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.: 6:23-cv-00059

BRIEF OF AMERICAN SOCIETY OF ANESTHESIOLOGISTS, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, AND AMERICAN COLLEGE OF RADIOLOGY AS AMICI CURIAE IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTERESTS OF AMICI CURIAE

The American Society of Anesthesiologists ("ASA"), the American College of Emergency Physicians ("ACEP"), and the American College of Radiology ("ACR") (collectively, "Amici") are voluntary, national professional associations that advocate for the interests of their respective members, including adequate and fair reimbursement for physician services provided out-of-network, which is increasingly important because implementation of the No Surprises Act ("NSA") has enabled insurers to cancel contracts and push practices out of network. ASA is a professional association comprised of approximately 56,000 physician anesthesiologists and others involved in the medical specialty of anesthesiology, critical care, and pain medicine. ACEP is a professional association comprised of more than 40,000 emergency physicians, residents, and medical students. ACR is a professional association comprised of approximately 40,000 diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians, and medical physicists. Amici submit this brief on behalf of their members who provide items and services that are impacted by the NSA.

INTRODUCTION

Amici support Plaintiffs' motion for summary judgment, ECF No. 18, to declare unlawful and vacate specific provisions of the interim final rules, jointly published by the United States Department of Health and Human Services ("HHS"), the United States Department of Labor, the United States Department of the Treasury, and the United States Office of Personnel Management (collectively, "Departments") implementing the NSA, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 2757-890 (2020), and the December 2022 Fee Guidance published by the Centers for Medicare and Medicaid Services ("CMS"). Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021) ("October 2021 IFR"); CMS, *Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process*

under the No Surprises Act: Change in Administrative Fee (Dec. 23, 2023) ("December Fee Guidance").[1] Amici submit this brief to explain to the Court how the October 2021 IFR and the December Fee Guidance restrict access of Amici's members to Independent Dispute Resolution ("IDR") and stifle provider challenges seeking to obtain fair compensation for physician services. The October 2021 IFR and December Fee Guidance unlawfully empower insurers to dictate both in-network and out-of-network rates for physician services, which will force many physician practices to consolidate and will harm patient care by narrowing provider networks, particularly in underserved communities.

The Departments and CMS flout Congress's carefully crafted access to IDR and broad batching conditions by (1) improperly subjecting any provider initiating IDR to a cost-prohibitive, non-refundable $350 administrative fee and (2) unlawfully restricting the batching of claims to the same or similar service code. The December Fee Guidance's administrative fee renders IDR infeasible for many providers. The December Fee Guidance's administrative fee will drive down payments for the out-of-network services of Amici's members and effectively prevent them from challenging unfair payments. The lack of meaningful IDR will incentivize insurers to lower in-network rates, which, in turn, will reduce out-of-network rates. The inevitable result will be narrower provider networks and consolidation of physician practices, which will lead to fewer services in rural and other underserved communities. For these reasons, and the reasons stated in Plaintiffs' summary judgment brief, the Court should invalidate the provisions of the October 2021 IFR and the December Fee Guidance that unlawfully restrict access to IDR.

[1] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf.

BACKGROUND

I. NSA IDR

The NSA establishes IDR, which requires an independent arbitrator—referred to as the IDR entity—to determine appropriate payments for out-of-network health care items and services. 42 U.S.C. § 300gg-111(c)(5). Congress delineated factors that the IDR entity "shall consider" when identifying the appropriate payment amount: 1) the QPA for the item or service; and 2) "information on any circumstance described in clause (ii), such information as requested [by the IDR entity relating to the party's offer], and any additional information [submitted by a party relating to such offer of either party]." *Id.* § 300gg-111(c)(5)(C)(I)–(II). In "clause (ii)," Congress identified five additional factors that the IDR entity "shall consider."

A. IDR Fees

The NSA outlines two different categories of fees payable by IDR parties: 1) those relating to the "costs of [the] independent dispute resolution process" and 2) administrative fees.[2] 42 U.S.C. § 300gg-111(c)(5)(F), (c)(8). For the administrative fees, the NSA dictates that "[e]ach party to a determination . . . shall pay to the Secretary . . . a fee for participating in the IDR process." *Id.* § 300gg-111(c)(8)(A). This fee is to be paid "at such time and in such manner as specified by the Secretary," and each party must pay "an amount established by the Secretary." *Id.* § 300gg-111(c)(8)(B). The NSA limits the Departments' discretion in setting the administrative fee by requiring that fees be established "in a manner such that the total amount of fees paid . . . for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process." *Id.* § 300gg-111(c)(8)(B).

[2] Fees relating to the cost of the IDR process under § 300gg-111(c)(5)(F) are not at issue in this case. Complaint for Declaratory and Injunctive Relief at 12, ECF No. 1.

