IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

GUARDIAN FLIGHT, LLC, Plaintiff, v. AETNA HEALTH INC., et al. Defendants.	)	Case No.: 4:22-cv-03805 Lead Consolidated Case

MOTION FOR LEAVE TO FILE BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS AETNA HEALTH INC. AND KAISER FOUNDATION HEALTH PLAN'S MOTIONS TO DISMISS

Under Local Rule 7.1, America's Health Insurance Plans, Inc. ("AHIP") moves for leave to file a brief as *amicus curiae* in support of Defendant Aetna Health Inc.'s Motion to Dismiss for Failure to State a Claim in No. 4:22-cv-3805 (Doc. No. 12) and Kaiser Foundation Health Plan's Motion to Dismiss for Failure to State a Claim in No. 4:22-cv-3979 (Doc. No. 25). The proposed amicus brief is attached as Exhibit A to this motion. Per Local Rule 7.1(D), counsel for AHIP has conferred with counsel for the parties and counsel cannot agree about the disposition of the motion. Defendants do not oppose the motion. Plaintiffs oppose the motion.

INTRODUCTION AND INTEREST OF PROPOSED *AMICUS CURIAE*

America's Health Insurance Plans, Inc. (AHIP) is the national trade association representing the health insurance community. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. AHIP's members have extensive experience working with

nearly all health care stakeholders to ensure that patients have affordable access to needed medical services and treatments. That experience gives AHIP broad first-hand knowledge and a deep understanding of how the nation's health care and health insurance systems work.

AHIP has frequently been granted leave to file amicus briefs in cases of importance to the health insurance community, including in cases about the interpretation and implementation of the No Surprises Act. *See, e.g.*, *Tex. Med. Ass'n v. U.S. Dep't of Health & Human Servs.*, 587 F. Supp. 3d 528 (E.D. Tex. 2022); *Am. Med. Ass'n v. U.S. Dep't of Health & Human Servs.*, No. 1:21-cv-3231 (D.D.C.); *Ass'n of Air Med. Servs. v. U.S. Dep't of Health & Human Servs.*, No. 1:21-cv-3031 (D.D.C.).

AHIP's members strive to reach agreements with health care providers to offer consumers affordable networks that provide choices in the delivery of quality medical care. When unable to secure network agreements before treatment is rendered, health insurance providers seek to negotiate reasonable out-of-network payments to prevent surprise medical bills and reduce costs for patients. But before the No Surprises Act, some providers—particularly air ambulance providers—often leveraged their refusal to participate in networks to send patients excessive surprise bills and extract payments well above typical market rates.

Congress, after significant debate, ultimately arrived at a bipartisan solution in the No Surprises Act to protect consumers from out-of-network payment disputes and surprise bills. The Act does this by encouraging health plans and providers to resolve out-of-network payments through negotiation and establishing Independent Dispute Resolution (IDR) as a streamlined baseball-style arbitration process. Congress intended IDR to promptly and conclusively resolve payment disputes in what should be rare instances where the parties do not agree on fair payment rates.

AHIP agrees with Defendants' legal arguments, but its proposed amicus brief does not repeat them. Rather, AHIP writes separately to explain how accepting a limitless conception of judicial review under the Act would undercut the efficiency and finality that the Act's procedures are designed to achieve and ultimately harm consumers by driving up administrative and health care costs that Congress intended to constrain.

ARGUMENT

Because "[n]o statute, rule, or controlling case defines a federal district court's power to grant or deny leave to file an amicus brief," amicus briefing "lies solely within the court's discretion." *United States ex rel. Gudur v. Deloitte Consulting LLP*, 512 F. Supp. 2d 920, 927 (S.D. Tex. 2007). "Generally, courts have exercised great liberality in permitting an *amicus curiae* to file a brief in a pending case." *United States v. Davis*, 180 F. Supp. 2d 797, 800 (E.D. La. 2001). Courts in this district typically consider "whether the proffered information is 'timely and useful' or otherwise necessary to the administration of justice." *Gudur*, 512 F. Supp. 2d at 927 (quoting *Waste Management of Pa. v. City of York*, 162 F.R.D. 34, 36 (M.D. Pa. 1995)). Courts also sometimes consider "whether the organization submitting the amicus brief is an advocate for a one of the parties, and whether the amicus has unique information or perspective beyond what the parties can provide." *Canamar v. McMillin Tex. Mgmt. Servs., LLC*, No. SA-08-CV-0516, 2009 U.S. Dist. LEXIS 108986, *2 (W.D. Tex. Nov. 20, 2009) (citing *Sierra Club v. FEMA*, No. H-07-0608, 2007 U.S. Dist. LEXIS 84230 (S.D. Tex. Nov. 14, 2007)). All factors weigh in favor of permitting an amicus brief here.

First, the proposed amicus is timely and useful. As an organization with extensive experience in the nation's health care and health insurance systems, AHIP can provide a unique perspective on the broader implications of the parties' competing interpretations of the No

Surprises Act, as well as useful background regarding the market dynamics for air ambulance and other medical services before and after the Act. This sort of broader perspective and useful background is a common basis for amicus participation. *See, e.g.*, *United States v. Ford Motor Co*., 516 F. Supp. 2d 770, 771 (W.D. Tex. 2007) (Alliance of Automobile Manufacturers permitted leave to file in support of Ford's motion to dismiss); *Statoil USA E&P Inc. v. U.S. Dep't of Interior,* 352 F. Supp. 3d 748, 751 (S.D. Tex. 2018) (American Petroleum Institute permitted to file amicus brief in support of oil company's Administrative Procedures Act claims). In addition, AHIP"s proposed brief provides data about the implementation of the IDR system useful to the Court's consideration of the issues. Such data is particularly relevant to the Court's consideration of the likelihood that judicial review here would open the floodgates to litigation whenever parties are dissatisfied with IDR, a question on which the Court requested supplemental briefing. *See, e.g.*, Supplemental Brief of Aetna Health Inc., Doc. No. 43, at 1 (Apr. 28, 2023).

