ambulance providers are never aware of a patient's ability to pay or their health insurance status. Instead, the goal is to efficiently provide the highest quality of transport safety and patient care and to respond to transport requests within minutes.

44. Air ambulance providers operate under an incredibly complex regulatory regime, with regulatory obligations flowing from numerous federal and state authorities. Air ambulances typically must maintain an air carrier certificate from the Federal Aviation Administration (FAA) to conduct on-demand operations under 14 C.F.R. Part 135 (called a Part 135 certificate), maintain a state-issued ambulance license, and meet the conditions of participation for Medicare, Medicaid, and other federal and state healthcare programs. The Part 135 certificate authorizes the air ambulance to engage in air transportation, while the state ambulance license is necessary for providing medical ambulance operations and billing for the services rendered.

45. The overlap between federal and state regulatory authority is important because more than 33% of helicopter air ambulance flights will cross a state border and nearly all cross a county or municipal boundary. Nearly all fixed-wing air ambulances cross state borders. Seamless interstate delivery of services is possible in part because the Airline Deregulation Act preempts many state laws relating to air carriers. *See* 49 U.S.C. § 41713(b).

46. The delivery of on-demand, heavily regulated, life-saving air ambulance services in emergencies requires substantial investments in specialized aircraft, air bases, technology, personnel, and regulatory compliance systems. For example, to maintain a 24-hour on-demand service, an air ambulance provider would need to have on staff at least 4 pilots, 4 nurses, 4 paramedics, and a mechanic. These costs remain the same regardless of how many transports a provider makes. Variable costs—like fuel and consumed medical supplies—are an important but relatively small proportion of a provider's costs.

47. Though an air ambulance provider's costs are mostly fixed, the volume of emergent and unplanned transports, particularly in rural areas, can vary greatly across both geography and time for reasons outside the air ambulance provider's control. A rural community without a hospital may only need a helicopter air ambulance on an infrequent basis, but, when the need arises, it is most often critical. And it is increasingly critical given that 138 rural hospitals have closed since 2010. *Rural Hospital Closures*, Cecil G. Sheps Ctr. for Health Servs. Rsch. (visited Nov. 15, 2021), perma.cc/LE9K-U3QX.

48. Because of the emergent and unplanned need for services, transport volume can be unpredictable. Regardless, issuers or group health plans cannot steer patients toward particular air ambulance providers in exchange for discounted rates like they can by putting a particular physician or hospital in their network to encourage patients to choose those providers. These structural features of air ambulance operations provide a natural disincentive for issuers and group health plans to contract with air ambulance providers.

49. The structure of air ambulance providers also affect their ability to procure network contracts. Air ambulance services are not typically offered as a public service, like police and fire department services are. Some air ambulances are operated by a hospital or a community organization or split between two or more such entities. But most air ambulances are operated by

standalone operators that hold both federal and state authorizations and are not affiliated with a single hospital or community organization.

50. These differences in structure have naturally driven how air ambulance providers negotiate rates for services. For example, entities that bill through a hospital system commonly enter into a network agreement with an issuer based on a much broader universe of hospital-based services that the hospital system offers and can take into account the universe of hospital services when negotiating payment. A negotiating hospital is not likely to focus on a discrete and comparatively small service line like air ambulance when negotiating a global agreement; indeed, they sometimes agree to an air ambulance rate even when they do not offer the service. As a result, air ambulance transport rates in hospital contracts are often far lower than the true cost of providing care in the area. Hospital-contract rates are thus a factually insupportable comparator for rates that independent air ambulance service providers could agree to.

51. Group health plans have, at various times, offered to bring air ambulance providers in-network by offering to pay at rates equal to Medicare rates. But Medicare rates are often significantly below the cost of providing air ambulance services. Xcenda, *Air Medical Services Cost Study Report* 15 (Mar. 24, 2017), perma.cc/H4M3-W93D; *see also* Gov't Accountability Off., *Air Ambulance: Data Collection and Transparency Needed to Enhance DOT Oversight* 13-14, 16-18 (July 2017), perma.cc/3XGW-JNGA. An air ambulance provider that was paid only on Medicare rates could not generate sufficient revenue to cover its costs. Indeed, in areas with a high percentage of Medicare and Medicaid patients, air ambulance bases have been forced to close.

B. The No Surprises Act

52. The disincentives for group health plans and issuers to bring air ambulance providers in network have historically placed patients and air ambulance providers in an untenable situation. Patients needed the emergency air ambulance transport, and air ambulance providers had a duty to provide it as safely and efficiently as possible without regard to the patient's ability to

pay. Those same features of the air ambulance industry made it exceedingly difficult for air ambulance providers (especially independent ones) to procure network contracts that would enable them to cover their high fixed costs and meet all federal and state regulatory requirements.

53. By keeping air ambulance service providers out of network, group health plans and issuers left patients with the responsibility to pay out-of-pocket substantial portions of the bill for critical air ambulance services. If the patient could not afford the bill, the burden of covering the cost would fall on the air ambulance provider, jeopardizing its ability to recoup sufficient revenue to cover its costs and maintain its ongoing operations.

54. Patients also found themselves in the middle of payment disputes. It was common for a group health plan or issuer to send a below-cost payment for the air ambulance services to the patient and then instruct the provider to bill the patient. That practice put the patient in the position of conducting a three-way arbitration of the payment amount.

55. Congress sought to address the problem of placing patients in the middle of what is, at bottom, a payment dispute between the patient's group health plan or issuer and the provider.

56. On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260 into law. The No Surprises Act (or the Act) was enacted as Title I to Division BB of the Consolidated Appropriations Act, 2021.

57. The Act generally obligates group health plans and issuers to apply the same cost-sharing levels to out-of-network and in-network emergency services, prevents emergency service providers from holding a patient liable for the balance of a bill, and provides an independent dispute resolution process for group health plans and issuers and out-of-network providers to reach a fair payment amount.

58. Given the unique nature of air ambulance services, Congress addressed such services on their own, separate from all other services. Section 105 of the Act includes provisions specific to air ambulance services. It includes the same provisions three times over—by amending

the Public Health Service Act, the Employee Retirement Income Security Act (ERISA) of 1974, and the Internal Revenue Code—so that it reaches commercially insured patients whether enrolled in private sector group health plans or health insurance coverage. It also amended the Federal Employees Health Benefit (FEHB) Program Act to require carriers offering FEHB plans and providers serving FEHB-insured patients to comply with the substantive obligations of the Act with respect to FEHB plans.[5]

59. The Act is designed to establish parity between in-network and out-of-network providers from the patient's perspective. It thus provides that when a participant enrolled in a relevant group health plan or insurance product "receives air ambulance services from a nonparticipating provider" and "if such services would be covered if provided by a participating provider," then:

> (1) the cost-sharing requirement shall be the same for the nonparticipating provider as for a participating provider, and any coinsurance or deductible shall be based on rates applicable to a participating provider;
>
> (2) any cost-sharing amounts will be counted towards the in-network deductible and in-network out-of-pocket maximum in the same way as if it were furnished by a participating provider; and
>
> (3) the plan or issuer shall (A) send an initial payment or notice of denial of payment to the provider within 30 calendar days after the provider transmits its bill and (B) pay a total plan payment to the provider equal to the determined out-of-network rate less the amount of any patient cost-sharing or any initial payment to the provider.

See PHSA § 2799A-2(a).

[5] For ease, we cite to the provisions amending the Public Health Service Act only, by citing to the PHSA itself. The provisions enacted into ERISA and the Internal Revenue Code are the same in all material respects.

60. The Act then establishes a two-stage process for resolving disputes about the applicable out-of-network rate for an air ambulance provider. The parties first engage in open negotiations and, if negotiations fail, they enter the IDR process to have a neutral party independently determine the amount owed.

