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

TEXAS MEDICAL ASSOCIATION, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants*.	)	Case No.: 6:22-cv-00450-JDK Lead Consolidated Case

TMA PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND MEMORANDUM IN SUPPORT THEREOF

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Plaintiffs Texas Medical Association ("TMA"), Dr. Adam Corley, and Tyler Regional Hospital, LLC, respectfully move for summary judgment on Counts I and II of their complaint.[1]

INTRODUCTION

In the No Surprises Act ("NSA"), Congress significantly changed how out-of-network healthcare providers are compensated for their services. Under the Act, Congress eliminated out-of-network providers' ability to "balance bill" patients for amounts not covered by their insurers, and instead required insurers to pay reasonable compensation to the provider when one of their insureds receives services covered by the Act. To determine the amount the insurer must pay, Congress created an independent dispute resolution ("IDR") process under which billing disputes that the parties cannot resolve through negotiation are submitted to an independent arbitrator.

Under the NSA, one metric arbitrators must consider in determining the appropriate reimbursement rate is the qualifying payment amount, or "QPA." Congress generally defined the QPA as the insurer's median in-network contracted rate for the relevant item or service in 2019, adjusted for inflation. Congress charged the defendant Departments with (1) establishing a methodology for insurers to use to calculate their QPAs; (2) specifying the information insurers must disclose to providers about their QPA calculations; and (3) establishing a complaint process for providers to challenge insurers' QPA calculations. The Departments did so through an interim final rule, issued without notice and comment, in July 2021. *See* 86 Fed. Reg. 36,872 (July 13, 2021).

Unfortunately, the QPA calculation methodology the Departments established in the July Rule directly conflicts with the NSA's clear text in multiple, critical respects. And each of the Departments' departures from the statutory text predictably skews QPAs downward, slanting the

[1] Attached hereto as Exhibits A–D and incorporated herein by reference are plaintiffs' declarations in support of this motion.

Act's IDR process in insurers' favor and ultimately leading to unacceptably low payments to providers and creating devastating impacts for the nation's healthcare system.

Compounding the problem, although the NSA mandates that the Departments require insurers to make meaningful disclosures about how they calculate their QPAs, the Departments required insurers to make only the most barebones disclosures, leaving providers almost completely in the dark about whether insurers complied with the NSA and unable to meaningfully access the NSA's complaint process or to provide relevant information to arbitrators about the QPA.

The challenged portions of the July Rule and subsequent guidance are manifestly unlawful. They conflict with the statute's unambiguous terms and thus fail at *Chevron* step one. And they also fail at *Chevron* step two and are arbitrary and capricious because they do not permissibly interpret "QPA," as Congress defined the term, or reasonably implement the process Congress created in the NSA for providers to learn about and challenge insurers' QPA calculations. Accordingly, and as discussed more fully below, the challenged provisions should be declared unlawful, vacated in part, and remanded for further rulemaking consistent with the NSA and APA.

STATEMENT OF THE ISSUE

The issue presented is whether the challenged provisions of the July Rule and subsequent guidance that artificially depress QPAs and prevent effective review of insurers' QPA calculations must be set aside because they conflict with the statute and are arbitrary and capricious.

STATEMENT OF UNDISPUTED MATERIAL FACTS

I. The No Surprises Act

When a patient with private insurance coverage receives medical care from an in-network provider, the insurer typically pays the provider the rate the insurer and provider previously negotiated and agreed to by contract. *See* 86 Fed. Reg. at 36,874. The patient is responsible for only the

cost-sharing that is required by the insurance plan, such as a co-pay, coinsurance, and any deductible. *See id.* If there is a difference between a provider's billed charges and the contracted rate a provider receives from the insurer, the provider does not bill the patient for the difference. *See id.*

When a patient receives care from a provider who is out-of-network, however, the insurer and provider have not signed an agreement determining what will be paid. *Id.* The provider therefore submits a bill to the patient's insurer, and the insurer determines what (if anything) it will pay the provider. *Id.* If the insurer chooses not to pay some or all of the bill, the difference between what the provider billed and how much the insurer paid has historically been the patient's responsibility. *Id.* To collect that balance, the provider traditionally sent the patient a "balance bill." *Id.*

The NSA addresses these situations.[2] Under the Act, the patient's insurer must pay the provider an amount determined through a statutorily mandated negotiation and arbitration process, while the patient's cost-sharing responsibility is limited. For emergency services furnished by an out-of-network provider, or non-emergency services furnished by an out-of-network provider at an in-network facility, the patient's cost-sharing responsibility may not exceed the amount that would apply if the services had been provided by an in-network provider or facility. 42 U.S.C. § 300gg-111(a)(1)(C)(ii), (b)(1)(A). And the patient's insurer must pay the provider an "out-of-network rate," less the patient's cost-sharing. *Id.* § 300gg-111(a)(1)(C)(iv)(II), (b)(1)(D).

The "out-of-network rate" is governed by any applicable All-Payer Model Agreement or, if there is none, then by any applicable specified state law providing a method for determining out-of-network reimbursement. *Id.* § 300gg-111(a)(3)(K). Otherwise, insurers make an initial payment

[2] The NSA amended the Public Health Service ("PHS") Act, enforced by the Department of Health and Human Services ("HHS"); the Employee Retirement Income Security Act ("ERISA"), enforced by the Department of Labor; and the Internal Revenue Code ("IRC"), enforced by the Department of the Treasury. Relevant provisions generally appear in triplicate and are identical in all material respects. For ease of reference, this brief cites the PHS Act and implementing regulations.

in an amount of their choosing, which the provider may dispute. *Id.* § 300gg-111(b)(1). To resolve disputes, the NSA establishes an open negotiation process, followed, if necessary, by arbitration.

A. The IDR Process

The statute prescribes a "baseball-style" arbitration process in which the provider and insurer submit their best and final offers for the amount each considers to be reasonable payment. *Id.* § 300gg-111(c)(5)(B), (C)(ii). Subparagraph (C) details the factors arbitrators "shall consider" in choosing between the parties' offers. One of those factors is the QPA "as defined" by the NSA "for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region." *Id*. § 300gg-111(c)(5)(C)(i)(I). Arbitrators also must consider "information on" five "[a]dditional circumstances" specified by Congress, as well as any other information the arbitrator requests or a party submits relating to its offer. *Id.* § 300gg-111(c)(5)(C)(i)(II). After "taking into account" these "considerations," the arbitrator must select one of the parties' offers as the payment amount. *Id*. § 300gg-111(c)(5)(A)(i).

Unfortunately, the Departments' initial implementation of the NSA's arbitration process materially deviated from Congress's design by "treat[ing] the QPA … as the default payment amount and impos[ing] on any provider attempting to show otherwise a heightened burden of proof that appears nowhere in the statute." *Texas Med. Ass'n v. United States Dep't of Health & Hum. Servs.* ("*TMA I*"), 587 F. Supp. 3d 528, 543 (E.D. Tex. 2022); *see also LifeNet, Inc. v. United States Dep't of Health & Hum. Servs.* ("*LifeNet I*"), No. 6:22-cv-162, 2022 WL 2959715 (E.D. Tex. Jul. 26, 2022). Following this Court's decisions in *TMA I* and *LifeNet I*, the Departments issued a new IDR rule—the subject of separate pending challenges[3]—under which arbitrators must

[3] *See Texas Med. Ass'n v. United States Dep't of Health & Hum. Servs.* ("*TMA II*"), No. 6:22-cv-00372 (E.D. Tex.); *LifeNet, Inc. v. United States Dep't of Health & Hum. Servs.* ("*LifeNet II*"), No. 6:22-cv-373 (E.D. Tex.).

consider the QPA first and may not give weight to any other information unless, among other things, it is not "already accounted for by the" QPA. 87 Fed. Reg. 52,618, 52,652 (Aug. 26, 2022).

The QPA is therefore a required input into the process Congress created in the NSA for determining provider reimbursement. Under the statute, it is one of the enumerated factors that arbitrators must always consider. And under the Departments' regulations, it is given outsized importance, serving as a *de facto* benchmark rate. In fact, even before the IDR process begins, "many plans and issuers make initial payments that are equivalent to or are informed by the corresponding QPA for the item or service at issue." 87 Fed. Reg. at 52,625 n.29.

In short, for the negotiation and arbitration process to function as Congress intended, it is critical both that insurers calculate their QPAs correctly under the statute and that providers have meaningful information about the basis for insurers' QPA calculations.

B. QPA Definition, Methodology, and Disclosure

Conscious of the role QPAs may play in influencing the "out-of-network rate" that insurers pay to providers, Congress carefully defined the term QPA. The NSA provides two alternate definitions. First, in general, "[t]he term 'qualifying payment amount' means":

> the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market …) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on 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,

with annual inflation adjustments. 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I).

Second, when an insurer "does not have sufficient information to calculate the median of the contracted rates described in clause [(E)](i)(I)," QPA "means the rate" determined by reference to an independent database, such as a state all-payer claims database, reflecting "allowed amounts

paid to a health care provider or facility for relevant services furnished in the applicable geographic region." *Id.* § 300gg-111(a)(3)(E)(iii).

Congress directed the Departments to promulgate rules establishing "the methodology" that insurers "shall use to determine the [QPA]." *Id.* § 300gg-111(a)(2)(B)(i). Congress further commanded the Departments to establish through rulemaking "the information" that insurers "shall share" with providers when determining a QPA, as well as "a process to receive complaints of violations" of applicable requirements. *Id.* § 300gg-111(a)(2)(B)(ii), (iv). The complaint process must allow for complaints that a QPA calculated by an insurer violates the requirement that the QPA "satisf[y] the definition" of QPA laid out in the NSA. *Id.* § 300gg-111(a)(2)(A)(i)(II).

II. The Departments' Implementing Regulations and Guidance

A. The July Interim Final Rule

On July 1, 2021, the Departments issued the rule at issue here. 86 Fed. Reg. 36,872 (July 13, 2021). The July Rule is an interim final rule, and the Departments issued it without providing notice or an opportunity for interested parties to comment on the Departments' approach. As relevant here, the July Rule sets forth (1) the methodology for insurers to calculate QPAs, 45 C.F.R. § 149.140(a)–(c); *see* 86 Fed. Reg. at 36,888–98; and (2) the information insurers must disclose to providers about their QPA calculations, 45 C.F.R. § 149.140(d); *see* 86 Fed. Reg. at 36,898–99.

1. The July Rule's QPA Methodology

First, in laying out the methodology for how insurers must calculate QPAs, the July Rule provides that "contracted rates," 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I), are "the total amount (including cost sharing) that a group health plan or health insurance issuer has *contractually agreed to pay* a participating provider, facility, or provider of air ambulance services for covered items and services," 45 C.F.R. § 149.140(a)(1) (emphasis added). Thus, although the NSA defines the QPA as the "median of the contracted rates" for an item or service "that is *provided* by a *provider*"

and "*provided* in the [same] geographic region," 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I) (emphasis added), the Departments' definition of "contracted rate" broadly encompasses all contracted rates, without regard to whether any item or service has ever been "provided" at that rate under that contract, *see* 86 Fed. Reg. at 36,889 (confirming that "each contracted rate for a given item or service" should "be treated as a single data point when calculating a median contracted rate … *regardless of the number of claims paid at that contracted rate*" (emphasis added)). The Departments did not explain their choice to define "contracted rate" to include rates for items and services not provided by the relevant provider (commonly known in the industry as "ghost rates").