The amicus brief also provides timely information and would not delay resolution of the issues in these cases. No hearing has yet been scheduled on Defendant Kaiser Foundation Health Plan's Motion to Dismiss in No. 4:22-cv-3979, which was consolidated only last week. And although the Court has held a hearing on Aetna Health Inc.'s Motion to Dismiss, the Court ordered further post-hearing briefing from the parties which concluded only within the past 20 days, and the proposed amicus brief is directly related to the issues covered in that supplemental briefing.[1]

Second, while "the partiality of an amicus is a factor," *Waste Mgmt. Inc.*, 162 F.R.D. at 36,

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[1] Although courts have sometimes considered the Federal Rule of Appellate Procedure's seven-day timeline in assessing motions for leave, they have emphasized that the rule is not controlling, *see, e.g.*, *Gudur*, 512 F. Supp. 2d at 928, and have permitted amicus briefs filed after that window, *see, e.g.*, *Blair v. Houston Indep. Sch. Dist*., No. H-13-2628, 2015 U.S. Dist. LEXIS 40945, *4 (S.D. Tex. Mar. 31. 2015) (permitting amicus brief by Texas Association of School Boards Legal Assistance Fund filed at reconsideration stage).

AHIP is not a partial to a particular outcome in the challenged IDR proceedings. Consistent with its role as the national trade association representing the health insurance community, AHIP's Board of Directors is comprised of executives from companies that provide health and supplemental benefits coverage, including from Kaiser Permanente and an Aetna Health affiliate. As a non-profit corporation whose members have no ownership interests, however, AHIP has no pecuniary or other interest in the resolution of the specific payment disputes and IDR decisions under review. AHIP has no stake at all in the amount of the payment for the air ambulance transports at issue. It is therefore not improperly "partisan." By "the nature of things an *amicus* is not normally impartial," and there "is no rule … that amici must be totally disinterested." *Sierra Club*, 2007 U.S. Dist. LEXIS 84230, at *9 (citations omitted; omission in original). Accordingly, "[o]ther courts routinely permit organizations to file amicus briefs when their interests are closely aligned with those of one party." *Id.* at *9, *11 (denying leave where "[n]ot only are [the amicus's] interests aligned … but [it] has as much of a stake in the outcome" as the supported party).

Finally, because AHIP's proposed amicus brief presents "ideas, arguments, theories, insights, facts, or data that are not to be found in the parties' briefs," its participation as amicus is appropriate. *Voices for Choices v. Ill. Bell Tel. Co.*, 339 F.3d 542, 545 (7th Cir. 2003); *see Canamar*, 2009 U.S. Dist. LEXIS 108986, *2 (granting leave to file amicus where "the information supplied is … beyond that which the parties themselves have provided in their extensive briefing"). Rather than repeat the legal arguments of the parties, AHIP's proposed amicus brief provides insights and data regarding the impact of competing interpretations of the No Surprises Act, and in particular, how the scope of judicial review of IDR decisions under the Act will directly affect the employers and consumers to whom AHIP's members provide health coverage.

Courts have "found the participation of an amicus especially proper" where "an issue of

general public interest is at stake." *Liberty Res., Inc. v. Philadelphia Housing Auth.*, 395 F. Supp. 2d 206, 209 (E.D. Pa. 2005); *see Texas v. United States*, 328 F. Supp. 3d 662, 672 (S.D. Tex. 2018) (noting amicus participation by "numerous … groups and entities" in case with national impact). This is just such a case. As the Court's consolidation order indicates, this case addresses questions of first impression regarding the implementation of the No Surprises Act, and in particular "when a court may review and/or vacate an IDR award." Order, Doc. No. 35, at 2 (May 10, 2023). AHIP's proposed amicus brief explains how resolution of those questions will affect not just the two specific payment disputes at issue, but also shape the system for resolving out-of-network payments more generally, with implications for the health care system writ large.

CONCLUSION

For the foregoing reasons, AHIP respectfully requests that this motion be granted and that it be permitted to file the proposed amicus brief. A proposed order is attached as Exhibit B.

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Dated: May 18, 2023

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on May 18, 2023, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system, which will send a notice of electronic filing to all counsel of record.

/s/Hyland Hunt
Hyland Hunt

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	)	
Plaintiff,	)	
	)	
v.	)	Case No.:
	)	4:22-cv-03805
	)	Lead Consolidated Case
AETNA HEALTH INC., et al.	)	
	)	
Defendants.	)	
	)	

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS AETNA HEALTH INC. AND KAISER FOUNDATION HEALTH PLAN'S MOTIONS TO DISMISS

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INTEREST OF *AMICUS CURIAE*[1]

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AHIP's members strive to reach agreements with health care providers to offer consumers affordable networks that provide choices in the delivery of quality medical care. When unable to secure network agreements before treatment is rendered, health insurance providers seek to negotiate reasonable out-of-network payments to prevent surprise medical bills and reduce costs for patients. But before the No Surprises Act, some providers—particularly air ambulance providers—often leveraged their refusal to participate in networks to send patients excessive surprise bills and extract payments well above typical market rates.