61. First, there are private negotiations between the provider and the group health plan or issuer. Within 30 days after the provider receives an initial payment or notice of denial of payment, the provider or group health plan or issuer may "initiate open negotiations . . . for purposes of determining, during the open negotiation period, an amount agreed on by such provider, and such plan or coverage for payment (including any cost-sharing) for such service." The open-negotiation period lasts for 30 days following the date of initiation of open negotiations. PHSA § 2799A-2(b)(1)(A).

62. Second, if no payment determination is reached by the close of the open-negotiation period, the parties can proceed through the IDR process wherein a neutral party will decide the amount owed. Either the provider or the group health plan or issuer may "initiate the independent dispute resolution process" within the four days following the close of the open-negotiations period by submitting a notification to the other party and to the relevant Secretary. PHSA § 2799A-2(b)(1)(B).

63. The parties must then agree to use a particular certified IDR entity within three business days or the Secretary will select one. PHSA §§ 2799A-2(b)(4)(B), 2799A-1(c)(4)(F).

64. The statute then provides for a "final offer" or "baseball-style" determination of the payment amount. That is, within 10 days after selection of the IDR entity, each party must "submit to the certified IDR entity" "an offer for a payment amount for such services furnished by such provider" along with any information requested by the IDR entity and any information relating to the offer the party wants to submit. PHSA § 2799A-2(b)(5)(B).

65. The IDR entity must then, within 30 days following its appointment, "select one of the offers submitted" by the parties to be the payment amount for the services. PHSA § 2799A-2(b)(5)(A).

66. The statute describes in detail what the IDR entity must consider in determining the payment amount. *See* PHSA § 2799A-2(b)(5)(C). It does not state or imply that any particular factor is the primary or presumptive factor. Instead, it provides that the IDR entity "*shall consider*" "the qualifying payment amounts" for the applicable year for "comparable" services "in the same geographic region" *and* "information on any [additional] circumstance" listed in the statute or requested by the IDR entity. *See id.* § 2799A-2(b)(5)(C)(i)(I), (II) (emphasis added).

67. The statute enumerates the relevant additional circumstances, in addition to the QPA and information the IDR entity requests, that it "shall consider." Those include:

> (I) The quality and outcomes measurements of the provider that furnished such services.
>
> (II) The acuity of the individual receiving such services or the complexity of furnishing such services to such individual.
>
> (III) The training, experience, and quality of the medical personnel that furnished such services.
>
> (IV) Ambulance vehicle type, including the clinical capability level of such vehicle.
>
> (V) Population density of the pick up location (such as urban, suburban, rural, or frontier).
>
> (VI) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider and the plan or issuer, as applicable, during the previous 4 plan years.

PHSA § 2799A-2(b)(5)(C)(ii).

68. The "qualifying payment amount" is also defined in the statute. PHSA § 2799A-2(c)(2) (incorporating PHSA § 2799A-1(a)(3)). It is generally the "median of the contracted rates

recognized by the plan or issuer" "for the same or a similar item or service" as of January 31, 2019, that are offered in the same insurance market (i.e., the individual market, large group market, small group market, or self-insured group health plan market) and in the same geographic region, increased by the consumer price index. *Id.* § 2799A-1(a)(3)(E)(i).

69. The statute further directs the Secretaries to determine "the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas" and that they may "take into account . . . quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities." PHSA § 2799A-1(a)(2)(B).

70. When the group health plan or issuer lacks sufficient information to determine a median contracted rate, the statute authorizes the plan or issuer to determine the QPA through resort to information from a third-party database (*e.g.*, FAIR Health). PHSA § 2799A-1(a)(3)(E)(iii).

71. The statute prohibits the IDR entity from considering certain specific factors—the usual and customary charges of the provider, the amount that the provider would have billed the patient absent the ban on balance billing, or the reimbursement rate that would be paid under governmental health programs. PHSA § 2799A-2(b)(5)(C)(iii).

72. Aside from the prohibition on considering certain factors, the No Surprises Act does not deem any other circumstances presumptively reasonable or owed more weight. Instead, the IDR entity is required to consider them all. This was purposeful. Congress specifically considered and rejected a proposal that would have mandated that payment be "the recognized amount," i.e., an amount set by state law or the median contracted rate. *See* Ban Surprise Bill Act, H.R. 5800, 116th Cong. § 2(a) (2020) (proposing new PHSA § 2719A(f)).

73. Instead, under the No Surprises Act, after considering the QPA, the additional circumstances, and any requested information, the IDR entity then selects one of the party's offers to be the rate for the service.

74. The statute requires the group health plan or issuer to pay the amount owed to the provider (less any cost-sharing or initial payment amounts) not later than 30 days after the IDR entity makes its independent determination. PHSA § 2799A-2(b)(6).

75. To ensure that disputes over payment remain between the provider and the group health plan, the statute also bars air ambulance providers from billing a plan participant for more than the cost-sharing amount if she has air ambulance benefits. In other words, the statute prohibits "balance billing." The statute provides that, when a participant has air ambulance benefits under her plan, an air ambulance provider "shall not bill" the participant "for a payment amount for such service furnished by such provider that is more than the cost-sharing amount for such service." PHSA § 2799B-5.

76. To ensure the timely implementation of the Act, Congress directed the Secretaries of Health and Human Services, of the Treasury, and of Labor to engage in rulemaking by specified statutory deadlines.

(a.) By July 1, 2021, the Secretaries were to "establish through rulemaking" the "methodology" to "use to determine the qualifying payment amount"; the "information" the plan or issuer must "share with the nonparticipating provider … when making such a determination"; the "geographic regions . . . taking into account access to items and services in rural and underserved areas"; and "a process to receive complaints of violations." PHSA § 2799A-1(a)(2)(B). In setting "the geographic regions" the rulemaking is required to "tak[e] into account access to items and services in rural and underserved areas, including health professional shortage areas" (*id.* § 2799A-1(a)(2)(B)(iii)) and may "take into account quality or facility type

(including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities" (*id.* § 2799A-1(a)(2)(B)).

(b.) Within one year of enactment, i.e., December 27, 2021, the Secretaries were to "establish by regulation one independent dispute resolution process" under which "a certified IDR entity . . . determines . . . the amount of the payment under the plan or coverage" for qualified air ambulance services. *Id.* § 2799A-2(b)(2)(A).

C. The Interim Final Rules

77. To implement the Act, the Departments issued two interim final rules without a notice-and-comment period. But the voluminous IFRs are "interim" in name only. They could have been developed and issued only through a coordinated inter-agency process driven to conclusion by the Executive Office of the President and are thus plainly the consummation of the Departments' collective decision-making process. They create rights and impose obligations on air ambulance providers, group health plans, and issuers. While the Departments invited comment on certain aspects of the IFRs, they are not under any binding legal obligation to review and consider comments, much less issue final, superseding rules. Indeed, the Departments designed the IFRs to operate ad infinitum by enacting a QPA-calculation methodology that adjusts with the consumer price index (86 Fed. Reg. at 36,894) and a fee structure for IDR entities that the Departments will "review and update . . . annually" (86 Fed. Reg. at 56,005).

1. IFR Part I: Qualifying payment amount methodology

78. On July 13, 2021, the Departments issued the interim final rule entitled *Requirements Related to Surprise Billing; Part I*, 86 Fed. Reg. 36,872 (July 13, 2021). IFR Part I took effect on September 13, 2021, and is applicable to plan and policy years beginning on or after January 1, 2022. 86 Fed. Reg. at 36,872.