Second, the rule defines the statutory phrase "provider in the same or similar specialty," 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I), to mean "the practice specialty of a provider, *as identified by the plan or issuer consistent with the plan's or issuer's usual business practice*," 45 C.F.R. § 149.140(a)(12) (emphasis added). Under the rule, therefore, insurers must separate contracted rates by specialty only if "consistent with … [their] usual business practice," *id.*, despite the NSA's categorical mandate that a QPA is the median of contracted rates for an item or service provided "by a provider in the same or similar specialty," 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I). The Departments recognized that not all insurers "vary contracted rates by provider specialty" and "considered requiring a plan or issuer to calculate separate median contracted rates for every provider specialty," but opted against it. 86 Fed. Reg. at 36,891. They stated that they made this choice: (1) "to provide plans or issuers with the flexibility necessary to calculate the median contracted rate, relying on their contracting practices"; (2) to reduce the "burden associated with calculating the QPA"; and (3) to avoid "instances in which the plan or issuer would not have sufficient information to calculate the QPAs using its contracted rates." *Id.* With regard to the third justification, the Departments asserted that a "statutory goal" of the NSA is to limit the instances in which an

insurer "has insufficient information to calculate a median contracted rate." *Id.* at 36,888. While the NSA "specifies an alternative methodology for determining the QPA" in those instances, the Departments believed the statute "envisions that these alternative methodologies … will be used in only limited circumstances" and thus designed the rule to "generally seek to ensure that plans and issuers can meet the sufficient-information standard when determining the QPA and that use of alternative methodologies is minimized wherever possible." *Id.*

Third, the July Rule says that insurers must "[e]xclude" from rates used to calculate QPAs "risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments." 45 C.F.R. § 149.140(b)(2)(iv). The Departments recognized that insurers and providers sometimes agree that payments to providers will be "reconciled retrospectively to account for utilization, value adjustments, or other weighting factors that can affect the final payment" and sometimes "agree to certain incentive payments during the contracting process." 86 Fed. Reg. at 36,894. The Departments offered no textual basis for excluding such payments from the rates used to calculate QPAs, which Congress specified must be the "total maximum payment" recognized by the insurer. 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I). Instead, the Departments contended that excluding such payments is "consistent with how cost sharing is typically calculated for in-network items and services, where the cost-sharing amount is customarily determined at or near the time an item or service is furnished, and is not subject to adjustment based on changes in the amount ultimately paid to the provider or facility as a result of any incentives or reconciliation process." 86 Fed. Reg. at 36,894. The Departments did not explain why, under the statute, typical calculation of cost-sharing obligations is relevant to calculating the total maximum payment under a contract.

Finally, the rule permits self-insured group health plans, "at the option of the plan sponsor," to decide to calculate QPAs using rates from the contracts of "all self-insured group health plans

administered by the same entity (including a third-party administrator contracted by the plan)." 45 C.F.R. § 149.140(a)(8)(iv) (emphasis added). As the Departments recognized, "many" such group health plans "are administered by entities other than the plan sponsor (such as a third-party administrator contracted by the plan)." 86 Fed. Reg. at 36,890. In these situations, a patient's health insurance can be provided by a self-insured health plan of, for example, the patient's employer, while the plan is administered by a different third-party entity. By permitting the plan sponsor to opt to calculate QPAs using "*all* self-insured group health plans *administered*" by that third-party entity, 45 C.F.R. § 149.140(a)(8)(iv) (emphasis added), the July Rule allows plan sponsors to use the contracted rates of *another* sponsor for purposes of calculating their own QPAs. The Departments permitted this despite the NSA's requirement that QPAs must be "determined with respect to all such plans *of such sponsor*." 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I) (emphasis added). The Departments again offered no textual justification for their choice. Instead, they asserted that allowing this opt-in process would "reduce the burden imposed on sponsors of self-insured group health plans." 86 Fed. Reg. at 36,890. The Departments also said that they "anticipate" that under this approach, "there will be fewer instances where a self-insured group health plan sponsor will lack sufficient information to calculate a median contracted rate." *Id.*

2. The July Rule's Systematic Depression of QPAs

In the July Rule, the Departments concluded that Congress intended for QPAs to "reflec[t] market rates under typical contract negotiations." *Id.* at 36,889. Thus, according to the Departments' own telling, the QPA—whether calculated using median in-network rates or identified by selecting a median volume-weighted payment from an independent database—is supposed to serve

as one measure of typical negotiated market rates.[4] Yet, in establishing the QPA methodology, the Departments made a series of deliberate choices that not only violate the statute's clear text, but consistently drive down QPAs *below* "market rates under typical contract negotiations."

First, allowing insurers to include ghost rates drives down QPAs. Providers who do not provide a given item or service have little incentive to negotiate the reimbursement rate for that item or service. Dep'ts, *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55* (Aug. 19, 2022) ("August 2022 FAQs"[5]) at 16 (FAQ 13). Ghost rates therefore are generally lower than they would be if providers had an incentive to meaningfully negotiate them, and can be as low as $0. August 2022 FAQs at 16 (FAQ 13). Including these artificially low rates in QPA calculations drives down the median rate, depressing QPAs.

Second, including out-of-specialty rates tends to drive down QPAs. For one thing, out-of-specialty rates are often ghost rates.[6] Many insurers "establish contracted rates by offering most providers the same fee schedule for all covered services, and then it is up to the providers to negotiate increases to the rates for the services that they are most likely to bill." August 2022 FAQs at 16 (FAQ 14). Therefore, for example, a primary care physician may have contracted rates for radiology services, even though the primary care physician does not provide those services, and therefore did not meaningfully attempt to negotiate those rates with the insurer. *See* August 2022 FAQs at 16 (FAQ 14). Including such rates when determining QPAs for radiology services therefore skews the QPAs away from market rates. Even if a provider in a different specialty provides

[4] The Act does not, however, "trea[t] the QPA as a proxy for the in-network price," let alone as a "proxy for the out-of-network price." *TMA I*, 87 F. Supp. 3d at 543 n.4.

[5] *Available at* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf.

[6] *See* Compl., *LifeNet, Inc. v. United States Dep't of Health & Hum. Servs.* (*LifeNet III*), 6:22-cv-00453-JDK, ¶¶ 54–55 (Dec. 1, 2022).

a service occasionally, but not frequently, the provider is likely to prioritize negotiating rates for the provider's high-volume services, meaning that the provider's rate for a low-volume service is likely to be well below the market rate for the service when provided by specialists who frequently provide it. *See* August 2022 FAQs at 16 (FAQ 14). Including out-of-specialty rates therefore drives down QPAs below market rates for specialties most likely to provide an item or service.

Third, excluding "risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments" from QPA calculations generally depresses QPAs. 45 C.F.R. § 149.140(b)(2)(iv). Providers often negotiate for shared savings payments made later in time. In these arrangements, the provider typically accepts a *lower* fixed per-service rate with the expectation that it will earn at least some additional, incentive-based payments. If the provider did not believe it would earn the additional, incentive-based payments, then the provider would demand a higher fixed per-service rate. These later-in-time payments can account for a significant portion of the rate an insurer ultimately pays a provider for a particular item or service. The Departments' decision to exclude "incentive-based or retrospective payments or payment adjustments" from QPA calculations therefore tends to depress QPAs.

Finally, by giving self-insured group health plans the option to use either rates from only their own plans or rates from all plans administered by their third-party administrator to calculate QPAs, the Departments allowed self-insured group health plans to pick whichever method leads to lower QPAs on balance. These plans can be expected to opt into their third-party administrator's group calculation if it generally serves to lower their applicable QPAs. Again, this lowers QPAs.

The Departments did not address how each of their choices regarding the QPA methodology depresses QPAs or how their choices are consistent with their own understanding that QPAs should "reflec[t] market rates under typical contract negotiations." 86 Fed. Reg. at 36,889.

3. The July Rule's Disclosure Requirements

The July Rule also addressed the NSA's command to the Departments to establish through rulemaking the "information" that an insurer "shall share with the nonparticipating provider or nonparticipating facility" when determining a QPA. 42 U.S.C. § 300gg-111(a)(2)(B)(ii).

In the preamble, the Departments "recognize[d]" that providers "need transparency regarding how the QPA was determined." 86 Fed. Reg. at 36,898. Specifically, they acknowledged that understanding how the QPA was calculated is "important in informing the negotiation process," and that in order to "decide whether to initiate the IDR process and what offer to submit," providers "must know not only the value of the QPA, but also certain information on how it was calculated." *Id.* The Departments thus claimed that the disclosures required by the rule sought "to ensure transparent and meaningful disclosure about the calculation of the QPA." *Id.*

Nonetheless, again citing their goal of "minimizing administrative burdens on plans and issuers," *id.*, the Departments required insurers to provide only minimal information about their QPA calculations. Under the July Rule, when an insurer sends a provider or facility an initial payment or notice of denial of payment, the only information the insurer must provide about the QPA is (1) the QPA as determined by the insurer (without any underlying calculations) and (2) a statement certifying that the QPA applies and "was determined in compliance with" the methodology in the July Rule. 45 C.F.R. § 149.140(d)(1); *see also* 86 Fed. Reg. at 36,933.[7] At a provider's request, the insurer must provide additional limited information: (1) whether the QPA included contracted rates that were not on a fee-for-service basis and whether the QPA for those items or services was determined using underlying fee schedule rates or a derived amount; (2) if the plan

[7] The insurer must also provide information about the availability of the negotiation period and the IDR process, as well as contact information. 45 C.F.R. § 149.140(d)(1).

or issuer used an eligible database to determine the QPA, information to identify which database was used; (3) if a related service code was used to determine the QPA for a new service code, information to identify the related service code; and (4) if applicable, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, or other incentive-based or retrospective payments or payment adjustments for covered items and services that were excluded for purposes of calculating the QPA. 45 C.F.R. § 149.140(d)(2); *see also* 86 Fed. Reg. at 36,933.[8]

Insurers are not required to disclose the "contracted rates recognized by the plan or issuer" that were used in determining the median rate, or the "specialt[ies]" of the providers who contracted for those rates. 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I). Nor do insurers have to disclose whether they calculated the median rate using plans of the plan sponsor or rates of other self-insured group health plans administered by the same third-party administrator. And while insurers must disclose upon request whether they excluded incentive-based or retrospective payments from the rates used, they are not required to disclose the amount of those excluded payments.

The Departments did not explain how the minimal disclosures their rule requires provide the "transparency" that they themselves recognized is "need[ed]." 86 Fed. Reg. at 36,898. They also did not grapple with the need to provide enough information to allow providers to discover and articulate the basis for a complaint under the complaint process created by the NSA. Specifically, the Departments are required to establish a process for receiving complaints, 42 U.S.C. § 300gg-111(a)(2)(B)(iv), including complaints that an insurer has violated the NSA's requirement that the QPA be calculated in a way that "satisfies the [statutory] definition" of the QPA, *id.*

[8] In a later rule, the Departments added a QPA-disclosure requirement applicable only when a QPA is calculated "based on a downcoded service code or modifier"—that is, one "alter[ed]" by an insurer to a new code "associated with a lower [QPA] than the service code or modifier billed by the provider." 45 C.F.R. § 149.140(a)(18), (d)(1)(ii). In this situation, the Departments require the insurer to disclose certain information related to the downcoding. *Id.*

§ 300gg-111(a)(2)(A)(i)(II), *id.* § 300gg-111(a)(2)(B)(iv). The Departments did not consider the complaint process at all in establishing the information insurers must disclose.

B. The August 2022 FAQs

In August 2022, the Departments issued a set of Frequently Asked Questions ("FAQs") addressing aspects of the July Rule. There, the Departments acknowledged that the rule allows insurers to include rates for services that "providers do not provide." August 2022 FAQs at 17 (FAQ 14). And they noted "concerns that the inclusion of these rates in the calculation of QPAs may artificially lower the QPA, as these providers have little incentive to negotiate fair reimbursement rates for these service[s]" and sometimes accept "$0 as their rate." *Id.* at 16 (FAQ 13). The Departments concluded that insurers "should not include $0 amounts in calculating median contracted rates." *Id.* at 17 n.29 (FAQ 14). But they did not prohibit insurers from including other non-negotiated rates that are artificially low, if not quite $0, because the services are never actually provided by the providers whose contracted rates form the basis for insurers' QPA calculations.

The FAQs also elaborated on when the Departments believe QPAs should be calculated using only rates associated with the same or similar specialty. The Departments recognized that some insurers "establish contracted rates by offering most providers the same fee schedule for all covered services," and then leave it "up to the providers to negotiate increases to the rates for the services that they are most likely to bill." *Id.* at 16 (FAQ 14). Yet all rates, including for services not provided, "may be included in the provider contract." *Id.* Thus, "an anesthesiologist's contract may also include contracted rates for other services the anesthesiologist does not provide (for example, dermatology services)." *Id.* at 17 (FAQ 14). To address the reality that such rates are likely to be lower than contracted rates for providers in the relevant specialty, the Departments stated that insurers must calculate "separate median contracted rates" for different specialties not only when they expressly vary their contracted rates by specialty, but also "when the plan's or issuer's

contracting process unintentionally results in contracted rates that vary based on provider specialty." *Id.* According to the Departments, contracted rates "vary based on provider specialty if there is a material difference in the median contracted rates … between providers of different specialties, after accounting for variables other than provider specialty." *Id.* The Departments left it to insurers to determine when a difference in median contracted rates is "material" based on "all the relevant facts and circumstances." *Id.* The Departments acknowledged that insurers "may have not understood the July 2021 interim final rules to require the calculation of separate median contracted rates" in these circumstances and gave insurers 90 days to recalculate their QPAs. *Id.*

The FAQs also reiterated that "to reduce burden on self-insured group health plans," the July Rule permits the plans' sponsors to "allow their [third-party administrators] to determine the QPA on behalf of the sponsor by calculating the median contracted rate using the contracted rates recognized by all self-insured group health plans administered by the [administrator], as opposed to only those of the particular plan sponsor." *Id.* at 18 (FAQ 15).