Congress, after significant debate, ultimately arrived at a bipartisan solution in the No Surprises Act to protect consumers from out-of-network payment disputes and surprise bills. The Act does this by encouraging health plans and providers to resolve out-of-network payments through negotiation and establishing Independent Dispute Resolution (IDR) as a streamlined baseball-style or final offer arbitration process. Congress intended IDR to promptly and conclusively resolve payment disputes in what should be rare instances where the parties do not

[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than the amicus, its members, or its counsel made a monetary contribution intended to fund the brief's preparation or submission.

agree on fair payment rates.

AHIP agrees with Defendants' legal arguments that Plaintiffs' conclusory and *ipse dixit* complaint must be dismissed. Such generalized allegations fall far short of what is necessary to plausibly allege a basis for vacating an IDR determination under the exceedingly narrow grounds permitted by the No Surprises Act and its incorporation of Federal Arbitration Act standards. AHIP writes separately to explain how accepting Plaintiffs' limitless conception of judicial review under the Act would undercut the efficiency and finality that the Act's procedures are designed to achieve and ultimately harm consumers by driving up administrative and health care costs that Congress intended to constrain.

INTRODUCTION AND SUMMARY OF ARGUMENT

The No Surprises Act addressed the urgent need to protect Americans from surprise medical bills and spiraling out-of-network costs, particularly for medical specialties where patients lack the opportunity to choose their provider. The need to protect patients was particularly acute for air ambulance services, due to a broadly written federal statute that was found by courts to preempt state efforts to address otherwise unconstrained pricing, a business model based on refusing to join networks, and an influx of private equity firms—all of which led to sky-high and ever-escalating air ambulance charges. Before the Act, when air ambulances could send surprise bills to patients, health insurance providers routinely faced pressure to pay exorbitant air ambulance charges—completely divorced from the cost to provide the service or reasonable market rates negotiated *ex ante*—and did so to protect patients from what would otherwise be astronomical surprise bills. Although paying the charges protected individual patients from medical bills running to tens of thousands of dollars, all Americans paid for unconstrained air ambulance charges in the form of higher premiums.

Congress shielded Americans from this market dysfunction by prohibiting surprise bills

and establishing IDR as a streamlined process for resolving out-of-network payments when a reasonable payment was declined or negotiations were unproductive. Central to Congress's solution is the Qualifying Payment Amount (QPA), which reflects a health insurance provider's median negotiated rate for a given service in the local area. Patients' cost-sharing is based on the QPA, health insurance providers must disclose the QPA when making payments for out-of-network claims, and IDR entities must consider the QPA when choosing one of two offers to conclusively resolve the out-of-network payment amount. For any questions about QPA calculations, Congress contemplated an agency-led complaint process, together with agency audits of QPA calculations for accuracy and compliance.

Congress did not authorize IDR entities to recalculate QPAs. IDR entities may not re-examine the QPA, because to do so would duplicate the agencies' audit function and risk uncertainty and confusion caused by multiple disparate QPA (re-)calculations in case-by-case decisions. Instead, IDR entities are meant to take the accuracy of a QPA as a given, and follow a simple, speedy, and final process for choosing between two offers.

Interpreting the Act to permit judicial review and vacatur of ostensibly final IDR determinations based on conclusory assertions that the QPA was miscalculated or misrepresented cannot be squared with the Act's structure or purpose. As Defendants explain, Plaintiffs' interpretation of the Act would wrongly convert exceptionally circumscribed judicial review criteria into truck-sized loopholes. *See* Aetna Mot., Doc. 12, at 10-13; Kaiser Mot., Doc. 25, at 11-18. It would also lead to the unlikely outcome that Congress, without saying so, effectively created a new right for medical providers to sue insurance providers whenever they are dissatisfied with out-of-network payments. This even though providers before the Act could not sue insurance providers that they declined to contract with. The statute that Congress wrote allows only limited

federal baseball-style arbitration in IDR, with extremely circumscribed judicial review; it is not an open invitation to federal court.

Besides being legally untenable, the anything-goes pitch for judicial review is disastrous from a practical standpoint, especially given the unexpectedly high IDR volume experienced over the Act's first year. Interpreting the Act to condone re-opening of IDR determinations based on conclusory allegations of "undue means" or "partiality" would contravene congressional design, and substitute laborious, costly, and frequent litigation for the speedy, low-cost, and rare arbitral decision-making that Congress intended. Americans would pay the price in unnecessary administrative costs—the exact opposite of Congress's central goal of protecting patients from unpredictable, inflated medical costs.

ARGUMENT

I. The No Surprises Act Aims To Remedy Market Dysfunction Where Patients Have No Opportunity To Choose Their Providers—A Particular Concern For Air Ambulances.

For most medical services, rates are set in advance through negotiation between health insurance providers and health care providers. Health plans typically work together with providers to offer networks that provide Americans access to affordable, high-quality care. *See* AHIP, *Charges Billed by Out-of-Network Providers: Implications for Affordability*, 3 (Sept. 2015), https://tinyurl.com/3k8mfr98. Such networks benefit patients, providers, health plan sponsors like employers, and the entire health care system by reducing costs, promoting access to and utilization of care, and providing high-quality choices for enrollees. *See* AHIP, *Provider Networks*, https://tinyurl.com/2p94p4xz. The goal is to achieve the highest value for patients, considering factors such as quality of care, breadth of choice, and legal requirements for network adequacy, along with cost. *See* Gary Claxton et al., *Employer strategies to reduce health costs and improve quality through network configuration*, Peterson-KFF Health Sys. Tracker (Sept. 25, 2019),

https://tinyurl.com/ydzxn6ux; Nat'l Conf. of State Legislatures, *Health Insurance Network Adequacy Requirements* (Apr. 27, 2023), https://tinyurl.com/sy4cz9hw. The resulting contracts limit the provider to the payment amount the provider has agreed to accept from the plan and prohibit surprise bills to patients. *See* 86 Fed. Reg. 36,872, 36,874 (July 13, 2021).