79. Among other things, IFR Part I generally addresses the calculation of the QPA pursuant to Congress's directive to issue regulations on methodology by July 1, 2021. *See* PHSA § 2799A-1(a)(2)(B).

80. In particular, IFR Part I purports to establish the methodology for calculating the QPA for air ambulance services.

81. In the preamble, the Departments posit that the "statutory intent" of the Act was to "ensur[e] that the QPA reflects market rates under typical contract negotiations." 86 Fed. Reg. at 36,889. But in practical effect, the IFR administratively deflates the QPA well below what market conditions actually produce.

82. IFR Part I defines the "same or similar item or service" as a service "billed under the same service code." 86 Fed. Reg. 36,954. For air ambulance services, there are generally two air mileage service codes—A0435 (fixed-wing) and A0436 (rotary-wing). *Id.* at 36,895, 36,955.

83. Though it defines a "provider in the same or similar specialty" generally as "the practice specialty of a provider, as identified by the plan consistent with the plan's usual business practice," it sets a completely different definition for air ambulance services: "with respect to air ambulance services, *all* providers of air ambulance services are considered to be a single provider specialty." 86 Fed. Reg. 36,954 (emphasis added).

84. It defines a "geographic region" "[f]or air ambulance services" as "one region consisting of all metropolitan statistical areas . . . in the State, and one region consisting of all other portions of the State, determined based on the point of pick-up." 86 Fed. Reg. at 36,954. When a plan does not have "sufficient information" to calculate the median contracted rate, then the geographic region becomes "one region consisting of all metropolitan statistical areas . . . in each Census division and one region consisting of all other portions of the Census division." *Id.*[6]

[6] There are only nine Census divisions: Pacific, Mountain, West North Central, East North Central, Middle Atlantic, New England, South Atlantic, East South Central, and West South Central.

85. The plan must then calculate the "median contracted rate" by "arranging in order from least to greatest the contracted rates of all group health plans of the plan sponsor (or the administering entity . . .) in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished and selecting the middle number." 86 Fed. Reg. at 36,954. For purposes of contracted rates, the health plan only looks at rates it has "contractually agreed to pay a . . . provider of air ambulance services for covered items or services," expressly excluding any "single case agreement, letter of agreement, or other similar arrangement . . . for a specific participant or beneficiary in unique circumstances" as "not constitu[ting] a contract." *Id.* at 36,953. The preamble to the rule does not justify this exclusion.

86. The plan then calculates the QPA by increasing the median contracted rate consistent with the consumer price index and then multiplying it by the number of "loaded miles," *i.e.*, the number of miles the individual is transported. 86 Fed. Reg. at 36,955.

87. If the plan lacks sufficient information to calculate a median contracted rate, then the plan may determine the QPA via third-party database. 86 Fed. Reg. at 36,895-36,897.

2. IFR Part II: IDR process

88. On October 7, 2021, the Departments issued the interim final rule entitled *Requirements Related to Surprise Billing; Part II*, 86 Fed. Reg. 55,980 (Oct. 7, 2021). IFR Part II took effect on October 7, 2021, and is, in general, applicable to plan, policy, or contract years beginning January 1, 2022, though a handful of requirements took effect immediately. 86 Fed. Reg. at 55,980.

See Census Regions and Divisions of the United States, Census.gov (last visited Oct. 29, 2021), https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf.

89. Among other things, IFR Part II generally addresses the IDR dispute resolution process pursuant to Congress's directive to issue a single set of regulations on the process within one year. *See* PHSA § 2799A-2(b)(2)(A).

90. IFR Part II flips the statutory IDR process on its head by giving the QPA nearly conclusive weight in an IDR entity's decision. Specifically, IFR Part II dictates that "[t]he certified IDR entity *must* select the offer closest to the qualifying payment amount" unless one of two circumstances occurs: "[1] the certified IDR entity determines that credible information submitted by either party under paragraph (c)(4)(i) *clearly demonstrates* that the qualifying payment amount is materially different from the appropriate out-of-network rate, or [2] if the offers are equally distant from the qualifying payment amount but in opposing directions." 86 Fed. Reg. at 56,104 (emphasis added). "In these cases, the certified IDR entity must select the offer as the out-of-network rate that the certified IDR entity determines best represents the value of the qualified IDR item or services, which could be either offer." *Id.*

91. To rebut the IFR-created presumption that the offer closest to the QPA should be the rate, IFR Part II requires the submission of additional information, including "information on the size of the provider's practice," "information on the practice specialty," "information on the coverage area of the plan, the relevant geographic region for purposes of the qualifying payment amount, whether the coverage is fully-insured or partially or fully self-insured," and "[t]he qualifying payment amount." 86 Fed. Reg. at 56,103.

92. IFR Part II then relegates the remaining factors Congress required the IDR entity to consider to afterthoughts, merely permitting submission of information concerning the "additional circumstances" that the statute expressly requires the IDR entity to consider in every case. IFR Part II

- lists the statutory factors—"the level of training, experience, and quality and outcomes measurements of the provider"; "[t]he acuity of the participant . . . or the

complexity of furnishing the qualified IDR item"; "[d]emonstration of good faith efforts (or lack thereof) made by the provider . . . or the plan to enter into network agreements with each other" (*see* PHSA § 2799A-2(b)(5)(C)(ii));

- adds two circumstances—"[t]he market share held by the provider . . . or that of the plan in the geographic region" and the "[t]he teaching status, case mix, and scope of services of the facility"; and
- allows for "[a]dditional information submitted by a party, provided the information is credible and relates to the offer submitted by either party and does not include information on factors" on which consideration is barred.

Id. at 56,104.

93. But IFR Part II limits consideration of these additional circumstances and information only for purposes of rebutting the IFR-created presumption of choosing the QPA and only if it satisfies a heightened credibility standard. *Id.*

THE INTERIM FINAL RULES ARE UNLAWFUL

94. The Interim Final Rules are contrary to law and arbitrary and capricious. The purpose of the Act was to protect patients from surprise medical bills from out-of-network providers by limiting their cost-sharing to in-network levels and removing patients from payment disputes between plans and providers.

95. Congress intended to facilitate negotiations between the provider and the group health plan or issuer to resolve payment disputes and, when that does not work, to allow an independent entity to decide the payment amount by selecting between each party's final offer. This structure forces providers and group health plans or issuers to reach reasonable and efficient outcomes through rational business and legal judgments that account for available information about market rates, out-of-network payments, operating costs, and the IDR entity.

96. The Act does not authorize the Departments to artificially deflate payment amounts

from group health plans or issuers to air ambulance service providers in a manner entirely out of step with the history and economics of the air ambulance industry. That, however, is what the Departments have done through the IFRs. And they have done so in ways that directly contravene the statute.

97. IFR Part II dictates the outcome of the IDR process by making a purposefully deflated QPA—calculated exclusively by the group health plan or issuer—the presumptively correct payment amount. IFR Part I ensures that the QPA for air ambulance is at an artificially low rate by excluding from consideration the case-specific or other agreed-upon rates actually negotiated for covered air ambulance services and refusing to distinguish between hospital-based and non-hospital-based providers. The rule also extends the relevant geographic region without justification to certain Census-defined levels. These choices and the presumption defy the statute and squarely conflict with the Act's goal of facilitating reasonable and efficient outcomes while protecting patients from being put in the middle.

A. IFR Part II is unlawful.

98. Through IFR Part II, the Departments effectively nullify the statutory IDR process that Congress envisioned, replacing it instead with nearly insurmountable deference to the QPA.