Finally, the FAQs state that "[i]t is not the responsibility of a provider, facility, provider of air ambulance services, or certified IDR entity to verify a QPA's accuracy, and plans and issuers are not obligated to demonstrate that a QPA was calculated in accordance with the [applicable regulations] unless required to do so by an applicable regulator." *Id.* at 16 (FAQ 13). If a provider has "concerns about a plan's or issuer's compliance," the provider may "submit a complaint." *Id.* The Departments did not explain how providers could discover concerns or support a complaint about a QPA calculation without access to the bases of insurers' QPA calculations.

LEGAL STANDARDS

Summary judgment is proper "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). "In the context of a challenge under the APA, '[s]ummary judgment is the proper mechanism for

deciding, as a matter of law, whether an agency action is supported by the administrative record and consistent with the APA standard of review.'" *Texas v. EPA*, 389 F. Supp. 3d 497, 503 (S.D. Tex. 2019) (quoting *Blue Ocean Inst. v. Gutierrez*, 585 F. Supp. 2d 36, 41 (D.D.C. 2008)); *see, e.g.*, *Gulf Fishermens Ass'n v. Nat'l Marine Fisheries Serv.*, 968 F.3d 454, 459–60 (5th Cir. 2020). Under the APA, courts will "hold unlawful and set aside" agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2)(A), or "in excess of statutory jurisdiction, authority, or limitations," *id.* § 706(2)(C).

In assessing an agency's statutory interpretation, courts must first determine whether Congress authorized the agency "to speak with the force of law" with regard to the issue at hand. *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001). If so, then courts evaluate the agency's interpretation under *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). Under *Chevron*, courts "must give effect to the unambiguously expressed intent of Congress," *id.* at 843, deferring to the agency's interpretation only if "the statute is 'truly ambiguous' on the question" at hand and the agency's interpretation is a "permissible construction," *Gulf Fishermens Ass'n*, 968 F.3d at 460. Here, as discussed below, the challenged provisions are not entitled to *Chevron* deference, both because the statute unambiguously precludes the Departments' rules and because the rules are not a permissible construction of the NSA.

"The APA's arbitrary-and-capricious standard requires that agency action be reasonable and reasonably explained." *FCC v. Prometheus Radio Project*, 141 S. Ct. 1150, 1158 (2021). Although this standard is deferential and a court must not "substitute" its own "policy judgment for that of the agency," *id.*, arbitrary-and-capricious review "is not toothless," *Sw. Elec. Power Co. v. EPA*, 920 F.3d 999, 1013 (5th Cir. 2019). "In fact, … it has serious bite." *Wages & White Lion Invs., LLC v. FDA*, 16 F.4th 1130, 1136 (5th Cir. 2021). Agency action must be set aside if the

agency "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co*., 463 U.S. 29, 43 (1983). Further, a court cannot uphold a rule based on grounds not given by the agency in the rule. *See SEC v. Chenery Corp.*, 318 U.S. 80, 87 (1943); *Dish Network Corp. v. NLRB*, 953 F.3d 370, 379–80 (5th Cir. 2020).

ARGUMENT

The challenged portions of the July Rule and the August 2022 FAQs are unlawful. The Departments' QPA methodology rules conflict with the statute's unambiguous terms and therefore fail at *Chevron* step one. They also fail at *Chevron* step two and are arbitrary and capricious because they do not permissibly interpret the term "QPA," as Congress defined it in the NSA. Likewise, the Departments' QPA disclosure rules are arbitrary and unreasonable because they prevent providers from effectively utilizing the Act's complaint and IDR processes. And, in multiple respects, the challenged provisions flunk the APA's requirements of reasoned decisionmaking.

I. The July Rule And August 2022 FAQs Are Not In Accordance With Law.

A. The challenged provisions conflict with the NSA's unambiguous terms.

The statutory analysis here "begins where all [interpretive] inquiries must begin: with the language of the statute itself." *United States v. Ron Pair Enters., Inc*., 489 U.S. 235, 241 (1989). Because the NSA's definition of the term "QPA" is clear and unambiguous, the statutory language is "also where the inquiry should end." *Id.* "[F]or where … the statute's language is plain, 'the sole function of the courts is to enforce it according to its terms.'" *Id.*; *see also Forrest Gen. Hosp. v. Azar*, 926 F.3d 221, 234 (5th Cir. 2019) ("[W]hen legal texts are unambiguous, as these are, courts should stand firm and decide, not tiptoe lightly and defer."). Because the method for calculating QPAs in the July Rule conflicts with the statute's plain language, the challenged provisions of the

rule violate the cardinal rule of administrative law that an "agency may not rewrite" or "revise clear statutory terms." *Util. Air Regul. Grp. v. EPA,* 573 U.S. 302, 327–28 (2014).

The Departments' rule is inconsistent with the NSA's text in four critical ways: (1) it tells insurers to include in QPA calculations rates for items and services that *were not* "provided," despite the NSA's requirement that QPAs be calculated using rates that *were* "provided"; (2) it instructs insurers to separately calculate rates by specialty "*only*" in certain situations, although the NSA requires insurers to *always* calculate QPAs based on the rates of providers "in the same or similar specialty"; (3) it requires insurers to exclude "risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments" from rates used in calculating QPAs, despite the NSA's requirement that each rate used in a QPA calculation be "the total maximum payment … under such plans or coverage"; and (4) it allows self-insured group health plans to calculate QPAs "using the contracted rates recognized by all self-insured group health plans administered by the [plan's] third-party administrator (not only those of the particular plan sponsor)," while the NSA says that QPAs must be "determined with respect to all such plans *of such sponsor*." In each of these respects, the July Rule violates the "core administrative-law principle that [the Departments] may not rewrite clear statutory terms to suit [their] own sense of how the statute should operate." *TMA I*, 587 F. Supp. 3d at 541 (quoting *Util. Air*, 573 U.S. at 328).

1. Including ghost rates violates the Act.

The July Rule tells insurers to *include* rates in QPA calculations that the plain text of the NSA requires them to *exclude*. The NSA requires each QPA to be derived from "contracted rates" for only those items and services that are "*provided* by a provider" and "*provided* in the geographic region." 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I) (emphasis added). Yet the July Rule defines "contracted rate" to encompass contracted rates without regard to whether the relevant item or service was ever "provided" under that contract. Specifically, the rule defines "contracted rate" broadly as

"the total amount (including cost sharing) that a group health plan or health insurance issuer has *contractually agreed to pay* … for covered items and services." 45 C.F.R. § 149.140(a)(1) (emphasis added). The rule's preamble clarifies that "each contracted rate for a given item or service" should "be treated as a single data point when calculating a median contracted rate … *regardless of the number of claims paid at that contracted rate*." 86 Fed. Reg. at 36,889 (emphasis added). Thus, under the Departments' rules, even if no service has been provided and no claim has been paid under a contract, the contract's rate for that service factors into the QPA calculation.

The Departments acknowledged in the August 2022 FAQs that the July Rule allows insurers to include rates for items and services that "providers do not provide." August 2022 FAQs at 17 (FAQ 14). The Departments' solution—instructing that insurers "should not include $0 amounts in calculating median contracted rates," *id.* at 17 n.29 (FAQ 14)—is not sufficient to bring the Departments' rule in line with the NSA's text, because the Departments still failed to prohibit insurers from including other, not-quite-$0, ghost rates. The NSA's plain text prohibits insurers from including *any* rates for items or services that were not provided, whether those rates are $0 or some other amount. 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I). And the July Rule cannot permit what the NSA prohibits. *See TMA I*, 587 F. Supp. 3d at 542 (holding that the Departments violated the statute by "impermissibly 'rewrit[ing] statutory language'" (quoting *Texaco Inc. v. Duhe*, 274 F.3d 911, 920 (5th Cir. 2001)); *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 2367, 2381 (2020) (an agency may not "alter" a statute's clear terms).

2. Including rates for providers in different specialties violates the Act.

The NSA requires insurers to *always* calculate QPAs based on the rates of providers "in the same or similar specialty." 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I). Yet the July Rule instructs insurers to separately calculate rates by specialty "*only* where the [insurer] otherwise varies its contracted rates based on provider specialty," 86 Fed. Reg. at 36,891 (emphasis added), as part of

its "usual business practice," 45 C.F.R. § 149.140(a)(12). In the August 2022 FAQs, the Departments continued to provide that insurers can ignore the NSA's "same or similar specialty" requirement except in certain circumstances: if they (1) "purposefully" vary "contracted rates based on provider specialty," or (2) determine that "there is a material difference in the median contracted rates … between providers of different specialties." August 2022 FAQs at 16–17 (FAQ 14).

The FAQs' statement that insurers must calculate QPAs using in-specialty rates when there are "material differences" between the rates of providers by specialty narrows the scope of the statutory violation, but it does not eliminate it. Under the NSA, a QPA is the median of contracted rates for an item or service provided "by a provider in the same or similar specialty." 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I). The statute contains no exception to this requirement for cases where an insurer unilaterally determines that there is no "material difference" between different specialties' median contracted rates. The Departments were not free to create such an exception from "whole cloth." *Nat'l Pork Producers Council v. EPA*, 635 F.3d 738, 753 (5th Cir. 2011); *see also Kingdomware Techs., Inc. v. United States*, 579 U.S. 162, 171 (2016) (finding statutory language was unambiguous and mandatory where "[t]he text … ha[d] no exceptions"); *Am. Bankers Ass'n v. SEC*, 804 F.2d 739, 744 (D.C. Cir. 1986) (where statutory definition did not have exception, agency was not permitted to create an exception by regulation).

3. Excluding certain components of contracted rates violates the Act.

Under the NSA, each contracted rate in a QPA calculation must be based on "the total maximum payment … under such plans or coverage." 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I). "Total" means "[c]onstituting or comprising a whole; whole, entire." *Oxford Eng. Dict. Online* (Dec. 2022 ed.). And "maximum" is the "highest value or extreme limit," the "greatest value which a variable or function takes," or the "highest possible magnitude or quantity of something which is attained, attainable, or customary." *Id.* According to the plain meaning of these terms, the rates

included in a QPA calculation must be the "entire" amount of the "highest" payment for an item or service available under a contract. *See Taniguchi v. Kan Pac. Sai Pan, Ltd.*, 566 U.S. 560, 566 (2012) ("When a term goes undefined in a statute, we give the term its ordinary meaning.").

The July Rule, however, requires insurers *not* to use the total maximum payment. Instead, when a contracted rate includes "risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments," the Departments commanded that these amounts be subtracted from the rate included in the QPA. 45 C.F.R. § 149.140(b)(2)(iv). The Departments offered no textual basis—because there is none—for excluding such payments from the contracted rates used to calculate QPAs. Here again, the rule directly conflicts with the NSA's plain terms by creating an exception to the unqualified statutory command. *See Djie v. Garland*, 39 F.4th 280, 285 (5th Cir. 2022) ("When a regulation attempts to override statutory text, the regulation loses every time—regulations can't punch holes in the rules Congress has laid down.").

4. Aggregating contracted rates across plan sponsors violates the Act.

Finally, the NSA says that the QPA must be "determined with respect to all such plans *of such sponsor* or all such coverage offered by such issuer that are offered within the same insurance market." 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I) (emphasis added). According to the statute's plain terms, therefore, each plan sponsor must use only its *own* contracted rates when calculating QPAs, and multiple plan sponsors cannot aggregate their contracted rates to generate one QPA. However, the July Rule allows self-insured group health plans to instead "allow their third-party administrators to determine the QPA for the sponsor by calculating the median contracted rate using the contracted rates recognized by all self-insured group health plans administered by the third-party administrator (not only those of the particular plan sponsor)." 86 Fed. Reg. at 36,890; *see also* 45 C.F.R. § 149.140(a)(8)(iv). This too is directly contrary to the NSA's text and cannot stand.