Out-of-network providers, in contrast, often charge higher rates, and before the Act, sometimes sent patients surprise bills for any part of their unilaterally set billed charge that was not paid by the patient's health plan. *Id*. By leveraging the threat to "balance bill" patients, such providers were often able to obtain significantly higher payments than other medical specialties. *See id.*; Zack Cooper et al., *Out-Of-Network Billing and Negotiated Payments for Hospital-Based Physicians*, 39 Health Affairs 24, 26, 29 (Jan. 2020), https://tinyurl.com/bddeyrfj (finding average rates for specialties that could balance bill were over three times Medicare rates, compared to one and a half times Medicare rates for specialty unlikely to be able to balance bill).

Before the Act, air ambulance services were an extreme—but significant—example of this skewed market dynamic, resulting in exorbitant surprise bills for patients and higher health care costs for all Americans with health insurance. "[A]voidance of insurance network participation combined with aggressive collection" was "a business strategy of some providers of air ambulance services" before the Act. 86 Fed. Reg. at 36,923. Under that business model, air ambulance providers extracted payments from commercially insured patients well above costs. About 70% of air ambulance revenue came from the roughly 30% of transports covered by commercial insurance, while privately insured patients and their health insurance providers paid more than double the cost of services—by even the industry's estimate. Ass'n of Air Med. Servs., *Presentation to the U.S. Department of Transportation: Air Ambulance & Patient Billing Advisory Committee* 14-15 (Jan. 15, 2020), https://tinyurl.com/r5b2s6b8.

In addition, private equity firms have invested heavily in air ambulance providers, drawn by the ability to aggressively raise prices in part because of a pre-Act regulatory vacuum.[2] Loren Adler et al., *High air ambulance charges concentrated in private equity-owned carriers*, Brookings Inst. (Oct. 13, 2020), https://tinyurl.com/3dbyn523. Charges soared, nearly tripling over ten years. Erin C. Fuse Brown et al., *The Unfinished Business of Air Ambulance Bills*, Health Affairs Forefront (Mar. 26, 2021), https://tinyurl.com/yxbzfpb7.

Because air ambulance charges were so extremely high, health insurance providers "place[d] a high value on preventing enrollee surprise bills." Brown, *supra*. To help protect their beneficiaries from surprise bills and debt collection suits, health insurance providers often agreed to pay air ambulance providers' full billed charges. *See* 86 Fed. Reg. at 36,923. As the expert agencies implementing the No Surprises Act have recognized, such pre-Act payments to air ambulance providers do not "reflect[] market rates under typical contract negotiations," *id.* at 36,889, but instead result from threats to balance bill a patient for an often excessive amount. The upshot of those inflated payments was higher premiums for everyone who purchased health coverage, not just air ambulance patients.

The Act remedied this acute market dysfunction by taking several steps to protect patients from unpredictable and out-of-control out-of-network costs, including for air ambulance services. First, unless state law provides otherwise, the Act sets patients' cost-sharing based on the QPA, which is generally the health plan's median in-network contract rate for the same service in the same area.[3] Medical providers are prohibited from balance billing patients for the rest of their

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[2] Courts have held that air ambulance billing practices are protected from state regulation by the Airline Deregulation Act. *See, e.g., Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 755 (4th Cir. 2018).

[3] 42 U.S.C. § 300gg-111(a)(1)(C)(iii), (a)(3)(E), (b)(1)(B).

charges.[4] Second, the Act establishes IDR as a streamlined arbitration process to conclusively resolve the amount to be paid for out-of-network services, and requires IDR entities to consider the QPA when making payment determinations.[5] Plaintiffs' lawsuits would undermine both aspects of the Act.

II. Permitting Judicial Review Based On Conclusory Allegations Of Misrepresentation Or Partiality Would Contravene Congressional Design And Harm Consumers.

A. Congress Designed IDR to Be a Rarely Used, Efficient Process to Conclusively Resolve Payment Disputes.

To put an end to the practice of providers hounding patients to collect on surprise bills (and the resulting crushing medical debt), the Act created a new process for resolving the amounts to be paid for covered out-of-network services. Medical providers who are not in-network generally do not have the right "under state common law" to "recover payment directly from insurers for out-of-network services." *Haller v. U.S. Dep't of Health & Human Servs.*, No. 21-CV-7208, 2022 WL 3228262, at *7 (E.D.N.Y. Aug. 10, 2022), *appeal docketed*, No. 22-3054 (2d. Cir. Nov. 30, 2022). Congress therefore created "a distinct claim" and "assign[ed] [its] adjudication to arbitration," "devis[ing] an 'expert and inexpensive method for dealing with a class of questions … particularly suited'" to arbitral resolution. *Id.* at *7-8 (quoting *Stern v. Marshall*, 564 U.S. 462, 494 (2011)).

In allowing even arbitration, Congress created administrative costs that do not exist in some state systems that resolve out-of-network payments without resort to arbitration. *See* Jack Hoadley & Kevin Lucia, *Are Surprise Billing Payments Likely to Lead to Inflation in Health Spending?*, Commonwealth Fund (Apr. 26, 2021), https://tinyurl.com/w8mu5mve (describing how four states' surprise billing laws rely solely on payment standards, without arbitration). Congress took great

[4] *Id.* §§ 300gg-131, 300gg-132, 300gg-135.
[5] *E.g.*, *id.* § 300gg-112(b)(5)(C)(i) (air ambulances).

pains to minimize those costs, however, and designed the new IDR arbitration system with three key features: settlement focus, efficiency, and finality.