B. Batching

The NSA also specifies how the Departments must treat the "batching of items and services" under IDR. *Id.* § 300gg-111(c)(3). The purpose of batching items or services is to "encourag[e] the efficiency (including minimizing costs) of the IDR process." *Id.* § 300gg-111(c)(3)(A). With this objective, the NSA allows the batching of items or services "only if":

> (i) such items and services to be included in such determination are furnished by the same provider or facility;
> (ii) payment for such items and services is required to be made by the same group health plan or health insurance issuer;
> (iii) such items and services are related to the treatment of a similar condition; and
> (iv) such items and services were furnished during the 30 day period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by the Secretary, for use in limited situations, such as by the consent of the parties or in the case of low-volume items and services, to encourage procedural efficiency and minimize health plan and provider administrative costs.

Id. § 300gg-111(c)(3)(A)(i)-(iv).

II. The Departments' Interim Final Rules on IDR Fees and Batching

A. IDR Fees

The Departments published the October 2021 IFR without notice and comment. *Texas Med. Ass'n v. United States Dep't of Health & Hum. Servs.* ("*TMA I*"), 587 F. Supp. 3d 528, 548 (E.D. Tex. 2022). As part of the October 2021 IFR, the Departments implemented the IDR process and administrative fees. The regulations concerning the cost of IDR process fees mirror the requirements and parameters of the NSA. *See generally* 45 C.F.R. § 149.510(d)(1)(i)-(ii); 86 Fed. Reg. at 56,001.

Administrative fees are to be paid "at the time the certified IDR entity is selected." 45 C.F.R. § 149.510(d)(2)(i). Parties are to pay the "non-refundable" administrative fees "to the certified IDR entity," who will in turn remit the fees to the Departments. *Id.*; 86 Fed. Reg. at 56,001. These fees are non-refundable, "even in instances where the parties negotiate an out-of-

network rate before the certified IDR entity makes a determination or where the certified IDR entity determines that the case does not qualify for the Federal IDR process." 86 Fed. Reg. at 56,001.

The October 2021 IFR differs from the NSA by setting the administrative fee in guidance by the Departments. 45 C.F.R. § 149.510(d)(2)(ii). Further, the October 2021 IFR provides that multiple factors will be considered in "setting the administrative fee" to reflect "estimated costs for the Departments to administer the Federal IDR process." 86 Fed. Reg. at 56,001. The factors include "the staffing and contracting costs related to certifying and providing oversight to certified IDR entities; the costs of developing and publishing reports as required [by statute]; the costs of collecting the administrative fees from certified IDR entities; and the cost of maintaining the Federal IDR portal." *Id.* at 56,001–02.

B. Batching

The October 2021 IFR permits the batching of claims but "only if certain conditions are met." *Id.* at 55,994. The October 2021 IFR limits batching to "qualified IDR items and services" that "are the same or similar items and services." 45 C.F.R. § 149.510(c)(3)(i)(C).[3] The Departments defined "same or similar items or services" as those items or services "billed under the same service code, or a comparable code under a different procedural code system, such as [the CPT, HCPCS, or DRG]." *Id.* The Departments asserted that batching claims "is likely to reduce redundant IDR proceedings as well as streamline the certified IDR entity's decision-making" and permit IDR entities to "more efficiently focus on where the value of the qualified IDR items or services is consistently materially different from the QPA." 86 Fed. Reg.

[3] In contrast, the NSA states that batching can occur if "items and services are related to the treatment of a similar condition." 42 U.S.C. § 300gg-111(c)(3)(A)(iii).

at 55,994, 56,064. They contended that batching "may reduce the per-service cost of the Federal IDR process and potentially the aggregate administrative costs, since the Federal IDR process is likely to exhibit at least some economies of scale." *Id.* at 56,054. The Departments admitted that they did not "have data or a way to estimate how prevalent batching will be" or "potential cost savings that may result." *Id.*

C. The Departments' Fee Guidance

In 2021 and 2022, the Centers for Medicare & Medicaid Services ("CMS") released three sets of guidance relating to the cost of IDR process fees and administrative fees. On September 30, 2021, CMS released guidance that "the administrative fee due from each party for participating in the Federal IDR process is $50." CMS, *Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act* at 3 (Sept. 30, 2021) ("September Fee Guidance").[4] In October 2022, CMS issued its second guidance document regarding both categories of fees. CMS, *Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act* (Oct. 31, 2022) ("October Fee Guidance").[5] The October Fee Guidance stated that the administrative fee owed by each party would "remain $50 for the calendar year beginning January 1, 2023." *Id.* at 4. In a departure from the October 2021 IFR and the September Fee Guidance, the October Fee Guidance stated that "parties must pay the administrative fee by the time of offer submission" instead of when the certified IDR entity was selected. *Id.* at 1-2.