B. The challenged provisions are unreasonable and arbitrary and capricious.

Even if the challenged provisions were not expressly foreclosed by the NSA, they are still unlawful because they do not reasonably construe the NSA, do not "reasonably effectuate Congress's intent," *Texas v. United States*, 497 F.3d 491, 506 (5th Cir. 2007), and are arbitrary and capricious, *see Sw. Elec.*, 920 F.3d at 1028–29 ("Because *Chevron* step two and the APA share the arbitrary and capricious standard, … analysis under the two standards proceeds similarly" or has "complete overlap" (cleaned up)); *see also Judulang v. Holder*, 565 U.S. 42, 53 n.7 (2011).

1. The challenged provisions unreasonably depress QPAs.

According to the Departments themselves, Congress intended for QPAs to reflect one measure of negotiated market rates, whether the QPA is calculated using median rates or identified by selecting a median volume-weighted payment from an independent database. *See* 86 Fed. Reg. at 36,889 (describing the Act's "statutory intent" as "ensuring that the QPA reflects market rates under typical contract negotiations"). Yet the Departments created a methodology for calculating QPAs that consistently depresses them to well below market rates. *See supra*, at 9–11. For example, the Departments' exclusion of incentive-based payments keeps QPAs from "reflect[ing] market rates under typical contract negotiations." 86 Fed. Reg. at 36,889. In a "typical contract negotiation," a provider would demand higher fixed per-service rates if the provider understood that it would not be reimbursed based on "risk sharing, bonus, or penalty, and other incentive-based and retrospective payments or payment adjustments." *Id.* at 36,894. The Departments ignored this, instead pretending that incentive-based payments did not matter to the providers who negotiated for them, and that those providers would have agreed to forgo those payments without demanding higher fixed per-service rates in return. This is not a rational analysis. It was unreasonable for the Departments to create a methodology that undermines the very purpose they believe Congress intended the methodology to achieve. *See Texas*, 497 F.3d at 506.

Indeed, for the most part, the Departments entirely failed to consider whether the choices they made would lead to QPAs that reflect market rates. This failure on its own dooms the Departments' decisions. *See Wages*, 16 F.4th at 1138 (holding that "omission" of discussion of a relevant factor "alone likely renders [agency] decision arbitrary and capricious" (cleaned up)); *see also Nat. Res. Def. Council, Inc. v. EPA*, 859 F.2d 156, 209–10 (D.C. Cir. 1988) (agencies must "come to grips with the obvious ramifications of [their] approach and address them in a reasoned fashion").

When the Departments did finally acknowledge the issue, at least with respect to ghost rates, in the FAQs, they failed to grapple with it. Specifically, while they acknowledged "stakeholder concerns that the inclusion of [ghost] rates in the calculation of QPAs may artificially lower the QPA," they responded by excluding only $0 rates, despite recognizing that the problem is broader. *See* August 2022 FAQs at 16 (FAQ 13) (acknowledging that "providers accept contracted rates … that they are not likely to bill or that are not utilized by their specific provider specialty" and recognizing concerns that "these providers have little incentive to negotiate fair reimbursement rates for these service codes, with some even accepting $0 as their rate for codes they do not utilize"). Failure to meaningfully grapple with stakeholders' concerns ran afoul of the APA. *See Huawei Techs. USA, Inc.* v. *FCC*, 2 F.4th 421, 449 (5th Cir. 2021) (an "agency violates the arbitrary-and-capricious standard if it fails to respond to significant points" (cleaned up)).

Further, Congress did not intend to create a system in which providers would be systematically undercompensated. As the Departments have elsewhere recognized, undercompensation of providers may "threaten the viability of these providers [and] facilities," which "in turn, could lead to participants, beneficiaries and enrollees not receiving needed medical care, undermining the goals of the No Surprises Act." 86 Fed. Reg. 55,980, 56,044 (Oct. 7, 2021). Yet the Departments'

methodology has led to reimbursement rates that threaten providers' viability, again unreasonably undermining what the Departments understand to be Congress's goals.

2. The Departments' purported justifications are unreasonable.

The Departments' attempts to justify the challenged provisions fell well short of their obligation to "reasonably effectuate Congress's intent," *Texas*, 497 F.3d at 506, and to "reasonably explai[n]" their choices, *Prometheus,* 141 S. Ct. at 1155.

To start, the Departments made no effort to defend their decision to include ghost rates in QPA calculations. Agencies always have an obligation to provide an adequate explanation for their actions. Yet the Departments failed to even acknowledge the statutory text stating that QPAs are the median of rates for an item or service that has been "provided," 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I), much less explain how incorporating ghost rates into QPAs could possibly "compor[t] with" that statutory command, *Texas v. Biden*, 20 F.4th 928, 992 (5th Cir. 2021), *rev'd and remanded on other grounds*, 142 S. Ct. 2528 (2022) (finding agency action arbitrary and capricious for failure to explain action's consistency with statute).

The Departments gave perfunctory explanations for other challenged provisions, but each is unreasonable and inadequate. First, they invented a statutory purpose that Congress did not share and invoked that purpose as a justification for rules that conflict with the text of the statute Congress enacted. According to the Departments, the NSA "envisions" that the alternative methodology for determining QPAs "will be used in only limited circumstances." 86 Fed. Reg. at 36,888. But Congress said simply that where there is insufficient information, QPAs *are* derived from an independent database. 42 U.S.C. § 300gg-111(a)(3)(E)(ii), (iii). It did not state that using databases should be avoided or otherwise indicate any preference against that methodology. Unsurprisingly, then, the Departments offered no statutory evidence—indeed, they offered no support at all—for their view that use of independent databases should be "minimized." 86 Fed. Reg. at 36,888. The

conclusory nature of their reasoning is itself arbitrary and unreasonable. *See Wages*, 16 F.4th at 1137 (rejecting agency explanation as "conclusory, unsupported, and thus wholly insufficient").

Worse still, the Departments unlawfully prioritized their imagined statutory goal over the NSA's text. Although the statute commands that QPAs be based on specialty-specific rates and on the plans of the sponsor alone, the Departments allowed insurers to include rates for providers outside the same or similar specialty and to aggregate rates across sponsors, in service of *their* wish to "minimiz[e] wherever possible" the use of "alternative methodologies" for calculating QPAs. 86 Fed. Reg. at 36,888, 36,890. The Departments were transparent about this: they "considered requiring a plan or issuer to calculate separate median contracted rates for every provider specialty," but ultimately "concluded that this approach" (*i.e.*, the approach of following the statutory text) "would lead to more instances in which the plan or issuer would not have sufficient information to calculate the QPAs using its contracted rates." *Id.* at 36,891. The Departments' "[p]olicy considerations cannot override … the text and structure of the Act." *Cent. Bank of Denver, N.A. v. First Interstate Bank of Denver, N.A.*, 511 U.S. 164, 188 (1994). The Departments are "bound" not by their own sense of how the statute should operate, but by the text that Congress enacted into the law and "by the means *it* has deemed appropriate, and prescribed, for the pursuit of th[e statute's] purposes." *MCI Telecomms. Corp. v. AT&T Co.*, 512 U.S. 218, 231 n.4 (1994).

Second, the Departments stated that the challenged provisions were designed to provide plans with "flexibility" and to reduce the "burden associated with calculating the QPA." 86 Fed. Reg at 36,888. The Departments pointed to nothing in the NSA indicating that Congress was concerned with the effort insurers would need to expend to comply with the statute's methodology for calculating QPAs, and the Departments' own desire to make the process easier for insurers is not

a legitimate justification for departing from Congress's clear instructions. The Departments apparently believed that it was. They: (1) allowed insurers to mix different specialties within the same QPA calculation "to provide plans or issuers with … flexibility," 86 Fed. Reg. at 36,891, despite the statute's command that QPAs be determined based on specialty-specific rates; (2) permitted insurers to calculate QPAs across all health plans administered by the same entity to "reduce the burden imposed on sponsors of self-insured group health plans," *id.* at 36,890, despite the statute's instruction that QPAs be calculated for each plan sponsor; and (3) excluded incentive-based and retrospective payments from QPAs because doing so is "consistent with how cost sharing is typically calculated" by insurers for "in-network items and services," *id.* at 36,894, despite the statute's mandate that the QPA reflect the "total maximum payment" the insurer agreed to pay the provider. Reducing burdens on regulated parties may sometimes be a laudable goal, but it is not one that may be pursued at the expense of compliance with the fundamental obligation to "enforce" the statute "according to its terms." *Ron Pair Enters.*, 489 U.S. at 241.

The Departments did not dig themselves out of the hole with the August 2022 FAQs. For one, they doubled down on their flawed reasoning that aggregating rates across plan sponsors was permitted "to reduce burden on self-insured group health plans." August FAQs at 18 (FAQ 15). And their clarifications to the July Rule regarding same or similar specialty rates only underscore the rule's arbitrariness. Although the Departments did not say so clearly the first time, *see* August FAQs at 17 (FAQ 14) (implicitly acknowledging this), they explained in the FAQs that insurers must calculate separate rates when their process "unintentionally results" in rates that are "material[ly] different" by specialty, *id.* The Departments did not explain how that determination would work, or even what a "material difference" is. The Departments also asserted that, under the July Rule, $0 ghost rates do not "represent a contracted rate" and should not be included in QPAs. *Id.*

at 17 n.29. The Departments did not explain why $0 ghost rates, but not other ghost rates, are not "contracted rates," despite recognizing that *all* ghost rates may be artificially low because providers "have little incentive to negotiate fair reimbursement" for such rates. *Id.* at 16 (FAQ 13). "Only [the Departments'] fiat supports" treating these two types of ghost rates differently. *Chamber of Commerce v. Dep't of Labor*, 885 F.3d 360, 382 (5th Cir. 2018). Unexplained inconsistency and illogical and shifting policies are "characteristic of arbitrary and unreasonable agency action." *Id.*

II. The Departments' Disclosure Rule Is Neither Reasonable Nor Reasonably Explained.

The Departments' regulations relating to the information insurers must disclose are also substantively and procedurally unreasonable. The NSA mandates that the Departments issue rules establishing the information insurers "shall share with the nonparticipating provider or nonparticipating facility" when determining the QPA. 42 U.S.C. § 300gg-111(a)(2)(B)(ii). These disclosures serve several crucial purposes under the statute. But the barebones disclosures the Departments decided to require are insufficient to serve any of those purposes. And the Departments failed to even consider whether they were sufficient, let alone to reasonably explain their decision.

A. Meaningful disclosures are necessary.

First, meaningful disclosures are crucial to the NSA's negotiation and arbitration process. As the Departments recognized, absent "transparency regarding how the QPA was determined," providers are ill equipped to assess "whether to initiate the [arbitration] process" or "what offer to submit." 86 Fed. Reg. at 36,898. And providers need meaningful insight into QPAs to effectively advocate before the arbitrator, especially when (as is common) the insurer offers the QPA. *See* 87 Fed. Reg. at 52,625 n.29. A provider might suspect that a QPA was not correctly calculated, or was calculated based on rates that were rarely paid, such that they are not reliable indicators of market value. But the provider has no way of credibly introducing this to the arbitrator because,

under the Departments' disclosure requirements, the QPA is a black box into which only the insurer can see. *See* 86 Fed. Reg. at 36,889. Arbitrators—who by statute *must* consider the QPA "as defined in" the Act, 42 U.S.C. § 300gg-111(c)(5)(C)(i)(I)—are similarly hamstrung. *See* 86 Fed. Reg. at 36,898; *see also* Compl. at ¶ 93, *LifeNet III*, Dkt. 1.

Second, Congress required the Departments to set up a "process to receive complaints" that insurers "violat[ed]" the requirement to calculate QPAs in accordance with the NSA's terms. *Id.* § 300gg-111(a)(2)(B)(iv); *see also id.* § 300gg-111(a)(2)(A)(i)(II). The Departments may audit an insurer on the basis of such a complaint. *Id.* § 300gg-111(a)(2)(A)(ii)(II). To make this complaint process meaningful, providers must receive sufficient information to determine whether a QPA calculated by an insurer "satisfies the definition" of QPA in the NSA. Providers cannot evaluate whether a QPA was calculated correctly if they are given only the insurer's say-so. Particularly with HHS performing only *nine* audits of QPAs per year, *see* 86 Fed. Reg. at 36,935, and with the Departments *still* having failed to finalize audit regulations that were due in October 2021, *see* 42 USC 300gg-111(a)(2)(A)(i), providers' ability to meaningfully evaluate insurers' QPA calculations and file complaints is a crucial check on those calculations. Yet the complaint process is toothless when providers are given no information about how insurers calculated their QPAs.