1. For starters, the Act encourages prompt, voluntary resolution of out-of-network payment disputes within a few months of a claim. Health insurance providers must pay or deny claims within 30 days of receiving a sufficient claim, followed by up to 30 days to initiate a 30-day open negotiations period.[6] If the parties still cannot agree, then one may initiate IDR, but only if it does so within 4 days.[7] Even after IDR is initiated, however, the parties may continue negotiations and settle at any time before the IDR entity makes a decision.[8] Moreover, the certified IDR entity is limited to selecting one of the two offers submitted by the parties.[9]

These features, often called "baseball-style" arbitration due to the historical association with Major League Baseball salary disputes, have long been recognized as reducing costs by encouraging settlement. *See* Jeff Monhait, *Baseball Arbitration: An ADR Success*, 4 J. Sports & Ent. L. 105, 131 (2013) ("[T]he system lowers costs by encouraging the parties to negotiate reasonably, and it incentivizes settlement prior to a hearing."). "In nearly every sector that has been studied, … the presence of a [baseball-style arbitration] clause often leads to a negotiated settlement prior to the need for a hearing." Erin Gleason & Edna Sussman, *Final Offer/Baseball Arbitration: The History, The Practice, and Future Design*, 37 Alt. to High Costs Litigation, Jan. 2019, at 8, 9. Baseball-style arbitration is so effective at encouraging settlement because it "leads to a convergence of offers." Monhait, *supra*, at 133. It does so because—unlike more open-ended arbitration, where the arbitrator might be expected to split the difference—parties have incentives

[6] 42 U.S.C. § 300gg-112(a)(3), (b)(1)(A) (governing air ambulance claims); *see also id.* § 300gg-111(c) (materially same process for medical providers).
[7] *Id.* § 300gg-112(b)(1)(B).
[8] *Id.* § 300gg-112(b)(2)(B).
[9] *Id.* § 300gg-112(b)(5)(A)(i).

to land on a more reasonable final offer, rather than an "aspirational" number. *Id.* at 132.

2. If the parties do not settle, Congress crafted IDR to be an expeditious yet well-informed process to arrive at an expert payment decision, not a drawn-out enterprise. IDR entities must have "sufficient medical, legal, and other expertise and sufficient staffing to make determinations ... on a timely basis."[10] To ensure timeliness, the Act requires parties to submit offers within 10 days, and the IDR entity to choose one of the offers within 30 days.[11] The IDR entity must consider the QPA (*i.e.*, the median network rate) when making its choice, and select the offer that "best represents the value of the … item or service."[12]

As with baseball-style arbitration generally, cost-effectiveness and speed are key features of the IDR process. *See* Monhait, *supra*, at 131 (finding "the [baseball] system lowers the costs of resolving salary disputes and avoids holdouts, comporting with cost-benefit analysis"). Congress's choices reflect its intent that IDR be efficient and minimize costs. *E.g.,* 42 U.S.C. § 300gg-111(c)(3)(A) (requiring batching to "encourag[e] … efficiency (including minimizing costs) of the IDR process"). All told, IDR should resolve payment disputes within about four months of a claim. Unfortunately, the system has yet to live up to its promise, largely due to the overwhelming volume of claims initiated by a tiny minority of providers and further stymied by repeated provider-initiated litigation. *See* pp. 12-14, *infra*.

3. Congress intended that payment disputes would be conclusively resolved by the well-informed, streamlined IDR process. IDR results are "binding upon the parties involved" except for a "fraudulent claim or evidence of misrepresentation of facts" to the IDR entity regarding "such

[10] 42 U.S.C. § 300gg-111(c)(4)(A)(i).
[11] *Id.* § 300gg-112(b)(5)(A)-(B).
[12] *Id.* § 42 U.S.C. § 300gg-111(a)(1)(C)(iii), (a)(3)(E), (b)(1)(B); 300gg-112(b)(5)(C)(i)(I); 45 C.F.R. § 149.510(c)(4)(ii)(A); *id.* § 149.520(b)(1) (generally applying § 149.510 to air ambulance determinations).

claim."[13] They "shall not be subject to judicial review" except in the constrained circumstances of the Federal Arbitration Act,[14] which are "among the narrowest known to the law." *Halliburton Energy Servs., Inc. v. NL Indus.*, 618 F. Supp. 2d 614, 634 (S.D. Tex. 2009). Moreover, IDR decisions preclude further IDR proceedings between the same parties about the same service for 90 days.[15]

Considering IDR design as a whole, "the congressional goal of promoting efficient dispute resolution" is clear. *See Commodity Futures Trading Comm'n v. Schor*, 478 U.S. 833, 837 (1986) (describing Congress's purpose in adopting administrative dispute system in lieu of litigation). As designed, IDR offers all the benefits of arbitration: "lower costs, greater efficiency and speed, and the ability to choose expert adjudicators to resolve specialized disputes." *Stolt-Nielsen S. A. v. AnimalFeeds Int'l Corp.*, 559 U.S. 662, 685 (2010).[16] Congress's choice of baseball-style arbitration—a particularly efficient process that is now used in a host of different commercial and government contexts, Gleason & Sussman, *supra*, at 10—is essential to reducing IDR administrative costs.

If implemented as designed, the Act will "minimize reliance on the … IDR process and encourage parties to submit reasonable offers." 86 Fed. Reg. at 56,053. Over time, strict adherence to IDR's statutory guardrails will benefit consumers and taxpayers by making health care more affordable for everyone.