In December 2022, CMS published fee guidance increasing the 2023 "administrative fee for the Federal independent dispute resolution (IDR) process from $50 to $350 per party for

[4] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf.
[5] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf.

disputes initiated during the calendar year beginning January 1, 2023." CMS, *Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process under the No Surprises Act: Change in Administrative Fee* at 1 (Dec. 23, 2022).[6] The Departments justified the increase in part because the "case load [was] nearly ten times greater than the Departments initially estimated it would be over the course of a full calendar year." *Id.* at 4. Also, the "Departments permit parties to pay the administrative fee on or before the time of offer submission. If an offer is not submitted because the certified IDR entity determines the dispute is ineligible for the Federal IDR process, the administrative fee is often not collected." *Id.* at 4 n.22. Ultimately, these ineligible claims "resulted in low collections of the administrative fee relative to the volume of disputes processed in the portal," necessitating a higher administrative fee. *Id.* at 5. The Guidance does acknowledge that the Departments recognize the "need to keep the Federal IDR process from being cost prohibitive for disputing parties" in relation to the "certified IDR entity fee." *Id.* at 6.

ARGUMENT

The December Fee Guidance stemming from the October 2021 IFR effectively makes IDR economically infeasible for most physicians by (1) raising the non-refundable IDR administrative fee to $350 and (2) limiting the types of claims that may be batched to those with the same CPT code. This distorted implementation of the NSA will suppress provider challenges to inadequate reimbursement when a QPA is not reflective of the fair market value of items and services furnished by out-of-network providers. Further, the unnecessarily limited batching of claims does not rectify the defects of the absurdly high administrative fee. Put together, the administrative fee and the limited batching criteria disincentivize providers from challenging low

[6] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf.

out-of-network rates, which will empower insurers to reduce their in-network rates significantly or terminate in-network agreements altogether. The December Fee Guidance hinders providers' ability to challenge unfair contract negotiations with insurers by making access to the IDR process cost prohibitive. If insurers can set rates with impunity, more providers will be forced out-of-network due to the December Fee Guidance, and patients will lose access to in-network care. Moreover, depressed rates will impose serious financial pressures on all providers, which will, in turn, threaten their ability to operate. If this occurs, small, independent providers may have no choice but to consolidate with larger practices or to cease operating. Patients will lose access to care, particularly in underserved areas.

I. The December Fee Guidance Will Effectively Exclude Physicians From IDR

CMS's sevenfold increase in the administrative fee is likely to shut many providers out of the IDR process. CMS decided to raise the administrative fee to $350 even though it repeatedly stated that it would stay at $50 in two previous guidance documents. *See* December Fee Guidance at 1, 6; October Fee Guidance at 4; September Fee Guidance at 3. Charging such a high, non-refundable amount will deter providers from invoking the IDR process to obtain fairer payment for the items or services they provide. In fact, Amici have received notification from some members that they have already begun foregoing pursuit of the IDR process because it is too costly and administratively burdensome.

Many claims for items and services provided by radiologists, anesthesiologists, and emergency physicians typically do not exceed, or barely exceed, $350. Providers will not initiate IDR if the administrative fee is higher than the claim itself. When given the choice between losing a substantial amount through IDR or accepting unfair payment, providers with predominantly small claims will forgo IDR and accept unfair compensation. In particular, providers in small to medium-sized community practices will suffer the greatest impact because

they are the most negatively impacted when plans and issuers pay unreasonably low rates.

Not only does the heightened administrative fee unreasonably obstruct access to the IDR process, but it also goes against CMS's own stated goals. In the same guidance document that raises the administrative fee amount, CMS recognizes "the need to keep the Federal IDR process from being cost prohibitive for disputing parties" when related to the "certified IDR entity fee." December Fee Guidance at 6. However, CMS fails to acknowledge that this same goal should be applied to the non-refundable administrative fee.

Further, the Departments' rationale for increasing the administrative fee most closely aligns with the purpose the certified IDR entity fee rather than the administrative fee:

> [T]here is a significant backlog of disputes pending eligibility determinations before certified IDR entities which has continued to grow since the publication of the prior 2023 guidance. To address this issue, the Departments have engaged a contractor and government staff to conduct pre-eligibility reviews, which include outreach and technical assistance in support of the certified IDR entities' eligibility determinations.

December Fee Guidance, at 3.

The Departments have shifted the burden of certified IDR entity duties onto IDR parties by charging parties for functions that certified IDR entities attested to provide as part of their certification. In the second interim final rule that the Departments issued to implement the NSA, the Departments explicitly described the functions that IDR entities must provide to the Departments in order to receive certification, which include the following:

> In order to be certified, an IDR entity must employ (directly or through contracts or other arrangements) sufficient personnel to make determinations within the 30 business days allowed for such determinations. To satisfy this standard, the written documentation the IDR entity submits must include a description of its organizational structure and capabilities, including an organizational chart and the credentials, responsibilities, and number of personnel employed to make determinations.