99. The Act provides for a "final offer" or "baseball style" determination of the payment amount by a certified independent dispute resolution entity after considering various factors listed in the statute. Final-offer dispute resolution "is designed to not only persuade parties to settle their disputes to avoid unpredictable and uncompromising hearings, but also to submit reasonable proposals before the hearing." Matt Mullarkey, Note, *For the Love of the Game: A Historical Analysis and Defense of Final Offer Arbitration in Major League Baseball*, 9 Va. Sports & Ent. L.J. 234, 245 (2010). The "all-or-nothing approach is designed to promote reasonable offers because every dollar that a [claimant] adds to his proposal moves up the midpoint and decreases his chance of winning." *Id.* In final-offer resolution, there is typically no written opinion or reasoning

behind the decision, further encouraging the push for reasonableness between the parties. *Id.* at 238.

100. Congress's design was thus to encourage payers and air ambulance providers to resolve their monetary disputes through negotiations between each other to avoid having to risk it all in an IDR determination with little guidance as to what a particular IDR entity would view as the reasonable payment amount. And, even if the parties could not reach an agreement through negotiations, final-offer dispute resolution creates strong incentives for both sides to put forth their most reasonable offer and then for the certified IDR entity to choose the one that it deems most reasonable. The need to make a reasonable offer is reinforced by the statute's obligation on the losing party to bear the costs of the IDR process.

101. IFR Part II unapologetically vitiates this design and, in so doing, conflicts with the statutory language.

102. The statute provides that the IDR entity shall, "taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such services determined under this subsection for purposes of subsection (a)(3)." PHSA § 2799A-2(b)(5)(A). The "considerations specified in subparagraph (C)" that the IDR entity "*shall consider*" are numerous—the QPA, the provider's quality and outcomes measurements, the medical personnel's level of training, experience, and quality, the acuity of the individual and complexity of service, ambulance vehicle type, population density of the pick up location, and each party's demonstration of good faith efforts to reach a contracted rate. *Id.* § 2799A-2(b)(5)(C). The statute treats each of these factors equally, with no weight placed on any particular one. But, under IFR Part II, these statutorily mandated factors are rendered nearly meaningless.

103. IFR Part II irrevocably slants the "independent" dispute resolution by dictating outcomes. It demands that the certified IDR entity "*must* select the offer closest to the qualifying

payment amount," subject only to two narrow exceptions: if "[1] the certified IDR entity determines that credible information submitted by either party under paragraph (c)(4)(i) clearly demonstrates that the [QPA] is materially different from the appropriate out-of-network rate, or if [2] the offers are equally distant from the [QPA] but in opposing directions." 86 Fed. Reg. at 56,104 (emphasis added). Then the IDR entity "must select the offer as the out-of-network rate that the certified IDR entity determines best represents the value of the qualified IDR item or services." *Id.*

104. According to the preamble, "emphasizing the QPA will allow for predictability" because "even before beginning negotiations, all parties involved will know that the QPA is the primary factor that the certified IDR entity will always consider (while other factors may be considered, depending on the circumstances)." 86 Fed. Reg. at 56,061. In the Departments' view, "[t]his certainty will encourage plans, issuers, providers, and facilities to make offers that are closer to the QPA, and to the extent another factor could support deviation from the QPA, to focus on evidence concerning that factor" and "may also encourage parties to avoid the Federal IDR process altogether and reach an agreement during the open negotiation period." *Id.*

105. IFR Part II thus writes the independent dispute resolution process out of the statute. No longer does the IDR entity determine *independently* a reasonable payment amount based on various inputs that the statute requires it to consider. Instead, the IDR entity is forced to choose the QPA in nearly all cases, despite that the QPA is effectively set by the payer itself.

106. If Congress intended the QPA to be practically dispositive, it would have said so. Indeed, it could have chosen to simply mandate the QPA as the payment amount. *See* Ban Surprise Bill Act, H.R. 5800, 116th Cong. § 2(a) (2020) (proposing new PHSA § 2719A(f)). It did not. It chose final-offer dispute resolution and called for open-ended consideration of a number of specified factors. The Departments, however, have disregarded that directive, casting aside all considerations other than the QPA in the vast majority of cases. Independent dispute resolution was not intended to be perfectly predictable, nor to force the parties to accept the QPA, especially a QPA

so unreliably derived. By strictly curtailing the IDR entity's ability to independently select the amount of payment, IFR Part II contravenes Congress's design.

107. It is no answer to say that a provider has a narrow escape hatch from the QPA by providing evidence to "clearly demonstrate[] that the qualifying payment amount is materially different from the appropriate out-of-network rate." 86 Fed. Reg. at 56,104. It is instead circular. The statute defines the "out-of-network rate" as the amount that the parties negotiate or the IDR entity selects for the service at issue. PHSA § 2799A-1(a)(3)(K). A party cannot logically provide evidence to "clearly demonstrate" that the "qualifying payment amount is materially different" from the amount the parties have not yet had a chance to negotiate or the IDR entity has not yet determined. In practical effect, the Departments have ensured that the QPA will end matters, an outcome that Congress could have adopted but instead rejected.

B. IFR Part I is unlawful.

108. IFR Part I dictates a QPA that is, by the Departments' own admission, administratively deflated for independent air ambulance service providers but will ensure that patients are not "required to pay higher cost-sharing amounts." *See* 86 Fed. Reg. at 36,891.

109. The statutory starting point for calculating the QPA requires taking "the median of the contracted rates recognized by the plan or issuer" as of January 31, 2019 "for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary." PHSA § 2799A-1(a)(3)(E)(i)(I).

110. By its plain terms, the contracted rates contemplated by § 2799A-1(a)(3)(E)(i)(I) include case-specific contracts for covered services. IFR Part I, however, excludes a wide range of relevant contracts from the calculation of the median contracted rate and instead focuses only on a small portion of inapposite payment arrangements. The QPA, for example, excludes historic out-of-network payments made under the patient's health plan, letters of agreement, arrangements

used to supplement a payer's network, incentive-based and retrospective arrangements, and single case agreements. Yet these are all "contracted rates recognized by the plan or issuer" for covered services from which Congress directed the calculation of median reimbursement. *Id.*

111. The Departments acknowledged in IFR Part I that only 25% of air ambulance transports in 2012 and 31% in 2017 were made under a traditional in-network contract. 86 Fed. Reg. at 36,923. Yet under the IFRs, this unrepresentative sample of transports drives the QPA for *all* transports. The Departments' unexplained decision to disregard the majority of actual contract rates is arbitrary and contrary to law. Given these unlawful exclusions, the Departments have ensured that the methodology will not produce QPAs that actually reflect how payers and providers have historically resolved payments via negotiation.

112. The statute further directs that the rulemaking must determine "the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas." PHSA § 2799A-1(a)(2)(B)(iii). And the rulemaking "may . . . take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities." *Id.* § 2799A-1(a)(2)(B).

113. For purposes of air ambulance services, however, the agency gives no meaning to the requirement that the service be the "same" and the "provider [be] in the same or similar specialty" nor does it adequately consider "facility type." PHSA §§ 2799A-1(a)(3)(E)(i)(I), 2799A-1(a)(2)(B). IFR Part I simply deems hospital-based and independent non-hospital-based air ambulance providers to be a "single provider specialty." 86 Fed. Reg. at 36,891. Yet the history and structure of the industry does not support treating these two vastly different service providers as the same. The Departments know this. The preamble to IFR Part I specifically explains that the

Departments "understand that hospital-based air ambulance providers sometimes have lower contracted rates than independent, non-hospital-based air ambulance providers." *Id.* But they refused to treat these distinct types of providers differently due solely to cost-sharing considerations: "The Departments, however, are of the view that because participants, beneficiaries, and enrollees frequently do not have the ability to choose their air ambulance provider, they should not be required to pay higher cost-sharing amounts (such as coinsurance or a deductible) solely because the air ambulance provider assigned to them has negotiated higher contracted rates in order to cover its higher costs, or because it has a different revenue model, than other types of air ambulance providers." *Id.*

114. That is unsupportable. *First*, the judgments made for hospital-based air ambulance providers negotiating global agreements for numerous hospital service lines do not reflect the economic considerations that would determine a reasonable rate for an independent air ambulance provider negotiating for only air ambulance services. Air ambulance service providers that bill only for air ambulance services must ensure that rates with group health plans or issuers are sufficient to maintain services in a community. Otherwise, they cannot cover their costs. Treating these two admittedly distinct types of providers as commanding the same negotiated rates is arbitrary and capricious.