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[13] 42 U.S.C. § 300gg-111(c)(5)(E); *id.* § 300gg-112(b)(5)(D) (incorporating § 300gg-111(c)(5)(E) for air ambulances).
[14] *Id.* § 300gg-111(c).
[15] 42 U.S.C. § 300gg-111(c)(5)(E)(ii).
[16] Although the agency may assign an IDR entity if the parties do not jointly select one, 42 U.S.C. § 300gg-111(c)(4)(F), the certification criteria ensure that all IDR entities are expert adjudicators of these specialized disputes.

B. Undermining the Finality of IDR Determinations Would Vitiate Congress's Cost-Effective Process, Especially Given High IDR Volume.

1. Preserving IDR finality is critical for the Act to work as Congress intended, especially given high IDR volume.

The benefits of arbitration generally depend upon finality, and IDR is no different. The "primary purpose served by the arbitration process is expeditious dispute resolution." *Univ. of Notre Dame (USA) in England v. TJAC Waterloo, LLC*, 49 F.4th 13, 21 (1st Cir. 2022). "Arbitration loses some of its luster, though, when one party refuses to abide by the outcome and the courts are called in after all." *Id.*; *see Light-Age, Inc. v. Ashcroft-Smith*, 922 F.3d 320, 322-23 (5th Cir. 2019) (describing "policy interests" in "efficiency and finality of the arbitration process").

For this reason, the Federal Arbitration Act's limited grounds for vacating an arbitration award—incorporated by reference into the No Surprises Act—"substantiat[e] a national policy favoring arbitration with just the limited review needed to maintain arbitration's essential virtue of resolving disputes straightaway." *Hall St. Assocs., L.L.C. v. Mattel, Inc.*, 552 U.S. 576, 588 (2008). Any other approach would "open[] the door to the full-bore legal and evidentiary appeals that can rende[r] informal arbitration merely a prelude to a more cumbersome and time-consuming judicial review process, and bring arbitration theory to grief in postarbitration process." *Id.* (citations omitted; second alteration in original).

a. Plaintiffs' theory of no-limits judicial review would invite just such post-arbitration grief and interfere with the carefully reticulated process that Congress designed to maximize efficiency.

If Plaintiffs were correct that each IDR can be converted into a court case on nothing more than "information and belief" that a health plan miscalculated and therefore "misrepresented" the QPA, or mere assertion that an IDR entity was "partial" because it made a purported legal error in selecting an offer, *see* Guardian Flight Compl., Doc. 1, ¶35, REACH Compl., Doc. 1, ¶¶ 51-52, IDR determinations would no longer be final or binding in any meaningful way. IDR would be

nothing more than a way station on the way to court. That result is startling because medical providers and air ambulance services generally had no pre-Act common law right to hale health insurance providers into court to seek payment for out-of-network services. *See Haller*, 2022 WL 3228262, at *7-8. It would be passing strange if by creating a novel federal process for recovering payments from insurance providers, circumscribed by an expeditious arbitration system with exceptionally narrow judicial review, Congress in effect invited providers to sue health insurance providers whenever they are dissatisfied with out-of-network payments.

Final payment determinations would also inevitably be delayed under Plaintiffs' approach—if the system did not break down altogether. Whenever a dissatisfied provider in search of higher payment runs to court, Congress's intended few-month process could be extended by a year or more. *See* Admin. Office of U.S. Courts, *Civil Judicial Business* (2022), Table C-5, https://tinyurl.com/j9u9smpe (median time of 11.8 months from filing to disposition for cases filed in district court and resolved before pre-trial stage). The overwhelming volume of IDR proceedings and associated backlog are already severely taxing the resources of the agencies tasked with overseeing the IDR process and hampering IDR entities' ability to resolve disputes.

What's more, lawsuits against the arbitrators themselves are likely to discourage an already limited pool of qualified entities from serving as certified IDR entities or from issuing IDR decisions involving frequent litigants. Indeed, AHIP has learned that the recent flurry of lawsuits has chilled certain IDR entities' willingness to resolve disputes involving litigious providers, such as Plaintiffs and their affiliates. It is increasingly clear that the pall cast by such suits will only further delay IDR decisions across the board, and risks bringing the processing of IDR claims for certain types of services and providers to a screeching halt.

b. Evidence from the Act's first year confirms the importance of ensuring that IDR works

as Congress intended—quickly, cost-effectively, and conclusively. The volume of IDR proceedings has dwarfed the Departments' initial estimates. Between mid-April 2022 and March 2023, nearly 335,000 proceedings were initiated. Ctrs. for Medicare & Medicaid Servs., *Federal [IDR] Process—Status Update*, at 1 (Apr. 27, 2023). https://tinyurl.com/2dp48eyd (IDR Status Update). This is nearly fourteen times the number of IDR proceedings projected for the first full calendar year. *Id*. And the avalanche has only begun. The dispute initiation rate has been accelerating; IDR volume in the final quarter of 2022 increased more than 50% from the preceding quarter. Ctrs. for Medicare & Medicaid Servs., *Partial Report on the [IDR] Process: October 1 – December 31, 2022*, at 7-8 (Apr. 27, 2023), https://tinyurl.com/mrx7sk66 (IDR Fourth Quarter Report).

Closer examination of this volume, however, indicates that it stems from concentrated exploitation of the IDR system by a handful of practice or revenue management companies for providers in a tiny fraction of specialties—typically, those that profited the most from surprise billing. Still, most medical providers appear to agree that out-of-network payments around the QPA reflect reasonable market rates, and Congress's choice of baseball-style arbitration to encourage voluntary settlements is mostly working. In the Act's first year, patients were protected from about 12 million surprise medical bills, and about 97% of out-of-network payments did *not* go to IDR. AHIP, *No Surprises Act Prevents More than 9 Million Surprise Bills Since January 2022* (Nov. 2022), https://tinyurl.com/2syeh838 (finding about 9 million surprise bills avoided in nine months).