86 Fed. Reg. 56,002.

The Departments have already expressly stated that the costs it cites as a rationale for increasing the 2023 administrative fee should be carried by the certified IDR entities and, if appropriate, reflected in the certified IDR entity fees:

> The Departments will also consider the anticipated time and resources needed for certified IDR entities to meet the requirements of these interim final rules, such as the time and resources needed to obtain certification, making payment determinations (including determining whether the dispute belongs in the Federal IDR process), data reporting, and audits. The Departments will also consider factors such as the anticipated volume of payment determinations under the Federal IDR process and adequacy of the Federal IDR process capacity to efficiently handle the volume of IDR initiations and payment determinations. The Departments will review and update the allowable fee range annually based on these factors and the impact of inflation and other cost increases. ***The Departments seek comment on these factors and any additional factors that should be considered when determining the range for allowable certified IDR entity fees***.

86 Fed. Reg. 56,005 (emphasis added). It is wholly inappropriate for the Departments to erect a major obstacle to accessing IDR by increasing administrative fees when the Departments published in the Federal Register the expectations for certified IDR entities' abilities and the factors that go into calculating the range of allowable certified IDR entity fees.

The option to batch claims will not prevent the administrative fee from becoming cost prohibitive for many providers. The October 2021 IFR implemented a regulation allowing batching for the "same or similar items or services" that are "billed under the same service code[s]." 45 C.F.R. § 149.510(c)(3)(i)(C). However, this regulatory implementation—which is much narrower than the NSA's "related to the treatment of a similar condition"—will often limit IDR submissions to batches that are so small that the transaction cost of initiating IDR proceedings will still exceed the potential recovery. 42 U.S.C. § 300gg-111(c)(3)(A)(iii).

The batching criteria for self-insured plans is particularly problematic. In October 2022 IDR guidance, the Departments stated that "services paid for by different self-insured group health plans are not allowed to be batched." Federal Independent Dispute Resolution (IDR)

Process Guidance for Certified IDR Entities, at 19 (October 2022).[7] Because physicians cannot batch claims together by a health plan, non-contracted physicians must sort claims by the employer that has contracted with those insurers to administer their health plans, even though this information is not readily available to physicians. This has divided disputes that otherwise would be "batchable" into single payment determination requests, each of which now carries a $350 administrative fee. Unnecessarily limiting batching to service codes will therefore cause providers with meritorious claims to lose access to IDR and, ultimately, fair payment. Batching conditions must be broad—at lease as broad as the NSA required—for joint claims to be monetarily feasible.

To make matters worse, batching fees relating to the costs of the IDR process were raised in the October Fee Guidance to anywhere "within the range of $268–$938." October Fee Guidance at 7. All these factors combined thwart Congress's stated purpose for batching items or services: to "encourag[e] the efficiency (including minimizing costs) of the IDR process." 42 U.S.C. § 300gg-111(c)(3)(A). Ultimately, a non-refundable $350 administrative fee coupled with the heightened batching fee will make IDR economically infeasible because providers are almost guaranteed to come out at a loss.[8]

II. The December Fee Guidance Incentivizes Insurers to Lower In-Network Rates, Ultimately Narrowing Provider Networks

Because the December Fee Guidance imposes an administrative fee that makes it cost-prohibitive to challenge reimbursement rates for items and services through IDR, providers will not be fairly reimbursed for their out-of-network services. The December Fee Guidance's newly

[7] https://www.cms.gov/files/document/rev-102822-idr-guidance-certified-idres.pdf.
[8] For example, one practice of approximately one hundred anesthesiologists report that their average batch is 1.2 claims. With batches of such a small size, the economics of submitting one or two claims with a non-refundable $350 and batching fees do not make sense.

imposed high administrative fee empowers insurers to reduce their in-network rates significantly or terminate in-network agreements altogether. Insurers will know that providers will almost never challenge claims under $350. As a result, the December Fee Guidance following the October 2021 IFR significantly diminishes providers' negotiating position with insurers that lack an incentive to enter into network agreements.

Indeed, when the Departments began implementing the NSA, 152 members of Congress expressed concerns that the Departments' implementation "could incentivize insurance companies to set artificially low payment rates," resulting in improperly depressed rates. Letter from Members of Congress to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep't Sec'ys 2 (Nov. 5, 2021).[9] These Congressmembers stressed that tying out-of-network payments to the QPA could result in "narrow provider networks … jeopardize[ing] patient access to care—the exact opposite of the goal of the [NSA]." *Id*. at 2.

The concerns expressed by these Congressmembers materialized. For instance, Blue Cross Blue Shield of North Carolina ("BCBSNC") sent letters to providers demanding a reduction in contracted rates as a direct result of the Departments' October 2021 IFR. Decl. of Dr. Nicola; Decl. of Dr. Raley. The letters from BCBSNC further state that if providers do not accept the rate reduction in light of the Departments' October 2021 IFR, their contracts will be "quickly terminated." *See* Decl. of Dr. Raley.