115. *Second*, the arbitrariness of the Departments' conclusion is confirmed by its treatment of hospital-based emergency departments differently from standalone emergency departments. 86 Fed. Reg. at 36,892. The Departments explained: "where a plan or issuer has established contracts with both hospital emergency departments and independent freestanding emergency departments, and its contracts vary the payment rate based on the facility type, the median contracted rate is to be calculated separately for each facility type. The Departments are of the view that this approach will maintain the ability of plans and issuers to develop QPAs that are appropriate to the different types of emergency facilities specified by statute." *Id.* The Departments' inexplicable

decision to treat air ambulance service providers differently from hospital-based and freestanding emergency departments is arbitrary and capricious.

116. *Third*, the statute does not tie a patient's cost-sharing amount to the QPA. *See* PHSA § 2799A-2(a)(1). Instead, it directs that cost-sharing for air ambulance services be "based on rates that would apply for such services if they were furnished by such a participating provider[.]" *Id.* Congress knew how to tie cost-sharing to the QPA because it did so for emergency services, requiring cost-sharing to be calculated based on the "recognized amount," which specifically includes the QPA as one base for its calculation. *See id.* § 2799A-1(a)(1)(C)(iii), (a)(3)(H). That Congress did not do so for air ambulance services shows that it rejected intertwining patient cost-sharing and the QPA and that such concerns about patient cost-sharing cannot support the Departments' efforts to depress air ambulance reimbursements.

117. *Finally*, IFR Part I arbitrarily ignores Congress's directive to consider service providers by "geographic region." Where there are an insufficient number of contracts to determine the QPA based on state lines, IFR Part I requires the QPA to be determined using all metropolitan statistical areas in a Census division or all other areas in that Census division. But Census divisions are large. *See Census Regions and Divisions of the United States*, Census.gov (last visited Oct. 29, 2021), perma.cc/4QWX-7738. This requirement would mean that a contracted rate from Alaska or Hawaii could dictate the QPA for a medical air transport in California; or a contracted rate in Florida could dictate the QPA in Washington, D.C. By requiring calculation tailored to a "geographic region," Congress cannot have meant to have geographically and economically unique markets dictate payments in completely different markets that are thousands of miles, and even oceans, apart. The over-broadening of the geographic region cannot be justified by concern about not having a sufficient number of "contracted rates." Instead, that is a problem of the Departments' own making by purposefully excluding substantial volumes of contracts and agreements from the QPA calculation. IFR Part I is thus contrary to law.

118. Put together, the Interim Final Rules take a statute intended to protect patients by removing them from payment negotiations between providers and payers and transform it into a rate-setting rule that will ensure that air ambulance providers receive artificially low rates (indeed, lower than the health plans paid previously) and drive them out of business, jeopardizing the access to emergency healthcare services by the very patients Congress sought to protect. The IFRs are arbitrary and capricious and contrary to law.

C. The IFRs harm air ambulance providers, including AAMS's members

119. As participants in the air ambulance industry, AAMS's members will be directly injured by the IFRs. Many of AAMS's members have been unable to procure in-network agreements with health plans or issuers in areas where they operate, and they are therefore subject to the No Surprises Act. The IFRs supplant the Act by purposefully depressing the QPA and then pushing AAMS's members into a one-sided dispute resolution process designed to impose the QPA. The natural and intended outcome of the implementation of the IFRs will be a reduction in payment to AAMS's members that could force its members out of the market altogether and, as a result, reduce access to critical emergency services for patients. These injuries are actual and imminent because the IFRs become effective for plan years starting January 1, 2022.

120. One publicly available data point that demonstrates the injury the IFRs will inflict on air ambulance providers is a report issued by FAIR Health—a non-profit claims database that CMS has certified as a Qualified Entity (QE) for the CMS QE Program. *See* FAIR Health, *Air Ambulance Services in the United States: A Study of Private and Medicare Claims* (Sept. 28, 2021), perma.cc/2EA6-PK8E. FAIR Health has determined that "[t]he average estimated allowed amount" for the base rate for an air ambulance transport is $18,668. *Id.* at 2 & n.1. The Act authorizes group health plans and issuers to use third-party databases such as FAIR Health to determine the QPA when the plan or issuer lacks sufficient information to calculate a median in-network rate. As such, FAIR Health is marketing its "average estimated allowed amount" and underlying

data to plans and issuers for that purpose, and their use of the FAIR Health information is imminent given the historically limited network contracting between plans and issuers and air ambulance providers.

121. PHI Health, LLC (PHI) is an AAMS members that will be directly injured by the IFRs. *See* Exhibit 5 (Foster Declaration). PHI delivers rotor-wing air ambulance services from 77 air bases located in 15 states and fixed wing air ambulance services from 3 air bases in California and Missouri. *Id.* ¶ 2. PHI expects that the IFRs will drive payments by group health plans or issuers to a level at or below the QPA because the IFRs eliminate any rational business reason for plans or issuers to enter into a network contract with an air emergency ambulance provider at a rate exceeding the plan's or issuer's QPA. *Id.* ¶ 11. PHI estimates that, if all plans and issuers began paying $18,668 or less for the base rate for out-of-network air ambulance transport beginning on January 1, 2022, then most of PHI's air bases would experience reductions in revenue. *Id.* ¶ 16. Indeed, PHI expects that the "reductions in revenue would be so great that as many as 33 of [PHI's] air bases would cease to cover their costs, and it would become necessary for [PHI] to close or consolidate some or all of those air bases as soon as possible in calendar year 2022," causing an irreparable injury. *Id.* ¶¶ 16-19.

122. Global Medical Response, Inc. (GMR) is an AAMS member that will be directly injured by the IFRs. *See* Exhibit 6 (Preissler Declaration). GMR delivers rotor-wing and fixed-wing air emergency ambulance services from 340 air bases located in 28 states. *Id.* ¶ 2. GMR likewise has concluded that the IFRs will drive payments by group health plans or issuers to a level at or below the QPA. *Id.* ¶ 11. GMR estimates that, if all plans and issuers began paying $18,668 or less for the base rate for out-of-network air ambulance transport beginning on January 1, 2022, then most of GMR's air bases would experience reductions in revenue. *Id.* ¶ 16. GMR anticipates that up to 10% of GMR's total annual emergency transports for all air bases in calendar year 2022 will be paid by reference to the FAIR Health database or other QPA equivalent. *Id.* ¶ 17. If group

health plans and issuers use the FAIR Health average estimated allowed amount of $18,668 as the base rate when paying for 10% of GMR's total annual transports for all air bases, then "most of GMR's bases would experience reductions in revenue for calendar year 2022." *Id.* ¶ 18.