The lion's share (over 80%) of non-air-ambulance claims that did go to IDR involved emergency services—another area where patients are often unable to choose their provider, and there is less incentive for providers to join networks—with over half of all IDR disputes relating

to just five emergency department visit codes. *See* Ctrs. for Medicare & Medicaid Servs., *Initial Report on the Independent Dispute Resolution (IDR) Process, April 15-September 30, 2022*, at 19 (Dec. 2022), https://tinyurl.com/mtp7kd3k (IDR Report); IDR Fourth Quarter Report, at 23. What's more, a single entity initiated one third or more of the total non-air-ambulance disputes. IDR Report, at 16; IDR Fourth Quarter Report, at 26. Air ambulance volume was similarly driven by a few providers, with three providers (out of more than 60) generating about three quarters of IDR proceedings. IDR Report, at 26; IDR Fourth Quarter Report, at 26.

The Act's market-rate-oriented approach and dispute resolution process is thus working well for most providers. But the IDR system has started to buckle under the strain caused by the few providers expending extensive resources to exploit the process. Fewer than a third of IDR disputes were resolved within the first year that the system was up and running, notwithstanding a 30-day statutory time limit for issuing determinations. IDR Status Update, at 1-2 (about 106,000 final resolutions out of nearly 335,000 initiated). There are growing indications, moreover, that decisions are taking substantially longer than 30 days. Flinging open the courthouse doors to make it ever easier to challenge IDR determinations will only make this already unsustainable dynamic worse, harming the millions of patients and tens of thousands of medical providers for whom the Act is working.

2. *The excessive and unwarranted costs generated by undermining IDR finality will be borne by consumers.*

Although IDR is streamlined and cost-effective, it is not cost-free. Congress understood that the new system would generate some administrative costs, but designed the Act so those costs would be minimal and more than offset by savings generated by aligning payments for out-of-network services with reasonable, negotiated market rates. *See* Cong. Budget Off., *Cost Estimate: H.R. 2328, Reauthorizing and Extending America's Community Health Act*, at 9 (Sept. 2019),

https://tinyurl.com/mryj3nmb (describing how predecessor bill would "create new administrative costs for insurers" but "net effect of all th[e] changes would be lower insurance premiums"). If, contrary to statutory design, providers can effectively sue whenever they are dissatisfied, it would encourage even more IDR proceedings and add on litigation costs. On net, the savings Congress intended to secure for consumers (and taxpayers) would likely evaporate and American consumers and patients would pay for this statutorily unauthorized litigation campaign.

As it is, the unexpectedly large number of IDR proceedings has already increased administrative costs. Both parties must pay an administrative fee (now $350), and the losing party must pay IDR fees that can reach $700 for a single item, or up to $1,200 for a batched claim with a substantial number of items. Ctrs. for Medicare & Medicaid Servs., *Amendment to the Calendar Year 2023 Fee Guidance for the Federal [IDR] Process under the No Surprises Act: Change in Admin. Fee*, at 6-7 (Dec. 2022) https://tinyurl.com/mwxerbj7. There are also substantial IDR-related staffing and technology expenses. Early experience indicates these costs have been substantially higher than anticipated due to the volume of IDR disputes submitted by providers.

Yet these already high administrative costs pale in comparison to the additional costs generated by vitiating Congress's efficient arbitration process and replacing it with no-limits judicial review. It goes without saying that petitions to vacate arbitral awards are costly and time-consuming to litigate. Administrative costs to litigate the validity of IDR decisions would almost certainly be orders of magnitude higher than IDR costs alone.

The upshot would be increased health care costs for all Americans—without one penny of the increased costs benefiting patients through improved health care value or quality. This wasteful spending, not contemplated (much less authorized) by Congress, directly harms consumers who purchase insurance and indirectly harms taxpayers by increasing expenditures for premium tax

credits. *See* 86 Fed. Reg. 55,980, 56,059 (Oct. 7, 2021). Health plans are subject to premium rate reviews by state or federal regulators, *e.g.*, 42 U.S.C. § 300gg-94, and some plans must be designed to cover a certain percentage of costs. For example, health plans sold on health care exchanges are classified into metal "tiers" based on the percentage of health care costs they cover for the average individual. *The health plan categories: Bronze, Silver, Gold & Platinum*, HealthCare.gov, https://tinyurl.com/z9s6rj76. One such "silver" plan must be designed to cover 70% of health care costs, on average. *Id.*; *see also* 42 U.S.C. § 18022(d). When costs go up, some mix of premiums, deductibles, and cost-sharing must go up, too, to maintain the specified level of coverage.

Given this regulatory obligation to set premiums and cost-sharing to cover costs, all Americans would ultimately bear the increased costs caused by vitiating the safeguards that keep IDR comparatively inexpensive and efficient. This outcome cannot be squared with either the Act's purpose to protect consumers from high out-of-network costs, or the broader legal, commercial, and regulatory imperatives for health plans to limit the amount spent on administrative costs. *See, e.g.*, 42 U.S.C. § 300gg-18(b).