The December Fee Guidance further distorts the IDR process in favor of the insurer-calculated QPA by making it economically cost prohibitive for providers to challenge those reimbursement rates. The first interim final rule sets an artificially low value for QPAs. Because most of the initial payments are based on those QPAs and because the IDR process is cost-

[9] https://www.acep.org/globalassets/new-pdfs/advocacy/2021.11.05-no-surprises-act-letter.pdf.

prohibitive, providers must either accept extremely low payments, close, or consolidate with larger groups. The December Fee Guidance all but guarantees that providers will not challenge claims under $350, enabling insurers to reduce in-network contracted rates further and threatening existing contractual arrangements with providers. Ultimately, this will result in narrower networks.

III. The December Fee Guidance Will Result in Under-Compensation of Care, Incentivizing the Consolidation of Practices, and Undermining Market Competition

CMS's flawed implementation of the IDR process administrative fee will systemically prevent providers from challenging artificially depressed payments. This will impose serious financial pressures on all providers that render services out-of-network. The ensuing financial strain will disproportionately affect small, independent practices and rural practices. *See* Letter from Am. Med. Ass'n to Janet Yellen, Sec'y, U.S. Dep't of Treasury, et al., AMA Comments on Interim Final Rule Requirements Related to Surprise Billing: Part II Implementing the No Surprises Act (Dec. 6, 2021).[10]

These practices may have no choice but to sell to larger corporate entities—a phenomenon that occurred in California after the state passed its surprise medical billing law. Cal. Health & Safety Code § 1371.31. Like the NSA, California's law requires insurers to make interim payments to out-of-network providers who could then begin the California IDR process if they felt the rate was inadequate. *See Id*. However, the interim rate was chosen as the "reasonable rate" 98% of the time, essentially functioning as a benchmark rate. Letter from Cal. Med. Ass'n to Chiquita Brooks-LaSure, Adm'r, CMS, No Surprises Act: Interim Final Rule: Part

[10] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-12-6-Letter-to-Yellen-Walsh-Becerra-re-IFR-Comments-v3.pdf.

I [RIN 0938-AU63; CMS 9909-IF] 10 (Sept. 7, 2021).[11] Here, unlike in California, the December Fee Guidance's $350 administrative fee practically ensures that providers will not find it economically viable to begin the IDR process for inadequate rates. This is even more likely to result in a QPA that functions as a benchmark rate.

The California law "changed the negotiation dynamics between hospital-based physicians and payers," resulting in leverage shifting "in favor of payers" and incentivizing them to "lower or cancel contracts with rates higher than their average as a means of suppressing [out-of-network] prices." Erin L. Duffy, *Influence of Out-of-Network Payment Standards on Insurer-Provider Bargaining: California's Experience*, 25 Am. J. Managed Care e243 (2019).[12] These drastic changes in negotiating power and lower rates accelerated "consolidation and exclusive contracting with facilities" among hospital-based specialists. *Id.* Similarly, routine under-compensation of out-of-network care resulting from providers' inability to challenge inadequate rates due to the administrative fee imposed under the December Fee Guidance threatens the viability of many smaller and independent physician practices and incentivizes the consolidation of practices.

IV. Market Disruptions and Narrower Provider Networks Stemming from the December Fee Guidance Will Harm Patients in Underserved Areas Struggling with Accessibility

The December Fee Guidance's administrative fee will result in fewer challenges to inadequate reimbursement rates. In turn, this will result in fewer provider networks and the consolidation of practices, thereby threatening the stability of the nation's already fragile health care system. Ultimately, patients' access to care, particularly in underserved areas, will suffer.

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[11] https://downloads.regulations.gov/CMS-2021-0117-7408/attachment_1.pdf.
[12] https://www.ajmc.com/view/influence-of-outofnetwork-payment-standards-on-insurer-provider-bargaining-californias-experience.

Patients who are unable to access care from in-network providers may delay care, seek care from an in-network provider in the wrong specialty, rely on emergency departments to receive care, or forgo care altogether. Simon F. Haeder, *Inadequate in the Best of Times: Reevaluating Provider Networks in Light of the Coronavirus Pandemic*, 12 World Med. & Health Pol'y 282, 284 (2020) ("These issues raise concerns, even under relatively normal circumstances" but "become exacerbated" with the effects of the COVID-19 pandemic).[13]

The IDR process—which favors a depressed QPA and imposes an administrative fee that is higher than most claims—will consistently undercompensate providers. *See* Decl. of Dr. Nicola; Decl. of Dr. Raley. Routine under compensation will threaten the viability of many smaller and independent physician practices that provide care to underserved areas already struggling with accessibility to care. Ultimately, losing providers in these areas will significantly harm patients and actively work against the Departments' longstanding efforts to preserve or bolster network adequacy. *See, e.g.*, 45 C.F.R. § 156.230(a)(1)(ii) (requiring each qualified health plan issuer that uses a provider network to maintain "a network that is sufficient in number and types of providers … to ensure that all services will be accessible without unreasonable delay").

CONCLUSION

For the foregoing reasons, Amici respectfully request that the Court grant Plaintiffs' Motion for Summary Judgment.

Respectfully submitted,

/s/Ronald S. Connelly
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[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7436480/pdf/WMH3-12-282.pdf.