123. Air Methods Corporation (AMC) is an AAMS member that will be directly injured by the IFRs. *See* Exhibit 7 (Portugal Declaration). AMC delivers rotor-wing air ambulance services from 257 air bases located in 42 states and fixed-wing air ambulance services from 27 air bases located in 15 states. *Id.* ¶ 2. AMC has concluded that, if all plans and issuers began paying $18,668 or less for the base rate for out-of-network air ambulance transport beginning on January 1, 2022, then eighty percent of AMC's air bases would experience reductions in revenue. *Id.* ¶ 16. AMC estimates that up to 7% of AMC's total annual transports in calendar year 2022 will be paid by reference to the FAIR Health database or other QPA equivalent. *Id.* ¶ 17. If group health plans and issuers use the FAIR Health average estimated allowed amount of $18,668 as the base rate when paying for 7% of AMC's total annual transports for each air base, then "eighty percent of AMC's bases would experience reductions in revenue for calendar year 2022." *Id.* ¶ 18.

CLAIMS FOR RELIEF

Count I
Administrative Procedure Act
IFR Part II - arbitrary, capricious, and contrary to law weighting of QPA

124. AAMS incorporates and re-alleges the foregoing paragraphs as though fully set forth herein.

125. IFR Part II is final agency action subject to review under the APA. 5 U.S.C. § 704. IFR Part II marks the consummation of the Departments' collective decision-making, establishes the rights and obligations of air ambulance providers, group health plans, and issuers, and is one from which legal consequences will flow.

126. The APA empowers courts to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

127. It likewise authorizes courts to set aside agency action "in excess of statutory jurisdiction, authority, or limitations." 5 U.S.C. § 706(2)(C).

128. IFR Part II violates these APA requirements. It squarely conflicts with the provisions of the statute establishing the IDR process, which require equal consideration of all the enumerated factors, and it is therefore in excess of statutory limits.

129. IFR Part II is also arbitrary and capricious because it gives presumptively dispositive weight to a QPA that itself is calculated in an arbitrary and capricious manner, as described herein.

130. Accordingly, those elements of the Interim Final Rule Part II that require IDR entities to give presumptively dispositive weight to the QPA must be set aside. 5 U.S.C. § 706(2).

Count II
Administrative Procedure Act
IFR Part I - arbitrary, capricious, and contrary to law derivation of QPA

131. AAMS incorporates and re-alleges the foregoing paragraphs as though fully set forth herein.

132. IFR Part I is final agency action subject to review under the APA. 5 U.S.C. § 704. IFR Part I marks the consummation of the Departments' collective decision-making, establishes the rights and obligations of air ambulance providers, group health plans, and issuers, and is one from which legal consequences will flow.

133. The APA empowers courts to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

134. It likewise authorizes courts to set aside agency action "in excess of statutory jurisdiction, authority, or limitations." 5 U.S.C. § 706(2)(C).

135. The Interim Final Rule Part I violates these APA requirements. IFR Part I conflicts with the relevant provisions of the statute, and it is therefore in excess of statutory limits, by excluding swaths of case-specific contracts and agreements from the definition of "contracted rates."

136. The preamble to IFR Part I also recognizes, but then disregards, the critical differences between hospital-based and independent air ambulance service providers, justifying its decision to treat them the same based purely on a desire to reduce patient cost-sharing. That reasoning fails to "articulate . . . a 'rational connection between the facts found and the choice made,'" "offer[s] an explanation for its decision that runs counter to the evidence before the agency," "fail[s] to consider an important aspect of the problem," and "relie[s] on factors which Congress has not intended it to consider." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

137. Further, by lumping independent and hospital-based air ambulance providers together, while not doing so in similar cases (like hospital-based and freestanding emergency facilities), it "applies different standards to similarly situated entities and fails to support this disparate treatment with a reasoned explanation and substantial evidence in the record." *Anna Jaques Hosp. v. Sebelius*, 583 F.3d 1, 7 (D.C. Cir. 2009).

138. IFR Part I also broadly construed the geographic region to reach the Census-division level, potentially allowing contracted rates in Hawaii to dictate rates in rural Washington. By doing so, the agency "failed to consider an important aspect of the problem." *State Farm*, 463 U.S. at 43. And it did so without "articulat[ing] . . . a 'rational connection between the facts found and the choice made'" because the only justification is lack of sufficient volume of contracted rates—a problem the agency created for itself by defining "contracted rates" to exclude substantial volumes of contracts contrary to the statute. *Id.*

139. Accordingly, those elements of the Interim Final Rule Part I that govern QPA determinations for air ambulance services must be set aside. 5 U.S.C. § 706(2).

PRAYER FOR RELIEF

AAMS respectfully requests that the Court enter judgment in its favor and that the Court:

(a.) Vacate the following elements of the interim final rule entitled *Requirements Related to Surprise Billing; Part II*, 86 Fed. Reg. 55,980 (Oct. 7, 2021):

- Section 54.9816-8T(c)(4)(B)(ii)'s direction that "[t]he certified IDR entity must select the offer closest to the qualifying payment amount unless the certified IDR entity determines that credible information submitted by either party under paragraph (c)(4)(i) clearly demonstrates that the qualifying payment amount is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the qualifying payment amount but in opposing directions. In these cases, the certified IDR entity must select the offer as the out-of-network rate that the certified IDR entity determines best represents the value of the qualified IDR item or services, which could be either offer."

(b.) Vacate the following elements of the interim final rule entitled *Requirements Related to Surprise Billing; Part I*, 86 Fed. Reg. 36,872 (July 13, 2021):

- Section 54.9816-6T(a)(1)'s direction that "[s]olely for purposes of this definition, a single case agreement, letter of agreement, or other similar arrangement between a provider, facility, or air ambulance provider and a plan, used to supplement the network of the plan for a specific participant or beneficiary in unique circumstances, does not constitute a contract."
- Section 54.9816-6T(a)(7)(ii)'s provision that "[i]f a plan does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an air ambulance service provided in a geographic region

described in paragraph (a)(7)(ii)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau, determined based on the point of pick-up (as defined in 42 CFR 414.605)."

- Section 54.9816-6T(a)(12)'s provision that "except that, with respect to air ambulance services, all providers of air ambulance services are considered to be a single provider specialty."

(c.) Issue a declaratory judgment that these portions of the interim final rules were issued in violation of the Administrative Procedure Act;

(d.) Enjoin Defendants from implementing, enforcing, or otherwise carrying out these portions of the interim final rules;

(e.) Award AAMS attorney's fees and costs; and

(f.) Award AAMS such other and further relief as the Court may deem just and proper.

Dated: November 16, 2021

Respectfully submitted,

/s/ *Sarah P. Hogarth*
Brian R. Stimson (petition for admission pending)
Sarah P. Hogarth (D.C. Bar. No. 1033884)
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Attorneys for Plaintiff
Association of Air Medical Services

EXHIBIT B

No Surprises Act

Implementation of Air Ambulance Services

Meeting with Air Methods
April 27, 2021

Air Methods®

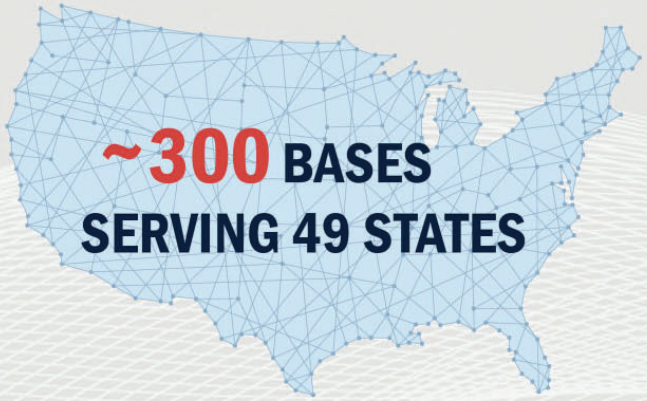
Air Methods Participants

- Chris Myers, Executive Vice President, Customer Experience, Reimbursement & Strategic Initiatives, Air Methods
- Chris Brady, Senior Vice President & General Counsel, Air Methods
- Carolyn Mayle, Vice President, Government Affairs, Air Methods
- Ken Choe, Partner, Hogan Lovells
- Beth Roberts, Partner, Hogan Lovells
- Victoria Wallace, Senior Associate, Hogan Lovells

Agenda

- Introduction to Air Methods
- Unique challenges associated with establishing a rate for air ambulance services
- Suggested regulatory framework for appropriate implementation of the No Surprises Act for air ambulance services

AIR METHODS AT A GLANCE



~300 BASES SERVING 49 STATES

130,000+/ FLIGHT HOURS

400+ HELICOPTERS & FIXED WING AIRCRAFT

64,000+/year PATIENT TRANSPORTS

5,000+ TEAMMATES

PATIENT ADVOCACY IS IN OUR DNA

IT'S PART OF OUR CORE VALUES TO GIVE **OUR PATIENTS THE BEST EXPERIENCE POSSIBLE FROM BEGINNING TO END.**

WE'RE AN AIRBORNE ICU,
AND WE RESPOND ONLY WHEN A PHYSICIAN OR A FIRST RESPONDER CALLS US.