B. The Departments' disclosure rule requires no meaningful disclosures.

Despite acknowledging the importance of transparency, the Departments promulgated regulations that fail to require insurers to divulge even the most basic information about their secret QPA calculations. For example, insurers are not required to disclose (1) each rate that was included in the QPA; (2) the specialty of the provider who agreed to that rate; (3) the number of times that rate was *actually paid* by the insurer; or (4) the amount of any incentive payments excluded from the rates. *See also, e.g.*, Compl., *LifeNet III*, ¶ 91 (listing additional missing information, including relevant geographic region and insurance market).

The Transparency in Coverage Act now requires insurers to publish data on *current* in-network rates, including the names of providers and their specialty codes.[9] The Davanzo Declaration, an exhibit to the air-ambulance plaintiffs' complaint, 22-cv-00453, Dkt. 1-1, contains an analysis of one insurer's rate data made public as the result of this Act. Yet the Departments' regulation fails to require insurers to provide any data on the *2019* rates insurers must use to calculate QPAs.

C. Failure to require meaningful disclosures was unreasonable.

The Departments acted unreasonably in requiring that insurers make essentially no disclosures regarding their QPA calculations, certainly none that would achieve the purposes apparent from the NSA's text and structure. It was patently unreasonable for the Departments to issue regulations that do not do what even the Departments believe they must do: give providers the "transparency" necessary to assess "whether to initiate the [arbitration] process" or "what offer to submit." 86 Fed. Reg. at 36,898; *Cigar Ass'n v. FDA*, 964 F.3d 56, 61 (D.C. Cir. 2020) (invalidating action that likely would not have the impact Congress mandated). And it was unreasonable to gut the NSA's complaint process: providers cannot meaningfully access that process if, as is true under the Departments' rules, insurers are required to reveal nothing of substance about their QPAs.

Compounding the problem, the Departments failed to meaningfully grapple with this fundamental "aspect of the problem." *Cigar Ass'n*, 964 F.3d at 61. Rather than addressing whether disclosures would provide the necessary transparency, the Departments engaged in rulemaking by "ipse dixit," asserting that this was so. *Music Choice v. Copyright Royalty Bd.*, 970 F.3d 418, 429 (D.C. Cir. 2020). And they neglected to consider any alternative to the minimalist approach to disclosures they adopted. These flaws are fatal. *See Tice-Harouff v. Johnson*, No. 6:22-cv-201-

[9] *See* 45 C.F.R. § 147.211(b)(1)(iii); FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (Aug. 20, 2021), *available at* https://perma.cc/B7L7-QEKM; D. Gordon, *New Healthcare Price Transparency Rule Took Effect July 1, But It May Not Help Much Yet*, Forbes.com, July 3, 2022, *available at* https://perma.cc/3YHP-TQQQ.

JDK, 2022 WL 3350375, at *11 (E.D. Tex. Aug. 12, 2022) (Kernodle, J.). The only justification the Departments gave was, again, to "minimiz[e] administrative burdens on plans and issuers." 86 Fed. Reg. at 36,898. And, once again, the Departments' desire to ease the burden on insurers cannot justify their unreasonable rules or excuse their failure to reasonably explain their choices.

III. The Challenged Provisions Should Be Declared Unlawful, Vacated In Part, And Remanded For Further Rulemaking Consistent With The NSA And APA.

As in *TMA I*, "vacatur of the challenged portions of the [July] Rule" relating to the QPA methodology, along with the challenged portions of the FAQs, "is the appropriate remedy." *TMA I*, 587 F. Supp. 3d at 548. The "seriousness of the deficiency weighs heavily in favor of vacatur." *Id.* And because the challenged provisions "conflic[t] with the unambiguous terms of the Act in several key respects," the Departments cannot "rehabilitate or justify" them on remand. *Id.* The Court should thus vacate the challenged provisions as set forth in the attached proposed order.

The Court should also declare that arbitrators may not consider any QPA affected by the unlawful provisions. The NSA instructs arbitrators to consider QPAs "as defined in subsection (a)(3)(E)." 42 U.S.C. § 300gg-111(c)(5)(C)(i)(I). QPAs affected by the errors described above are not QPAs "as defined in" the Act and cannot inform the IDR process.

The Court should not, however, vacate the QPA disclosure regulations. Otherwise there would be no required disclosures until a replacement rule issued. Instead, the Court should declare that the Departments violated the APA in issuing the regulations and remand for further rulemaking with regard to insurers' QPA disclosure obligations, consistent with the NSA and APA.

CONCLUSION

The Court should declare the challenged provisions unlawful, vacate them in part as set forth above, and remand the QPA disclosure regulations for further rulemaking.

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Respectfully submitted,

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†Admitted only in Massachusetts; pending approval of application for admission to the D.C. Bar, practicing law in the District of Columbia under the supervision of principals of the firm who are members in good standing of the D.C. Bar.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing document has been served on all counsel of record in accordance with the Federal Rules of Civil Procedure and this Court's CM/ECF filing system on January 17, 2023.

/s/ *Eric D. McArthur*
Eric D. McArthur

EXHIBIT A

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

TEXAS MEDICAL ASSOCIATION, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants*.	Case No.: 6:22-cv-00450-JDK Lead Consolidated Case

DECLARATION OF DR. CHRISTOPHER RYAN COOK

I, Dr. Christopher Ryan Cook, solemnly declare under penalty of perjury and to the best of my knowledge, information, and belief as follows:

1. I am over 18 years of age and with capacity, and I provide this declaration based on my personal knowledge.

2. I am a board-certified anesthesiologist, subspecialty fellowship-trained in regional anesthesia, and a member of the Texas Medical Association. I have been in private practice for 12 years, with the last four years in independent practice in Dallas–Fort Worth. I have cared for and delivered both general anesthetics and regional blocks for orthopedic trauma patients at a Level I Trauma Center, orthopedic oncology patients, patients for cardiac electrophysiology procedures, chronic pain patients for interventional pain procedures to minimize outpatient opioid usage, and morbidly obese patients for robotic bariatric services. A number of these cases

required complex airway management, rapid blood transfusion, and invasive intravascular access. In addition, regional anesthesia was often necessary to avoid general anesthesia, minimize opioid use, and decrease the risk of opioid addiction. The surgeries in which I furnish anesthesia services are often lengthy procedures that can stretch late into the night.

3. I own 100% of Anesthesia and Acute Pain Experts Plano PLLC. My compensation model is based on billing and collecting, minus overhead expenses for anesthesia services rendered. This compensation varies based on a number of factors, including volume of cases, payor mixture (e.g., private health insurance versus Medicare), billing company expenses, malpractice premiums, corporate taxation, benefit expenses (including health insurance), accounting, transportation expenses, attorneys' fees, and medical school debt payments.

4. All of the services that I provide out-of-network are subject to the No Surprises Act's ("NSA") balance billing prohibition for patients with health insurance covered by the NSA, including Texas patients with coverage through an ERISA plan. Some of the out-of-network services that I provide qualify as "emergency services" covered under the NSA. Other out-of-network services that I provide are non-emergency medical services for which I am out-of-network, while the facility in which I am providing the services is in-network for my patient. Under the NSA, patients cannot consent to being balance-billed for either emergency services or "ancillary services," such as the anesthesiology services that I furnish.

5. I prefer to be in-network with health insurers where possible, but insurance companies do not always offer opportunities to be in-network or to negotiate network agreements with me in good faith.

6. I routinely see commercially-insured patients in my practice, the large majority of whom have coverage that is subject to the NSA's balance billing prohibition, and some of these

patients are out-of-network. Accordingly, since the NSA went into effect on January 1, 2021, I have furnished out-of-network services that are subject to reimbursement through the NSA's IDR process, and I will continue to do so.

7. Where claims for my services are subject to reimbursement through the NSA's IDR process, I, working with my medical practice's administrative staff and our third-party billing company, have attempted to engage in open negotiation with out-of-network insurers for a reasonable reimbursement rate, using the process set forth in the NSA's implementing regulations.

8. My experience with Open Negotiation under the NSA has been incredibly frustrating. When insurers make an initial payment to me for services, they often do not include the qualifying payment amount ("QPA") as they are required to do, and they also do not clearly identify whether a claim is subject to a state surprise medical billing law or the NSA, even though they could easily do so by using an appropriate and clear remittance advice remark code. Their failure to convey this information makes it very difficult to determine when a claim is even subject to the NSA's IDR process, including Open Negotiation. Working with my administrative staff and third-party billing company, I do my best to understand which claims are eligible for Open Negotiation.

9. Where I have participated in Open Negotiation, the process has been overwhelming, time-consuming, and not a true negotiation, as insurers have automatically rejected all of my offers and presented me with nothing more than "take it or leave it" offers generally tethered to the relevant QPA. Insurers are offering me $0–$30/unit for out-of-network anesthesia services subject to the NSA, which represents 0–34% of the 50th percentile allowed

payment based on independent non-conflicted databases for my geographic area. These payments are a substantial reduction from 2019, 2020, and 2021.

10. In my experience, the Open Negotiation process has rarely resulted in an out-of-network insurer offering me a reasonable reimbursement rate that is consistent with the reimbursement rates insurers were willing to pay before the NSA went into effect. Instead, insurers have just pushed down their reimbursement offers to the relevant QPA.

11. I expect that the bids I will submit to the NSA's IDR process will always be higher than the QPA, because the QPA is much lower than a reasonable reimbursement rate for my services. I expect that the bids submitted by insurers as part of the NSA's IDR process will always be lower and closer to the relevant QPA than my bids, because up through the Open Negotiation period of the NSA's dispute resolution process, insurers have only ever offered me reimbursement rates at or around the relevant QPA. In fact, in my experience so far, each insurer's bid is always the QPA, including in every IDR dispute that I have lost.

12. Further, while arbitrators must always consider the QPA, the Departments' rules privileging the QPA in the arbitration process make it more likely that the arbitrator will ultimately select the offer closer to the QPA (that is, the insurer's offer). *See* Mot. for Summary J., *Texas Med. Ass'n v. HHS (TMA II)*, No. 6:22-cv-00372 (E.D. Tex.), Dkt 41, Ex. As (Decl. of Dr. Christopher Ryan Cook).

13. In my experience, then, QPAs often color the entire Open Negotiation and IDR process.

14. Because of the importance of QPAs and because the figures are calculated by insurers, I would like to be able to understand how QPAs are calculated and would like some way to check the insurers' work. I would also like to be able to better evaluate as necessary how

the QPA deviates from market rates. But in my experience, insurers only disclose the information about QPAs that the Departments require to be disclosed. However, this information is wholly insufficient, and if I had additional information about what went into QPAs, I would use the complaint process to try to remedy noncompliance that drives down QPAs. For example, it would be useful to know the number of contracts on which a QPA was based, whether the contracts used to calculate a QPA had claims filed or paid under them, and whether a QPA includes contracted rates with an out-of-specialty provider. The lack of transparency into QPAs also hampers my ability to advocate for my offer for payment during the Open Negotiation and IDR process, making it more likely that the insurer's lower offer will prevail.

15. I understand that the federal agencies charged with implementing the NSA have adopted a regulation laying out a methodology that insurers must use in calculating QPAs. I am generally familiar with this regulation, and know that four aspects of the regulation are being challenged in this litigation. I also understand that the methodology laid out in this regulation will tend to drive down QPAs.

16. For example, I understand that the regulation permits insurers to count what are referred to in the healthcare industry as "ghost rates." These are rates included in contracts with providers who do not actually provide the specified item or service, and thus have little or no incentive to negotiate a fair and reasonable reimbursement rate. Ghost rates can be as low as $0, and are typically lower than the rates negotiated by providers that have an incentive to meaningfully negotiate them.