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Dated: February 21, 2023

CERTIFICATE OF SERVICE

The undersigned certifies that, on this 21st day of February 2023, the foregoing document was filed electronically in compliance with Local Rule CV-5(a), which provides service on counsel to all parties.

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Dated: February 21, 2023

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FOR THE EASTERN DISTRICT OF TEXAS
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TEXAS MEDICAL ASSOCIATION, et al., Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No.: 6:23-cv-00059

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EXHIBIT A	Declaration of Lauren Nicola, MD (previously filed in Case No. 6:22-cv-00372)
EXHIBIT B	Declaration of Christopher E. Young, MD (previously filed in Case No. 6:22-cv-00372)
EXHIBIT C	Declaration of Jennifer Raley, MD (previously filed in Case No. 6:22-cv-00372)

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.	Civil Action No. 6:22-cv-00372

DECLARATION OF LAUREN NICOLA, MD

I, Lauren Nicola, MD declare as follows:

1. I am a current member of the American College of Radiology ("ACR"). I have been a member of ACR since 2008.

2. I am licensed by the State of North Carolina as a physician, and I am in good standing. I am currently certified by the American Board of Radiology.

3. In 2006, I received a Doctor of Medicine degree from Duke University School of Medicine. I completed my medicine residency at Wake Forest University School of Medicine in 2011.

4. I have been practicing medicine in the field of radiology for over 15 years.

5. Currently, I serve as Chief Executive Officer at Triad Radiologists, which is located at 3010 Trenwest Dr., Winston Salem, NC. Triad Radiology Associates contracts with hospitals, hospital outpatient departments, outpatient imaging facilities, and critical access hospitals in the Winston-Salem area for the provision of radiology treatment and care.

6. I receive a salary and profit distributions from Triad Radiology Associates. The profit distributions that I receive are dependent, in large part, upon the revenues that Triad Radiology Associates receives from patients and insurance companies.

7. Triad Radiology Associates transmits the bills for my services to the insurance companies of the patient, and Triad Radiology Associates directly receives payments from these insurance companies. A radiologist who interprets any given examination is unaware whether a patient is in-network or out-of-network. Therefore, their service is equivalent.

8. Some of the patients that I treat are covered by a group health plan or a health insurance issuer offering group or individual health insurance coverage (collectively, "insurers").

9. I have entered into contractual arrangements with some, but not all, insurers as an "in-network" provider.

10. On average, I treat approximately 11 "out-of-network" patients per month. This includes patients who receive my out-of-network services at hospitals, hospital outpatient departments, and critical access hospitals that are within the network of the patient's insurer. Accordingly, some of my services are subject to the No Surprises Act.

11. I am aware that, on July 13, 2021, the United States Department of Health and Human Services, the United States Department of Labor, the United States Department of the Treasury, and the United States Office of Personnel Management ("Departments") published interim final rules implementing the methodology for calculating the qualifying payment amount ("QPA") pursuant to the No Surprises Act. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872 (July 13, 2021).

12. It is my understanding that the QPA is not reflective of the fair market value for out-of-network radiology care.

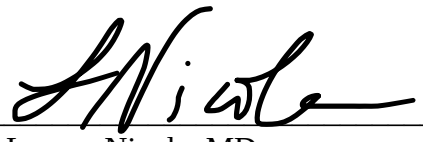
13. I also am aware that, on August 26, 2022, the Departments published final rules ("Final Rule") governing an independent dispute resolution ("IDR") process to determine how much reimbursement an insurer must pay for certain out-of-network items or services. Requirements Related to Surprise Billing, 87 Fed. Reg. 52,618 (Aug. 26, 2022).

14. It is my belief that the Final Rule will tilt IDR deliberations in favor of the QPA because certified IDR entities have limited capability to consider other non-QPA statutory factors. If certified IDR entities were able to consider all statutory factors, as contemplated by Congress, I would be better positioned to receive adequate and fair reimbursement for my out-of-network services.

15. I reasonably believe that the Final Rule will empower insurers to reduce Triad Radiology Associates' in-network contracted rate with insurers or refuse to contract with me as an in-network provider. Triad Radiology Associates has already received correspondence from Blue Cross Blue Shield of North Carolina demanding an immediate 10% reduction in our contracted rates, which were previously negotiated in good faith. This letter cites the Departments' October 7, 2021 interim final rules—which established a "rebuttable presumption" that the appropriate out-of-network rate was the offer closest to the QPA—as justification to "warrant a significant reduction in (our) contracted rates with Blue Cross NC" and warns of additional rate reductions once the qualifying payment amount is established. The letter states that if Triad Radiology Associates does not accept the immediate rate reduction, our contract will be "quickly terminated."

16. Because my profit distributions that I receive from Triad Radiology Associates dependent, in large part, upon the revenues from insurers, the Final Rule will adversely impact my profit distributions.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge and belief. Executed on October 17, 2022, in Winston Salem, North Carolina.