UNITED ROTORCRAFT
Aerospace design and manufacturing

LOCATED IN **OMAHA, NEBRASKA**
AirCom: National communications center
Direct Patient Logistics: Patient transfers

LOCATED IN **SAN BERNADINO, CA**
Patient Business Services/ Patient Advocacy

EMERGENT CARE

If called, we respond

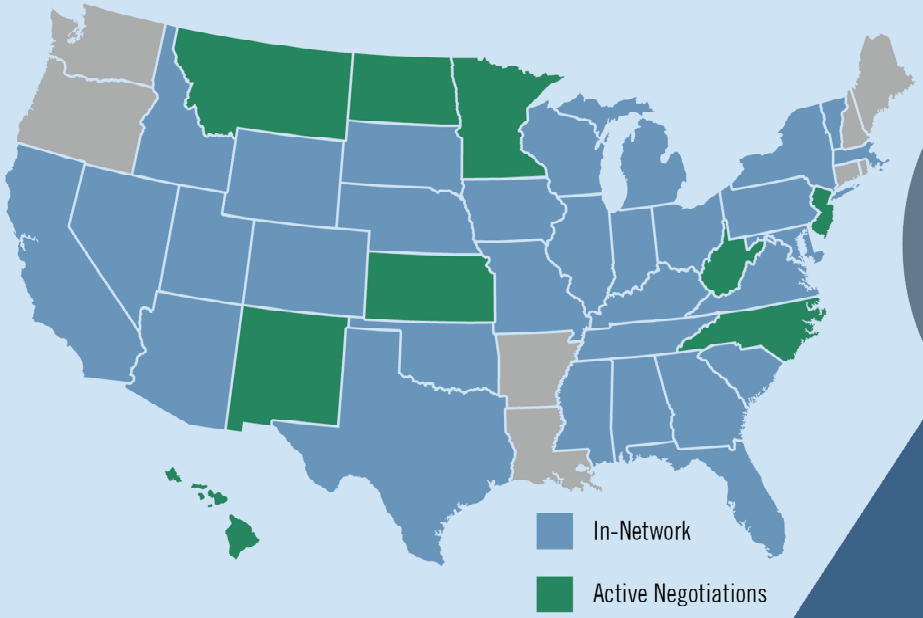
- Guided by the Emergency Medical Treatment and Labor Act (EMTALA), no payer information taken at the time of patient pickup – **WE TREAT REGARDLESS OF ABILITY TO PAY**
- **WE NEVER SELF-DISPATCH** – respond only if called by physician or first responder
- Those requesting air ambulance follow state protocols
- Whether scene or inter-facility, they are all emergency situations
- We cannot preauthorize due to the emergent nature of our transports
- 90% of our transports experienced trauma, cardiac, stroke or respiratory distress

Our communication center's (AirCom) average speed of answer is 6.4 seconds

From the time of intake, it takes our team just 1.8 minutes to have an emergent transport assigned

Aircraft takes off in under 10 minutes from the time of call intake

AGGRESSIVELY GOING IN-NETWORK



Air Methods is currently in-network with over 30 BCBS state plans across the U.S.

(Over 100 plans total [1])

In-Network Plans

- Anthem CA
- Anthem CO
- Anthem GA
- Anthem IN
- Anthem KY
- Anthem MO
- Anthem NV
- Anthem OH
- Anthem VA
- Anthem WI
- BCBS AL
- BCBS AZ
- BCBS FL
- BCBS IA
- BC of Idaho
- Regence BC of ID
- BCBS IL
- BCBS MD
- BCBS MI
- BCBS MS
- BCBS NE
- BCBS NY Empire
- BCBS NY Excellus
- BCBS OK
- BCBS PA Capital
- BCBS SC
- BCBS SD
- BCBS TN
- BCBS TX
- BCBS VT
- BCBS WY
- Blue Shield of CA
- Regence BCBS UT

$200 **Average out-of-pocket cost**

BOTTOM LINE

Today, ~51% of our privately insured patients are in-network. Goal is to be 100% in-network; however, big three insurers refuse to negotiate fairly.

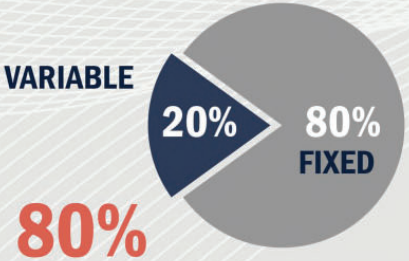
005815

[1] Total commercial and government plans

THE COST OF LIVESAVING AIR MEDICAL TRANSPORT

IT COSTS AN AVERAGE OF
$3 MILLION
ANNUALLY
TO OPERATE ONE
AIR MEDICAL BASE

This includes our
clinical crew, pilot, mechanic, equipment, helicopter and fuel.



80%
OF COSTS ARE INCURRED
WHETHER WE FLY OR NOT

AIR METHODS OPERATES MORE THAN 300 BASES ACROSS THE COUNTRY.

ADDITIONAL FIXED EXPENSES

- **24/7 Communication Center**
- **World-Class Clinical, Aviation and Mechanical Training**
- **Safety Investments** (Flight simulators, crash-resistant fuel systems, etc.)

005816

BASE MODELS

HBS (HOSPITAL-BASED SERVICE) MODEL

Our hospital partners own the program and provide the medical personnel and communications functions, while Air Methods provides aircraft operation and maintenance. We are honored to partner with some of the most prestigious hospitals and health systems in the nation.

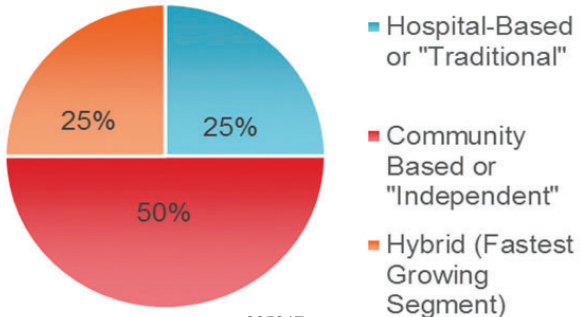
ADM (ALTERNATIVE DELIVERY) MODEL

Partners support these programs with marketing and, in most cases, medical staff and medical direction; however, clinical support can vary. Air Methods provides aviation, aircraft, fuel, maintenance, dispatch, billing, and EMS licensure. Branding is usually consistent with hospital partners' branding identities.