17. I am also aware that the regulation allows insurers to include rates of providers who are not in the same or similar specialty as the provider that provided the service at issue. In my experience, it is not uncommon for insurers to offer most providers the same fee schedule for

all covered services, leaving it up to the provider to negotiate increases in the rates that they are most likely to provide and bill for. Indeed, these out-of-specialty rates that appear in contracts are often ghost rates as low as $0. Providers are understandably less motivated to negotiate rates for services they are less likely to provide, or that they provide less frequently.

18. I would expect QPAs calculated with ghost rates and out-of-specialty rates to be lower than QPAs that exclude those rates. The Departments, in fact, recently acknowledged that QPAs can materially differ from relevant median market rates, as a result of insurers including rates from physicians in different specialties, or even $0 rates listed in fee schedules.[1]

19. I also understand that the regulation requires insurers to exclude incentive-based or retrospective payments or payment adjustments from QPA calculations. In my experience, providers sometimes accept a contract with an insurer that incorporates lower per-services rates, after negotiating for additional payments, including incentive-based payments or bonuses, that will be made later in time. Rationally, if a provider does not believe it will earn the additional payments, then the provider will demand a higher fixed rate. As a result, these retrospective and incentive payments could make up a meaningful amount of the rate an insurer in the end pays a provider for an item or service.

20. Finally, I am aware that the rules sometimes permit self-funded group health plans to ask their third-party administrators to calculate QPAs using the contracted rates of other self-funded group health plans administered by the third party. Because insurers in my experience have decided to tether their reimbursement offers to the QPA, and generally offer

[1] DEP'TS, *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55* at FAQ 14 (Aug. 19, 2022), *available at* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf.

nothing more than the QPA during Open Negotiation and IDR, it is in their financial interest for QPAs to be as low as possible. Accordingly, I would expect a reasonable self-funded group health plan to take advantage of this option if doing so would on balance decrease the health plan's QPAs.

21. QPAs will often be well below the true median contracted rate as paid out in the market where I work, Dallas–Fort Worth. In addition, QPAs often do not accurately reflect the costs I incur in providing medical services, including because of geographic disparities in input costs, differences in provider training, and differences in patient and case complexity.

22. Indeed, the QPA values that are actually provided by health plans in Open Negotiation are egregiously low when compared to historical single case contract agreements that the same insurers entered into with my medical practice in 2019, 2020, and 2021. For example, one insurer has reduced payment by 78% per unit this year when compared to 2019 and reduced my unit rate by 49% from 2020 to 2021 following the passage and effective date of the NSA. QPAs are also dramatically lower when compared to an independent non-conflicted database, with QPAs ranging from 0–34% of the 50th percentile allowed payment within the relevant geographic area.

23. QPAs that are below-market and lower than the costs of providing medical services undermine my ability to obtain adequate reimbursement for my services through the NSA's negotiation and arbitration processes, especially given how the QPA influences the outcomes of those processes. *See supra*, at ¶¶ 10–13.

24. Lower reimbursement rates for out-of-network services I furnish will decrease my compensation.

25. For these reasons, the Departments' rules challenged in this lawsuit directly harm my financial interests.

Pursuant to the requirements of 28 U.S.C. section 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on:

1/13/2023

DocuSigned by:
F1E6384DF602484...

Dr. Christopher Ryan Cook

EXHIBIT B

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

TEXAS MEDICAL ASSOCIATION, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants*.	)	Case No.: 6:22-cv-00450-JDK Lead Consolidated Case

DECLARATION OF DR. STEVEN FORD

I, Dr. Steven Ford, solemnly declare under penalty of perjury and to the best of my knowledge, information, and belief as follows:

1. I am over 18 years of age and with capacity, and I provide this declaration based on my personal knowledge.

2. I am a neuro-anesthesiologist, a resident of Dallas, Texas, and a member of the Texas Medical Association. As a neuro-anesthesiologist, I perform the anesthesia for neurosurgical operations, whether brain or spine, that commonly require special anesthesia techniques to facilitate intraoperative neuro-monitoring, which is unique to these types of operations, and often requires invasive monitoring to maintain hemodynamic stability and manage blood loss. None of these caregiving services are ever provided as telemedicine or from a laptop at home; they all require in-person, intensive one-on-one interactions between the neuro-

anesthesiologist and patient, which begins at the time the patient leaves the preoperative area, continues through the completion of the operation, and remains ongoing while the patient is transferred to a post-anesthesia care unit or intensive care unit after the operation.

3. I work at Optima Anesthesia PLLC, a small practice of four physicians who provide M.D.-only anesthesia services. All physicians are board-certified; two of the physicians have had additional formal fellowship training; and I have additional board certification in critical care medicine. Two of us, including me, were on faculty at large medical schools in the U.S. in the past at the Assistant Professor or Associate Professor level. I received my anesthesia and critical care training from Stanford University.

4. I am one of the three owners of this small medical practice. After all expenses are paid—including but not limited to credentialing expenses, scheduling expenses, revenue cycle management expenses, malpractice premiums, cross coverage expenses, profit-sharing expenses, employee expenses, legal expenses, banking fees, accounting expenses, hospital privilege expenses, state franchise taxes, arbitration fees, and mediation fees—the remaining revenue is distributed to the three separate professional associations of the three owners. Each professional association has many additional expenses, including but not limited to continuing medical education expenses, health insurance premium expenses, transportation expenses, legal expenses, banking expenses, accounting expenses, and retirement plan expenses.

5. All of the caregiving that I and other physicians furnish through Optima Anesthesia PLLC, if provided out-of-network, is subject to the No Surprises Act's ("NSA") balance billing prohibition for patients with health insurance covered through an ERISA plan. Out-of-network non-ERISA patients are generally subject to SB 1264, which is the State of Texas' version of the NSA and which is implemented by the Texas Department of Insurance.

Some of the out-of-network services that I provide qualify as "emergency services" covered under the NSA. Other out-of-network services that I provide are non-emergency medical services for which I am out-of-network, but the facility in which I am providing the services is in-network for my patient. Under the NSA, patients cannot consent to being balance-billed for either emergency services or "ancillary services," such as the anesthesiology services that I furnish.

6. I prefer to be in-network with health insurers where possible, but insurance companies do not always offer opportunities to be in-network or to negotiate network agreements with me in good faith. Optima Anesthesia PLLC has sent proposals with offers to all four major insurance plans in the last 13 months with either no reply, no counteroffer, or offers of 40% of the FAIR Health in-network median contracted rates for our market based on geozip. In other words, all offers for physician fees that cannot maintain practice solvency.

7. Optima Anesthesia PLLC furnishes caregiving services to approximately 40 to 50 patients per week and provides out-of-network services to approximately 50% of those patients. About 80% of those out-of-network patients are patients covered by ERISA plans, and as such, those patients are now covered by the NSA's rules for out-of-network reimbursement. Accordingly, since January 1, 2022, when the NSA went into effect, I and other members of Optima Anesthesia PLLC have provided out-of-network anesthesia services that are subject to reimbursement through the NSA's IDR process, and we will continue to do so.

8. Where claims for my services are subject to reimbursement through the NSA's IDR process, I, working with my medical practice's administrative staff, have attempted to engage in the Open Negotiation process with out-of-network insurers to obtain a reasonable reimbursement rate, using the process set forth in the NSA's implementing regulations. This is a

huge expense in time and money for my practice. During Open Negotiation, insurers currently do not negotiate in good faith. In fact, they do not negotiate at all, despite my good faith efforts to do so. My claims for anesthesia services just sit for 31 days with no negotiation and no change in payment beyond the initial payment offered by the insurer. Furthermore, when insurers send an initial payment to me for my services, they commonly do not identify the QPA for my services (as they are required by regulation to do), much less provide any verifiable information about how the QPA was calculated, so their QPA is a "non-verifiable black box."

9. In my experience, the Open Negotiation process has rarely resulted in an out-of-network insurer offering me a reasonable reimbursement rate that is consistent with the reimbursement rates insurers were willing to pay before the NSA went into effect. In fact, in the last six months, each time I have initiated the "good faith" open negotiations period for an NSA-eligible claim, the insurer has refused to make ANY counter-offer to me or otherwise engage in negotiations to resolve the disagreement over an appropriate reimbursement rate. Thus, each claim I submit through the Open Negotiation process just sits for another mandated 30 business days. As a result, since January 1, 2021, I have worked with my administrative staff to submit claims for medical services I provided to the NSA's IDR process. I will continue to use the NSA's IDR process to seek a reasonable reimbursement rate for services I furnish to out-of-network patients.

10. To my knowledge, the bids I have submitted to the NSA's IDR process have always been higher than the relevant QPA, which is much lower than a reasonable reimbursement rate for my services.

11. I expect that the bids submitted by insurers as part of the NSA's IDR process will always be lower and closer to the relevant QPA than my bids. Indeed, in my experience, each

insurer's bid is always the QPA, and in every IDR dispute I have lost, the insurer's offer is the QPA.

12. Further, while arbitrators must always consider the QPA, the Departments' rules privileging the QPA in the arbitration process make it even more likely that the arbitrator will ultimately select the offer closer to the QPA (that is, the insurer's offer). *See* Mot. for Summary J., *Texas Med. Ass'n v. HHS (TMA II)*, No. 6:22-cv-00372 (E.D. Tex.), Dkt 41, Ex. C (Decl. of Dr. Steven Ford).

13. Additionally, over the last 13 months, the arbitrators presiding over my claims have made clear in the explanations they issue in support of their payment determinations that they often refuse to give weight to any factors other than the QPA—a metric that was provided and calculated by the insurance plan and is currently non-verifiable. Specifically, arbitrators appear to be refusing to consider other factors that the NSA requires them to consider, including credible information related to the additional circumstances specified in the statute. For example, in the materials I submit to the arbitrator in support of my bid, I always include information relating to the five statutorily-enumerated "additional circumstances." However, I have received payment determinations in which the arbitrator selects the insurer's bid and simply explains its decision by stating that the evidence I provided "does not demonstrate how the level of training and experience of the provider, the patient acuity, the market share held by either party, or good faith efforts to enter into a network agreement with the non-initiating party would affect the appropriate out of network rate for the qualified IDR item or service in this instance." *See* Ex. 1. These determinations do not engage at all with the evidence I submitted that bears on the appropriate reimbursement rate, including the applicable FAIR Health median in-network reimbursement for the relevant market (which is independent, publicly available, and verifiable);

specific detail about my level of training and experience; details of the market share held by the provider; details of the acuity of the patient and the complexity of the services furnished; good faith efforts by the provider to enter into network agreements; and refusal of any good faith negotiations by the non-initiating party (insurance plan) during the mandated 30 business day Open Negotiation period. Instead, the arbitrator simply picked the insurer's bid, which was the QPA. Furthermore, how can the QPA even be considered credible if the Departments have offered no way to verify it and both third-parties and the Departments have acknowledged issues with the accuracy of QPAs.

14. For these reasons, in my experience, QPAs often color the entire Open Negotiation and IDR process.

15. Because of the importance of QPAs and because the figures are calculated by insurers, I would like to be able to understand how QPAs are calculated and would like some way to check the insurers' work. I would also like to be able to better evaluate as necessary how the QPA deviates from market rates. But in my experience, insurers only disclose the information about QPAs that the Departments require to be disclosed. However, this information is wholly insufficient, and if I had additional information about what went into QPAs, I would use the complaint process to try to remedy noncompliance that drives down QPAs. For example, it would be useful to know the number of contracts on which a QPA was based, whether the contracts used to calculate a QPA had claims filed or paid under them, and whether a QPA includes contracted rates with an out-of-specialty provider. The lack of transparency into QPAs also hampers my ability to advocate for my offer for payment during the Open Negotiation and IDR process, making it more likely that the insurer's lower offer will prevail.

16. I understand that the federal agencies charged with implementing the NSA have adopted a regulation laying out a methodology that insurers must use in calculating QPAs. I am generally familiar with this regulation, and I also understand that the methodology laid out in this regulation will tend to drive down QPAs.

17. For example, I understand that the regulation permits insurers to count what are referred to in the healthcare industry as "ghost rates." These are rates included in contracts with providers who do not actually provide the specified item or service, and thus have little or no incentive to negotiate a fair and reasonable reimbursement rate. Ghost rates can be as low as $0, and are typically lower than the rates negotiated by providers that have an incentive to meaningfully negotiate them.