10/17/2022

Lauren Nicola, MD Date

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.	Civil Action No. 6:22-cv-00372

DECLARATION OF CHRISTOPHER E. YOUNG, MD

I, Christopher Young, MD declare as follows:

1. I am a current member of the American Society of Anesthesiologists (ASA) and have been a member of ASA for approximately 30 years.

2. I am currently a licensed physician in good standing in Tennessee. I received my Doctor of Medicine degree from Georgetown University in 1985. I completed my residency at SUNY Health Science Center, Syracuse in 1989. I have 30 years of experience as a board certified anesthesiologist.

3. I am a physician anesthesiologist at Anesthesiology Consultants Exchange (ACE), which is located in Chattanooga, Tennessee. I have been employed by ACE since 1991.

4. ACE began billing insurers for my anesthesia services in 1991 and continues to bill for my services today. ACE receives payments directly from public and private insurers. I am a shareholder at ACE, and my income is directly dependent on ACE to bill and collect payments from private and public health insurers.

5. I provide anesthesia services at Erlanger Health System (EHS) in Chattanooga, Tennessee. In the course of my employment, I render anesthesia services to participants, beneficiaries, and enrollees (collectively, "patients") covered by a group health plan or a health insurance issuer offering group or individual health insurance coverage (collectively, "insurers").

6. I have entered into contractual arrangements with some, but not all, insurers as an "in-network" provider.

7. I also provide "out-of-network" anesthesia services to patients at EHS's hospital and ambulatory surgical center that are within the network of the patient's insurer.

8. It is my understanding that the No Surprises Act created an independent dispute resolution ("IDR") process to determine the amount of reimbursement that insurers must pay for certain out-of-network items or services.

9. I am aware that the "qualifying payment amount" for anesthesia services is calculated in accordance with the No Surprises Act and the policies set forth in the interim final rule entitled, "Requirements Related to Surprise Billing; Part I," 86 Fed. Reg. 36,872 (July 13, 2021). The qualifying payment amount strongly favors insurers and is significantly lower than my current reimbursement rates for providing out-of-network anesthesia services. In other words, the qualifying payment amount is not reflective of the fair market value for my out-of-network anesthesia services.

10. It is my understanding that the vacated interim final rules entitled, "Requirements Related to Surprise Billing; Part II," 86 Fed. Reg. 55,980 (Oct. 7, 2021) (the "October IFR"), required the certified IDR entity to "select the offer closest to the qualifying payment amount unless the certified IDR entity determines that credible information submitted by either party … clearly demonstrates that the qualifying payment amount is materially different from the

appropriate out-of-network rate, or if the offers are equally distant from the qualifying payment amount but in opposing directions." *Id.* at 56,104, 56,116, 56,128.

11. It is also my understanding that, on August 26, 2022, the United States Department of Health and Human Services, the United States Department of Labor, the United States Department of the Treasury, and the United States Office of Personnel Management ("Departments") published final rules ("Final Rule") establishing a new IDR process that restricts the certified IDR entity's ability to consider the non-qualifying payment amount statutory factors that the IDR entity must consider when identifying the appropriate reimbursement amount. Requirements Related to Surprise Billing, 87 Fed. Reg. 52,618 (Aug. 26, 2022). I reasonably believe that the Final Rule will result in a disproportionately high number of IDR decisions that are closer to the qualifying payment amount, which benefits insurers because the qualifying payment amount is tied to the insurer's median in-network rates.

12. Accordingly, it is my belief that the Final Rule will adversely impact the out-of-network payments that ACE receives for the anesthesia services that I provide to patients at EHS's hospital and ambulatory surgical center. This will, in turn, will negatively impact our income at ACE and diminish our ability to provide the level of high quality anesthesia services our patients currently receive.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge and belief. Executed on October __, 2022, in Chattanooga, Tennessee.

10/18/22

Christopher E Young, MD Date

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.	Civil Action No. 6:22-cv-00372

DECLARATION OF JENNIFER RALEY, MD

I, Jennifer Raley, MD declare as follows:

1. I am a current member of the American College of Emergency Physicians ("ACEP"). I have been a member of ACEP for approximately twenty-four (24) years.

2. I am licensed by the State of North Carolina as a physician, and I am in good standing. I am currently certified by the American Board of Emergency Medicine.

3. In 1998, I received a Doctor of Medicine degree from St. Louis University School of Medicine, St. Louis, Missouri. I completed my medicine residency at the University of North Carolina, Chapel Hill in 2001.

4. I have been practicing medicine in the field of emergency medicine for over twenty (20) years.

5. Currently, I serve as an emergency physician and a full shareholder at Wake Emergency Physicians, P.A. ("WEPPA"), which is located at 210 Towne Village Drive, Cary, NC 27513. WEPPA contracts with WakeMed in Raleigh, North Carolina, as well as hospital

systems in the surrounding Johnston, Nash, and Granville Counties respectively, to provide emergency medical services.