C. Judicial Review Directing QPA Recalculation Would Undermine the Act's QPA's Lynchpin.

Plaintiffs' open-ended approach to judicial do-overs for IDR would wrongly undercut finality across the board. Even more destructive to the Act's structure and operation, however, is the atextual theory that IDR can be re-opened based on an allegedly miscalculated QPA, *see* Guardian Flight Compl., Doc. 1, ¶ 35, REACH Compl., Doc. 1, ¶¶ 51. As the agencies implementing the Act have made clear, IDR entities themselves are not permitted to recalculate the QPA. 87 Fed. Reg. 52,618, 52,627 & n.31 (Aug. 26, 2022). Instead, IDR "payment determinations … should center on a determination of a total payment amount … based on the facts and circumstances of the dispute at issue, rather than an examination of a plan's or issuer's

QPA methodology." *Id.* at 52,626. IDR entities cannot look behind a given QPA because the "statute places the responsibility for monitoring the accuracy of plans' and issuers' QPA calculation methodologies with the Departments (and applicable state authorities) by requiring audits." *Id.*

The governing agencies maintain such tight oversight of the QPA because it serves as a lynchpin of the Act, providing a fixed input for several key statutory functions, well beyond the bounds of any individual IDR decision. First, the QPA often establishes the amount owed in patient cost sharing, enhancing the predictability of out-of-pocket costs.[17] Second, the QPA "as defined" by the Act is a mandatory IDR consideration in every case.[18] Finally, the Act requires IDR offers and results to be reported as percentages of the QPA.[19] If each IDR proceeding could recalculate the QPA, a single pull of the thread could unravel the important role Congress intended the QPA to serve throughout the Act.

Permitting courts to re-examine QPA calculations as a basis for vacating IDR decisions—when IDR entities cannot (and should not) themselves recalculate the QPA—is *a fortiori* destructive to the QPA's role as a fixed lodestar. And permitting providers to reopen IDR determinations based on a conclusory assertion that a QPA was miscalculated—on top of an attenuated theory that any QPA mistake counts as a "misrepresentation" to the IDR entity—is even worse. Accepting this invitation to impermissibly rewrite the statute would frustrate Congress's considered choice to assign QPA monitoring compliance to expert agencies, not a patchwork of IDR decisions, much less court rulings.

Given the QPA's role in cost-sharing, allowing a court to reopen the calculation of the

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[17] 42 U.S.C. § 300gg-111(a)(1)(C)(iii), (b)(1)(B).
[18] *Id.* § 300gg-111(c)(5)(C)(i)(I).
[19] Id. § 300gg-111(c)(7)(A)(v), (B)(iii)-(iv)..

QPA—or to require an IDR entity to do so—after the consumer already paid a cost-share based on an agency-audited QPA would introduce just the type of uncertainty for consumers that the No Surprises Act was intended to address. It would also introduce a host of questions for implementing the reporting provisions that depend on the QPA, like: which QPA should be used for reporting results? The statutorily defined one, calculated by health insurance providers, used to establish patient cost-sharing, and audited by the Departments? Or the one generated by a court reviewing an IDR decision? What should an insurance provider do if the Departments' audit confirms a QPA is accurately calculated, but a court decision says otherwise? The statute stops these questions from arising, because it provides for only a single QPA for each insurance provider and service, which neither IDR entities nor courts may recalculate.

In lieu of piecemeal review of IDR decisions through unauthorized judicial re-examination, Congress assigned QPA monitoring and compliance to an express statutory complaint and audit procedure. If Plaintiffs believe a QPA was miscalculated, they may file a complaint with the Department of Health and Human Services. *See* 42 U.S.C. § 300gg-111(a)(2)(B)(iv). The Department has set up a portal for that purpose. *See No Surprises Provider Complaint Form*, https://tinyurl.com/5n8htspa. The Department and other regulators may audit QPA calculations based on complaints, and the Act requires them to do so on a random sampling basis. *See* 42 U.S.C. § 300gg-111(a)(2), (a)(3)(E). Such audits are now underway and there is no evidence the Department is failing to respond to any provider's complaint that a QPA may be miscalculated. Allowing courts to perform the audit function that Congress assigned to the Department and other regulators (including state authorities) is contrary to the plain language of the statute and risks undermining oversight efforts already underway. *See* 87 Fed. Reg. at 52,627 & n.31.

Interpreting the Act to permit courts to vacate IDR determinations on allegations of QPA

miscalculation would contravene Congress's choice to delegate questions about the accuracy of QPA calculations to expert administrative judgement, while only creating uncertainty for consumer cost-sharing and other purposes. The No Surprises Act was meant to solve such problems, not create them. Unwanted uncertainty can be avoided by following Congress's vision of preserving the QPA as a fixed calculation wherever it is used in the statute, subject to compliance check through the regulatory audit process, not case-by-case reconsideration.

CONCLUSION

The Court should grant Defendants Aetna Health Inc. and Kaiser Foundation Health Plan's motions to dismiss for failure to state a claim.

Dated: May 18, 2023 Respectfully Submitted,

/s/Hyland Hunt
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CERTIFICATE OF SERVICE

I hereby certify that on May 18, 2023, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system, which will send a notice of electronic filing to all counsel of record.

/s/Hyland Hunt
Hyland Hunt

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

GUARDIAN FLIGHT, LLC,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Case No.:
	)	4:22-cv-03805
	)	Lead Consolidated Case
AETNA HEALTH INC., et al.	)	
	)	
Defendants.	)	
	)	

[PROPOSED] ORDER GRANTING MOTION FOR LEAVE TO FILE BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS AETNA HEALTH INC. AND KAISER FOUNDATION HEALTH PLAN'S MOTIONS TO DISMISS

Upon consideration of the Motion for Leave to File Brief of America's Health Insurance Plans as *Amicus Curiae* in Support of Defendants Aetna Health Inc. and Kaiser Foundation Health Plan's Motions to Dismiss, the Court finds that the Motion is hereby **GRANTED**. Accordingly, it is **ORDERED** that the Brief of America's Health Insurance Plans as *Amicus Curiae* is hereby filed.

SIGNED on this ___ day of ___________, 2023.

THE HONORABLE ALFRED H. BENNETT
UNITED STATES DISTRICT JUDGE