18. I am also aware that the regulation allows insurers to include rates of providers who are not in the same or similar specialty as the provider that provided the service at issue. In my experience, it is not uncommon for insurers to offer most providers the same fee schedule for all covered services, leaving it up to the provider to negotiate increases in the rates that they are most likely to provide and bill for. Indeed, these out-of-specialty rates that appear in contracts are often ghost rates as low as $0. Providers are understandably less motivated to negotiate rates for services they are less likely to provide, or that they provide less frequently.

19. I would expect QPAs calculated with ghost rates and out-of-specialty rates to be lower than QPAs that exclude those rates. The Departments, in fact, recently acknowledged that QPAs can materially differ from relevant median market rates, as a result of insurers including rates from physicians in different specialties, or even $0 rates listed in fee schedules.[1]

[1] DEP'TS, *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55* at FAQ 14 (Aug. 19, 2022), *available at*

20. I also understand that the regulation requires insurers to exclude incentive-based or retrospective payments or payment adjustments from QPA calculations. In my experience, providers sometimes accept a contract with an insurer that incorporates lower per-services rates, after negotiating for additional payments, including incentive-based payments or bonuses, that will be made later in time. Rationally, if a provider does not believe it will earn the additional payments, then the provider will demand a higher fixed rate. As a result, these retrospective and incentive payments could make up a meaningful amount of the rate an insurer in the end pays a provider for an item or service.

21. Finally, I am aware that the rules sometimes permit self-funded group health plans to ask their third-party administrators to calculate QPAs using the contracted rates of other self-funded group health plans administered by the third party. Because insurers in my experience have decided to tether their reimbursement offers to the QPA, and generally offer nothing more than the QPA during Open Negotiation and IDR, it is in their financial interest for QPAs to be as low as possible. Accordingly, I would expect a reasonable self-funded group health plan to take advantage of this option if doing so would on balance decrease the health plan's QPAs.

22. QPAs will often be well below the true median contracted rate as paid out in the market where I work. Even with this opacity around how insurers calculate QPAs, there is growing evidence, including from third parties such as Avalere Health,[2] that QPAs are not reasonable proxies for an average negotiated rate for my services. Indeed, these insurer-

https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf.

[2] https://www.acr.org/-/media/ACR/Files/Advocacy/2022-8-15-Avalere-QPA-Whitepaper_Final.pdf.

calculated QPAs are significantly lower than the reimbursement rates insurers were offering just last year for my services, before the NSA went into effect.

23. QPAs that are below-market and lower than the costs of providing medical services undermine my ability to obtain adequate reimbursement for my services through the NSA's negotiation and arbitration processes, especially given how the QPA influences the outcomes of those processes. *See supra*, at ¶¶ 11–14.

24. Lower reimbursement rates for out-of-network services I furnish will decrease my compensation. The NSA has decreased our practice compensation by over 50% for all claims that fall under the NSA, which is most of our non-government payor claims. This precipitous drop in reimbursement rates has significantly affected the solvency of my small business medical practice. Solely due to the devastating impact of the NSA, I have lost half of my physician workforce since the NSA was passed.

25. For these reasons, the Departments' rules challenged in this lawsuit directly harm my financial interests.

Pursuant to the requirements of 28 U.S.C. section 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on:
1/16/2023

DocuSigned by:
E5FF1E2F769B40E...
Dr. Steven Ford

EXHIBIT 1

From: Renee Baker [redacted]
Date: September 12, 2022 at 11:45:05 AM CDT
To: SFORD [redacted], STRAN [redacted] mpatel [redacted]
Cc: Donita Billings [redacted]
Subject: Written Payment Determination Notice- DISP-19496 / OPTI66

Hello –
This email is copied & pasted directly from MET regarding the determination of above named DISPUTE

IDR dispute status: Payment determination made

MET Healthcare Solutions has reviewed your Independent Dispute Resolution (IDR) dispute referenced in the subject above and determined:

Determination-CPT Code 01402

According to 29 Code of Federal Regulations 2590.716- 8 (c)(4)(iii)(C), the arbitrator's decision is based upon a thorough and careful consideration of the evidence submitted by both parties, "provided the information is credible and relates to the circumstances described in paragraphs (c)(4)(iii)(C)(1) through (5) of this section, with respect to a qualified IDR item or service of a nonparticipating provider, facility, group health plan, or health insurance issuer of group or individual health insurance coverage that is the subject of a payment determination."

The evidence provided by the initiating party does not demonstrate how the level of training and experience of the provider, the patient acuity, the market share held by either party, or good faith efforts to enter into a network agreement with the non-initiating party would affect the appropriate out of network rate for the qualified IDR item or service in this instance.

Therefore, the out-of-network payment amount of $1,197.96 offered by [redacted] non-initiating party under this dispute, has been selected as the appropriate out-of-network (OON) rate.

Next Step:

If any amount is due to either party, it must be paid not later than 30 calendar days after the date of this notification, as follows:

• If payment is owed by a plan or issuer to the non-participating provider, facility, or provider of air ambulance services, the plan or issuer is liable for additional payment when the amount of the offer selected exceeds the sum of 1) any initial payment the plan or issuer has paid to the non-participating provider, facility, or provider of air

ambulance services and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

• If the plan or issuer is owed a refund, the non-participating provider, facility, or provider of air ambulance services is liable to the plan or issuer when the offer selected by the certified IDR entity is less than the sum of the plan's or issuer's initial payment and any cost sharing paid by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. MET Healthcare Solutions has determined that the initiating party is the non-prevailing party in the dispute referenced in the subject above and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party in the amount of $350 will be returned to the prevailing party by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 26 CFR 54.9816–8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process, may not submit a subsequent Notice of IDR Initiation involving the same other party, with respect to a claim for the same or similar item or service that was the subject of the initial Notice of IDR Initiation during the 90-calendar-day suspension period following the date of this email, also referred to as a "cooling off" period.

If the end of the open negotiation period for such an item or service falls during the cooling off period, either party may submit the Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the No Surprises website for additional IDR resources.

Contact information

For questions, contact MET Healthcare Solutions at IDR@met-hcs.com. Reference your IDR reference number above.

Thank you,

MET Healthcare Solutions
IDRE# IDREApp-116
Thank you,

IDR Department

MET HEALTHCARE SOLUTIONS
When Quality Counts

713-961-7277 2211 W. 34th Street
713-961-7286 Houston, Tx 77018

urac ACCREDITED Independent Review Organization: External Review Expires 06/01/2025

IDRE Certified

Quality Reports, Quality Service. When Quality Counts, Count on MET.

Thanks so much,

Renee Baker
Accounts Receivables Specialist
Phone: (469)505 -1671
Fax: (972)739 -2604

National Partners in Healthcare

EXHIBIT C

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

TEXAS MEDICAL ASSOCIATION, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants*.	)	Case No.: 6:22-cv-00450-JDK Lead Consolidated Case

DECLARATION OF TYLER REGIONAL HOSPITAL, LLC

I, Glen Christensen, solemnly declare under penalty of perjury and to the best of my knowledge, information, and belief as follows:

1. I am the Chief Financial Officer for Tyler Regional Hospital, LLC (the "Hospital"). My responsibilities include negotiating with insurers to enter into network agreements and negotiating reimbursement for medical services furnished to out-of-network patients.

2. This declaration is based on my personal knowledge and is made with the authority of the Hospital.

3. The Hospital provides medical care to thousands of patients each year, with the mission of ensuring that East Texas residents receive world-class medical care. In addition to offering comprehensive, innovative, cutting-edge care for all patients, the Hospital provides a variety of services focused exclusively on the least fortunate in the Tyler community. These services include: (1) a primary healthcare program providing free primary care visits, diabetes

visits, mammograms, and blood pressure visits; (2) the Healthy Texas Women program, which offers free reproductive health services like HIV screening, screening and treatment for postpartum depression, breast and cervical cancer screenings, and pelvic exams; and (3) the Family Planning Program, which offers free pregnancy testing, cholesterol, diabetes, and high blood pressure screening, and prenatal benefits.

4. The Hospital also provides out-of-network services, including emergency services, that are covered by the No Surprises Act's ("NSA") balance billing prohibition and the independent dispute resolution ("IDR") process for determining reimbursement rates for certain out-of-network services.

5. The Hospital furnishes emergency services through its emergency department. When the Hospital furnishes emergency services to a patient with insurance that covers emergency services, the Hospital submits a claim on a UB-04 form through a third-party billing service to the patient's insurance company. The claim for services (known as a facility fee) is submitted in the Hospital's name, and the Hospital receives payment from the insurance company. This same process applies regardless of whether the Hospital is in-network or out-of-network.

6. The Hospital has furnished emergency services covered by the NSA's IDR process to patients since the NSA went into effect. The Hospital has not consistently been able to identify that claims are covered by the NSA's IDR process within the period to initiate Open Negotiation, as a result of a failure by insurers to clearly convey this information when making an initial payment. Nonetheless, the Hospital participated in Open Negotiation last year, will almost certainly submit additional claims through Open Negotiation this year, and, for at least some of those claims, will almost certainly choose to enter into the NSA's IDR process.

7. I expect that the bids submitted by insurers as part of the NSA's IDR process will almost always be lower and closer to the QPA calculated by the insurer than the Hospital's bids.

8. Further, I expect that the relevant QPA will influence the IDR process because arbitrators must always consider the QPA. The Departments' rules privileging the QPA in the arbitration process make it even more likely that the arbitrator will ultimately select the offer closer to the QPA (that is, the insurer's offer). *See* Mot. for Summary J., *Texas Med. Ass'n v. HHS (TMA II)*, No. 6:22-cv-00372 (E.D. Tex.), Dkt 41, Ex. D (Decl. of Tyler Regional Hospital).

9. Because of the importance of QPAs and because QPAs are calculated by insurers, the Hospital would like to be able to understand how QPAs are calculated and would like some way to check the insurers' work. It would also like to be able to better evaluate as necessary how the QPA deviates from market rates.. However, I anticipate that the minimal information about QPAs that the Departments require insurers to disclose is wholly insufficient for assessing their accuracy, credibility, and reliability. The lack of transparency into QPAs will hamper the Hospital's ability to advocate for my offer for payment during the Open Negotiation and IDR process, making it more likely that the insurer's lower offer will prevail.

10. I understand that the federal agencies charged with implementing the NSA have adopted a regulation laying out a methodology that insurers must use in calculating QPAs. I am generally familiar with this regulation and know that four aspects of the regulation are being challenged in this litigation. I also understand that the methodology laid out in this regulation will tend to drive down QPAs.

11. For example, I know that the regulation permits insurers to count what are referred to in the healthcare industry as "ghost rates." These are rates included in contracts with

providers who do not actually provide the specified item or service, and thus have little or no incentive to negotiate a fair and reasonable reimbursement rate. Ghost rates can be as low as $0, and, in my experience, are typically lower than the rates negotiated by providers that have an incentive to meaningfully negotiate them.

12. I am also aware that the regulation allows insurers to include rates of providers who are not in the same or similar specialty of the provider that provided the service at issue. Based on industry knowledge and in my experience, it is not uncommon for insurers to offer most providers the same fee schedule for all covered services, leaving it up to the provider to negotiate increases in the rates that they are most likely to provide and bill for. Indeed, these out-of-specialty rates that appear in contracts are often ghost rates that are well below negotiated market rates and can be as low as $0. Not all such rates are $0, however. Insurers often propose some low rate in fee schedules as an initial offer which the provider has the option to negotiate. Providers are understandably less motivated to negotiate rates for services they are less likely to provide, or that they provide less frequently.

13. I would expect QPAs calculated with ghost rates and out-of-specialty rates to be lower than QPAs that exclude those rates. The Departments, in fact, recently acknowledged that QPAs can materially differ from relevant median market rates, as a result of insurers including rates from physicians in different specialties, or even $0 rates listed in fee schedules.[1]

14. I also understand that the regulation requires insurers to exclude incentive-based or retrospective payments or payment adjustments from QPA calculations. Based on industry

[1] DEP'TS, *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55* at FAQ 14 (Aug. 19, 2022), *available at* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf.

knowledge, providers sometimes accept a contract with an insurer that incorporates lower per-service rates, after negotiating for additional payments, including incentive-based payments or bonuses, that will be made later in time. Rationally, if a provider does not believe it will earn the additional payments, then the provider will demand a higher fixed rate. As a result, these retrospective and incentive payments could make up a meaningful amount of the rate an insurer in the end pays a provider for an item or service.