CBS (COMMUNITY-BASED SERVICE) MODEL

Air Methods provides the entire aviation and clinical crews and support, as well as aircraft, fuel, maintenance, dispatch, billing, and EMS licensure. These are wholly-owned by Air Methods, and these bases can often be found in rural areas. Our highly-trained Air Methods clinicians are experienced in areas such as burns, cardiac, pediatrics, respiratory, and trauma. Air Methods can also assist with specialty team transports. In this model, branding of the aircraft is Air Methods, and the hospital's logo and colors may be incorporated into the aircraft design. Marketing will be done by Air Methods and may leverage the hospital's brand and colors on collateral in some cases.

Air Medical Industry by Ownership Type



005817

Dynamics of the Air Ambulance Industry

Unique Challenges for Rate Setting

- The costs associated with providing air ambulance services are high and mostly (80%) fixed. Air ambulance service providers are the most highly regulated healthcare provider type, subject to both healthcare and aviation oversight.
  - Provider type has a significant impact on negotiation power and propriety of rates.
    - Hospital-based providers are better-positioned than community-based providers to have in-network contracts because their contracts include services beyond air ambulance services and, therefore, any losses occasioned by low rates for air ambulance services can be offset by reimbursement for other types of services.
  - Geography
    - Most transports are picked up from either rural or super rural zip codes with a disproportionately high public payer mix. Public payer reimbursement is significantly lower than the cost to provide the services, rendering private payer reimbursement critical to the continuing availability of such services.
- These distortions render in-network rates a false benchmark for an appropriate rate, for all provider types.

No Surprises Act Regulations Must Take Such Dynamics into Account

General Considerations:

- Congress recognized the **unique** considerations of the air ambulance industry by treating air ambulance service providers **separately** from other provider types.
- The **qualifying payment amount methodology**, **conditions of certification and recertification of independent dispute resolution (IDR) entities**, and other aspects of the **IDR process** must be **tailored** to account for such considerations.
- Regulations must ensure that the IDR entity considers relevant information about **comparable** air ambulance services, including **ownership type** (e.g., hospital-based, community-based), **geographic region** (i.e., state), **transport type** (i.e., emergency or non-emergency), and **vehicle type** (i.e., fixed wing or rotary wing).
- The qualifying payment amount must be determined based on comparable air ambulance services, including provider type, to avoid reimbursement distortions.

Qualifying Payment Amount Methodology

Background:

- Most of the air ambulance industry is predominantly out-of-network due to the reluctance of plans, particularly the largest national insurers, to negotiate fair in-network contracts, i.e., in-network contracts are not standard for a majority of the industry.
- "**Contracted rates**" for air ambulance services must include rates under arrangements beyond conventional in-network contracts to ensure that there is enough information to determine a median contracted rate. They include rates under **wrapper, lease, rental, and supplemental network arrangements**, as well as **single case agreements**.
- Where there is insufficient information to determine a median contracted rate, the plan should refer to a **database of allowed amounts established by the HHS Secretary**.
  - The database should include the **average claim amount paid by the plan for a comparable service where there is no contracted rate** (for calendar year 2020, adjusted for inflation).
  - Such amount is the **best proxy** for a reasonable reimbursement amount as it represents the amount the plan has **in fact** been willing to pay.

Qualifying Payment Amount Methodology

Recommended Methodology for Plans to Determine the Qualifying Payment Amount for Air Ambulance Services:

- Identify contracted rates, which includes rates set forth in in-network agreements, wrapper, lease, rental and supplemental network agreements, and single case agreements, on January 31, 2019. In the case of single case agreements, the rate on January 31, 2019, is deemed to be the average of such rates during calendar year 2019.
- At least 3 rates must be identified to obtain a median.
- If no median contracted rate can be identified, refer to the database of average paid non-contracted claim amounts established by the HHS Secretary (the Secretary). The average paid non-contracted claim amount required to be submitted to the IDR entity by the plan in the instant IDR process is deemed to be included in such database.

Conditions for IDR Entity Certification

Background:

- In-network rates are a **false** benchmark for an appropriate rate for non-contracted air ambulance services. The **best proxy** for a reasonable reimbursement amount is the **average non-contracted paid claim amount**. Historically, this is what the plan has agreed to pay for services.
- The IDR entity should be required to **request** the plan to submit the average non-contracted paid claim amount. By statute, the IDR entity is authorized to request the submission of information by a party, a party is required to submit information requested by an IDR entity, and the IDR entity is required to consider information submitted by a party.
- The IDR entity should be required to give the average non-contracted paid claim amount **primary weight**.
- The **conditions for IDR entity certification and recertification** are the vehicle for establishing **enforceable** requirements on IDR entities, and the Secretary, in consultation with the Secretary of Labor and Secretary of the Treasury, has **broad** authority to establish such conditions.

Conditions for IDR Entity Certification

Recommended Conditions of Certification and Recertification of IDR Entities:

- The IDR entity must request from the plan both the qualifying payment amount and the average paid non-contracted claim amount, as well as the information used by the plan to determine such amounts.
- The IDR entity must give primary weight to the average paid non-contracted claim amount when deciding between the parties' offers.
- The IDR entity must submit to the Secretary the average paid non-contracted claim amount.

IDR Process

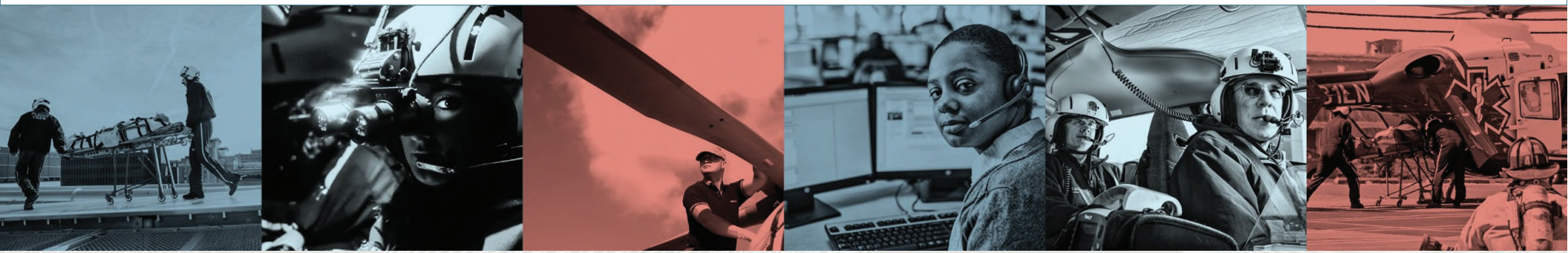
Establishment of a Database of Average Paid Non-Contracted Claim Amounts:

- Require IDR entities to submit to the Secretary the average paid non-contracted claim amount.
- Publish only non-confidential information.
- Establish and maintain a database of such amounts.
- Any administrative cost can be reflected in the fee amount established by the Secretary under PHSA section 2799A-1(c)(8) and/or 2799A-1(d).

Certification and Audit Requirements:

- Require all information submitted by the parties to the IDR entity to be true and accurate, and certified as such, and documentation to be maintained and made available to the IDR entity or the agencies upon request for 10 years.
- To redress a legislative oversight, regulations should subject ERISA plans to audit in the same manner as that provided under section 2799A-1(a)(2) of the PHSA and section 9816(a)(2) of the IRC.

Thank you



IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS

LIFENET, INC., Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	Civil Action No. 22-cv-00162-JDK

[PROPOSED] ORDER

Upon consideration of Defendants' motion to transfer, and any responses and replies thereto, it is hereby

ORDERED that Defendants' motion is **GRANTED**; and it is

FURTHER ORDERED that this case is **TRANSFERRED** to the U.S. District Court for the District of Columbia.

SO ORDERED.

Hon. Jeremy D. Kernodle
United States District Judge