6. As a WEPPA shareholder, the compensation that I receive is dependent, in large part, upon the revenues that WEPPA receives from patients and third-party payers, including insurance companies.

7. Some of the patients that I treat are covered by a group health plan or a health insurance issuer offering group or individual health insurance coverage (collectively, "insurers").

8. WEPPA has contracted with some, but not all, insurers as an "in-network" provider. When WEPPA is an in-network provider, I am an in-network provider.

9. When a patient is covered by insurance, WEPPA's contracted billing company transmits the bills for my services to the insurer, and WEPPA directly receives payments from the insurer.

10. Most patients, however, are not covered by a private insurer. Some are covered by Medicare or Medicaid. Others have no insurance at all (under federal law, emergency departments are obligated to treat every patient who seeks care, regardless of their insurance status).

11. WEPPA also treats patients who have insurance, but WEPPA has not reached an in-network agreement with their insurers. These are "out-of-network" patients. WEPPA has diligently worked over the last decade to be in network with all of the major local insurers. Referencing our most recent contracts, WEPPA has been in network with Cigna for more than a decade, Blue Cross Blue Shield of North Carolina for nearly a decade, and UnitedHealthcare since 2014. WEPPA has been in network with Aetna for the past two years.

12. Despite this focus on contracting, WEPPA nonetheless treats some "out-of-

network" patients each month. When WEPPA is an out-of-network provider, I am an out-of-network provider.

13. I am aware that the United States Department of Health and Human Services, the United States Department of Labor, the United States Department of the Treasury, and the United States Office of Personnel Management ("Departments") published interim final rules on July 13, 2021, implementing a method for calculating the qualifying payment amount ("QPA") under the No Surprises Act. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872 (July 13, 2021).

14. Furthermore, I am aware that the Departments published final rules ("Final Rule") on August 26, 2022, governing an independent dispute resolution ("IDR") process to determine how much reimbursement an insurer must pay for certain out-of-network items or services. Requirements Related to Surprise Billing, 87 Fed. Reg. 52,618 (Aug. 26, 2022). Because certified IDR entities have limited capability to consider other statutory factors under the Final Rule, the Final Rule will result in a disproportionately high number of IDR decisions that are closer to the QPA.

15. It is my understanding that the QPA is not reflective of the fair market value for emergency department care.

16. Accordingly, the Final Rule in favor of the QPA will result in significantly lower reimbursement rates than WEPPA is currently receiving for out-of-network emergency department care. Because the compensation that I receive from WEPPA depends, in large part, upon the revenues we receive from insurers, the Final Rule will adversely impact my compensation.

17. Moreover, I reasonably believe that the Final Rule will empower insurers to

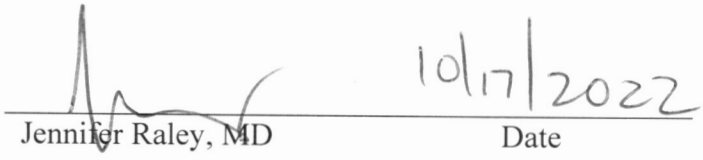
reduce WEPPA's/my in-network contracted rate with insurers or refuse to contract with WEPPA as an in-network provider.

18. Blue Cross Blue Shield of North Carolina sent WEPPA a letter on November 5, 2021, stating that the Departments' October 7, 2021 interim final rules—which established a "rebuttable presumption" that the appropriate out-of-network rate was the offer closest to the QPA—provides "enough clarity to warrant a significant reduction in [WEPPA's] contracted rate with Blue Cross NC." Despite WEPPA and Blue Cross Blue Shield of North Carolina's almost decade-long contractual arrangement, Blue Cross Blue Shield of North Carolina determined—after the promulgation of the October 7, 2021 interim final rules —that WEPPA was an "outlier in-network provider with respect to rates." Blue Cross Blue Shield of North Carolina's letter then asked that WEPPA (1) take an immediate 20% rate cut, and (2) negotiate a new, lower rate. The letter stated that "with an interim [rate] reduction in place, we will not need to quickly terminate outlier contracts as a means of avoiding payment levels after January 1, 2022 that are significantly higher than the default out-of-network QPA." It then stated that "[i]f we are unable to reach agreement on the reduction, our intention is to proceed with identifying and executing on terminations of outlier contracts where the out-of-network QPA will result in significant savings to the benefit of our customers."

19. In addition, I personally had separate conversations with representatives from UnitedHealthcare and Cigna in 2020 and 2021, respectively, where they demanded immediate and significant rate reductions and specifically raised the No Surprises Act during the conversation. On May 1, 2022, UnitedHealthcare terminated its in-network contract with WEPPA. On September 15, 2022, Cigna terminated its in-network contract with WEPPA.

I declare under penalty of perjury under the laws of the United States of America that the

foregoing is true and correct to the best of my knowledge and belief. Executed on October 17, 2022, in Pittsboro, North Carolina.



Jennifer Raley, MD

10/17/2022

Date