15. QPAs calculated pursuant to the regulation will therefore often be well below the true median contracted rate as paid out in the market where the Hospital is located. In addition, based on industry knowledge, I expect that the QPAs associated with the Hospital's services, which are calculated pursuant to the regulation, will be below a reasonable reimbursement rate. QPAs often do not accurately reflect the costs the Hospital incurs in providing emergency medical services, including because of geographic disparities, differences in provider training, and differences in patient and case complexity.

16. QPAs that are below-market and lower than the costs of providing medical services will undermine the Hospital's ability to obtain adequate reimbursement through the NSA's negotiation and arbitration processes, especially given how the QPA influences the outcomes of those processes. *See supra,* at ¶ 8.

17. The fact that the Final Rule privileges the QPA during the IDR process, exacerbates this problem, and further ensures that the Hospital's reimbursement for services covered by the NSA's IDR process will decline.

18. For these reasons, the Departments' rules establishing a methodology for calculating QPAs directly harm the Hospital's financial interests.

Pursuant to the requirements of 28 U.S.C. section 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on:
01-16-2023

Glen Christensen

EXHIBIT D

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

TEXAS MEDICAL ASSOCIATION, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants*.	Case No.: 6:22-cv-00450-JDK Lead Consolidated Case

DECLARATION OF DR. ADAM CORLEY

I, Dr. Adam Corley, solemnly declare under penalty of perjury and to the best of my knowledge, information, and belief as follows:

1. I am over 18 years of age and with capacity, and I provide this declaration based on my personal knowledge.

2. I am an emergency room physician who resides and practices in Tyler, Texas.

3. I work through Precision Emergency Physicians, PLLC and Banner State Emergency Physicians.

4. The majority of my patients are insured by commercial plans. I treat patients who receive services covered by the No Surprises Act's ("NSA") rules for out-of-network reimbursement, including the NSA's balance billing prohibition.

5. Some of the out-of-network services that I provide qualify as "emergency services" covered under the NSA. I am reimbursed at an hourly rate for my emergency medical services.

6. I also own a percentage of Hospitality Health ER ("Hospitality Health"), a freestanding emergency department in Tyler, Texas.

7. Some patients who receive medical treatment at Hospitality Health are covered by commercial plans. Hospitality Health treats patients who receive services covered by the NSA's rules for out-of-network reimbursement.

8. I prefer to be in-network with health insurers where possible, but insurance companies do not always offer opportunities to be in-network or to negotiate network agreements with me in good faith.

9. Since the NSA went into effect on January 1, 2021, both I and Hospitality Health have furnished out-of-network services that are subject to reimbursement through the NSA's IDR process, and I expect that we will both continue to do so. Claims for my services that are subject to the NSA's rules for out-of-network reimbursement have been submitted through the NSA's Open Negotiation and IDR processes. Hospitality Health has also submitted claims for its emergency services through the NSA's Open Negotiation and IDR processes.

10. In my experience, insurers often make initial payments that are equal to the applicable QPA for these NSA-covered services.

11. In my experience and through conversations with others who work with the NSA's Open Negotiation and IDR processes on behalf of Hospitality Health and myself, Open Negotiation has rarely resulted in out-of-network insurers offering reasonable reimbursement rates that are consistent with the reimbursement rates they were willing to pay before the NSA

went into effect. As a result, it has been necessary to use IDR to attempt to obtain a reasonable reimbursement rate. I expect that claims for my services and emergency services furnished at Hospitality Health will continue to be submitted through the NSA's IDR process.

12. The IDR bids for my services and emergency services furnished at Hospitality Health are generally higher than the relevant QPA. But the bids submitted by insurers as part of the NSA's IDR process are generally tethered to the relevant QPA. Insurers' bids thus are lower and closer to the relevant QPA than the bids for my services or Hospitality Health's services. When IDR entities have ruled in favor of the insurance company in reimbursement disputes for services I or Hospitality Health furnished, the insurer's offer is generally at or very near the QPA. In fact, in my experience so far, each insurer's bid is always the QPA, including in every IDR dispute that I have lost.

13. Further, while arbitrators must always consider the QPA, the Departments' rules privileging the QPA in the arbitration process make it even more likely that the arbitrator will ultimately select the offer closer to the QPA (that is, the insurer's offer). *See* Mot. for Summary J., *Texas Med. Ass'n v. HHS (TMA II)*, No. 6:22-cv-00372 (E.D. Tex.), Dkt 41, Ex. B (Decl. of Dr. Adam Corley).

14. In my experience, then, QPAs often color the entire Open Negotiation and IDR process.

15. Because of the importance of QPAs and because the figures are calculated by insurers, I would like to be able to understand how QPAs are calculated and would like some way to check the insurers' work. I would also like to be able to better evaluate as necessary how the QPA deviates from market rates. But in my experience, insurers only disclose the information about QPAs that the Departments require to be disclosed. However, this information

is wholly insufficient, and if I had additional information about what went into QPAs, I would use the complaint process to try to remedy noncompliance that drives down QPAs. For example, it would be useful to know the number of contracts on which a QPA was based, whether the contracts used to calculate a QPA had claims filed or paid under them, and whether a QPA includes contracted rates with an out-of-specialty provider. The lack of transparency into QPAs also hampers my ability to advocate for my offer for payment during the Open Negotiation and IDR process, making it more likely that the insurer's lower offer will prevail.

16. I understand that the federal agencies charged with implementing the NSA have adopted a regulation laying out a methodology that insurers must use in calculating QPAs. I am generally familiar with this regulation, and I also understand that the methodology laid out in this regulation will tend to drive down QPAs.

17. For example, I understand that the regulation permits insurers to count what are referred to in the healthcare industry as "ghost rates." These are rates included in contracts with providers who do not actually provide the specified item or service, and thus have little or no incentive to negotiate a fair and reasonable reimbursement rate. Ghost rates can be as low as $0, and are typically lower than the rates negotiated by providers that have an incentive to meaningfully negotiate them.

18. I am also aware that the regulation allows insurers to include rates of providers who are not in the same or similar specialty as the provider that provided the service at issue. In my experience, it is not uncommon for insurers to offer most providers the same fee schedule for all covered services, leaving it up to the provider to negotiate increases in the rates that they are most likely to provide and bill for. Indeed, these out-of-specialty rates that appear in contracts

are often ghost rates as low as $0. Providers are understandably less motivated to negotiate rates for services they are less likely to provide, or that they provide less frequently.

19. Finally, I am aware that the rules sometimes permit self-funded group health plans to ask their third-party administrators to calculate QPAs using the contracted rates of other self-funded group health plans administered by the third party. Because insurers in my experience have decided to tether their reimbursement offers to the QPA, and generally offer nothing more than the QPA during Open Negotiation and IDR, it is in their financial interest for QPAs to be as low as possible. Accordingly, I would expect a reasonable self-funded group health plan to take advantage of this option if doing so would on balance decrease the health plan's QPAs.

20. I would expect QPAs calculated with ghost rates and out-of-specialty rates to be lower than QPAs that exclude those rates. The Departments, in fact, recently acknowledged that QPAs can materially differ from relevant median market rates, as a result of insurers including rates from physicians in different specialties, or even $0 rates listed in fee schedules.[1]

21. I also understand that the regulation requires insurers to exclude incentive-based or retrospective payments or payment adjustments from QPA calculations. In my experience, providers sometimes accept a contract with an insurer that incorporates lower per-services rates, after negotiating for additional payments, including incentive-based payments or bonuses, that will be made later in time. Rationally, if a provider does not believe it will earn the additional payments, then the provider will demand a higher fixed rate. As a result, these retrospective and

[1] DEP'TS, *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55* at FAQ 14 (Aug. 19, 2022), *available at* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf.

incentive payments could make up a meaningful amount of the rate an insurer in the end pays a provider for an item or service.

22. QPAs will often be well below the true median contracted rate as paid out in the market where I work and where Hospitality Health is located: Tyler, Texas. Furthermore, QPAs often do not accurately reflect the costs I or Hospitality Health incur in providing medical services.

23. QPAs that are below-market and lower than the costs of providing medical services undermine my ability to obtain adequate reimbursement for my services through the NSA's negotiation and arbitration processes, especially given how the QPA influences the outcomes of those processes. *See supra*, at ¶¶ 12–14.

24. Lower reimbursement rates for my and Hospitality Health's services will decrease my compensation, and may ultimately threaten the viability of the practices where I work and hold an ownership stake.

25. For these reasons, the Departments' rules challenged in this lawsuit directly harm my financial interests.

Pursuant to the requirements of 28 U.S.C. section 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on:

1/17/2023

Dr. Adam Corley

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

TEXAS MEDICAL ASSOCIATION, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants*.	Case No.: 6:22-cv-00450 Lead Consolidated Case

[PROPOSED] ORDER GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Before the Court is plaintiffs' motion for summary judgment. Being fully advised in the premises, the Court finds that the motion should be **GRANTED**.

It is therefore **ORDERED** that the motion is hereby **GRANTED** and the following provisions are hereby **VACATED**:

a. 45 C.F.R. § 149.140(a)(1), from "means" to "benefit manager"; 45 C.F.R. § 149.140(a)(8)(iv), from "or at the option" to "on behalf of the plan."; 45 C.F.R. § 149.140(a)(12), from "as identified … to "practice"; 45 C.F.R. § 149.140(a)(15)(ii)(B), from "(or the administering entity" to "if applicable)"; 45 C.F.R. § 149.140(b)(1), from "(or the administering entity" to "if applicable)"; 45 C.F.R. § 149.140(b)(2)(i), from "(or the administering entity" to "if applicable)"; 45 C.F.R. § 149.140(b)(2)(iv); 45 C.F.R. § 149.140(b)(3)(i), from "If a plan or issuer" to "for the service code" and "as applicable"

b. 26 C.F.R. § 54.9816-6T(a)(1), from "means" to "benefit manager"; 26 C.F.R. § 54.9816-6T(a)(8)(iv), from "or at the option" to "on behalf of the plan."; 26 C.F.R. § 54.9816-6T(a)(12), from "as identified" … to "practice"; 26 C.F.R. § 54.9816-6T (a)(15)(ii)(B), from "(or the administering entity" to "if applicable)"; 26 C.F.R.

§ 54.9816-6T(b)(1), from "(or the administering entity" to "if applicable)"; 26 C.F.R. § 54.9816-6T(b)(2)(i), from "(or the administering entity" to "if applicable)"; 26 C.F.R. § 54.9816-6T(b)(2)(iv); 26 C.F.R. § 54.9816-6T(b)(3)(i), from "If a plan has" to "for the service code" and "as applicable";

c. 29 C.F.R. § 2590.716-6(a)(1), from "means" to "benefit manager"; 29 C.F.R. § 2590.716-6(a)(8)(iv), from "or at the option" to "on behalf of the plan."; 29 C.F.R. § 2590.716-6(a)(12) from "as identified" to … "practice"; 29 C.F.R. § 2590.716-6(a)(15)(ii)(B), from "(or the administering entity" to "if applicable)"; 29 C.F.R. § 2590.716-6(b)(1), from "(or the administering entity" to "if applicable)"; 29 C.F.R. § 2590.716-6(b)(2)(i), from "(or the administering entity" to "if applicable)"; 29 C.F.R. § 2590.716-6(b)(2)(iv); 29 C.F.R. § 2590.716-6(b)(3)(i), from "If a plan or issuer" to "for a service code" and "as applicable";

d. 5 C.F.R. § 890.114(a), insofar as it requires compliance with the foregoing provisions.

It is further **ORDERED** that FAQs 14 and 15 of *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55* (Aug. 19, 2022) are hereby **VACATED**.

Further, the Court **DECLARES** that it is unlawful for arbitrators to consider QPAs that were affected by the Departments' unlawful rules, and that arbitrators therefore should not consider any QPA for which the insurer (1) included ghost rates; (2) included out-of-specialty rates; (3) excluded risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments; or (4) included rates from a different plan sponsor.

It is further **ORDERED** that, for the reasons set forth in the Court's opinion, the Departments' disclosure regulations, *see* 45 C.F.R. § 149.140(d); 26 C.F.R. § 54.9816-6T(d); 29 C.F.R. § 2590.716-6(d), are hereby remanded to the Departments for further rulemaking consistent with the NSA, the APA, and this Court's decision.

SO ORDERED.

Date:

_____

Hon. Jeremy D. Kernodle
United States District Judge