No. 23-40605

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Texas Medical Association; Tyler Regional Hospital, L.L.C.; Dr. Adam Corley,
Plaintiffs-Appellees/Cross-Appellants,

v.

United States Department of Health and Human Services; Office of Personnel Management; United States Department of Labor; United States Department of Treasury; Xavier Becerra, Secretary, U.S. Department of Health and Human Services, in his official capacity; Kiran Ahuja, in her official capacity as the Director of the Office of Personnel Management; Janet Yellen, Secretary, U.S. Department of Treasury, in her official capacity; Julie A. Su, Acting Secretary, U.S. Department of Labor, in her official capacity;
Defendants-Appellants/Cross-Appellees.

LifeNet, Incorporated; Air Methods Corporation; Rocky Mountain Holdings, L.L.C.; East Texas Air One, L.L.C.,
Plaintiffs-Appellees/Cross-Appellants,

v.

United States Department of Health and Human Services; Office of Personnel Management; United States Department of Labor; United States Department of Treasury; Xavier Becerra, Secretary, U.S. Department of Health and Human Services, in his official capacity; Kiran Ahuja, in her official capacity as the Director of the Office of Personnel Management; Janet Yellen, Secretary, U.S. Department of Treasury, in her official capacity; Julie A. Su, Acting Secretary, U.S. Department of Labor, in her official capacity;
Defendants-Appellants/Cross-Appellees.

On Appeal from the United States District Court
for the Eastern District of Texas

RESPONSE TO PETITION FOR REHEARING EN BANC

BRIAN M. BOYNTON
Principal Deputy Assistant Attorney General

DAMIEN M. DIGGS
United States Attorney

JOSHUA M. SALZMAN
LEIF OVERVOLD
KEVIN B. SOTER
Attorneys, Appellate Staff
Civil Division, Room 7226
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530
(202) 305-1754

CERTIFICATE OF INTERESTED PERSONS

A certificate of interested persons is not required, as defendants-appellants/cross-appellees are all governmental parties. 5th Cir. R. 28.2.1.

s/ Leif Overvold
Leif Overvold

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases: **Page(s)**

Statutes:

Regulations:

Legislative Material:

Other Authorities:

INTRODUCTION

Plaintiffs brought suit to challenge certain provisions of regulations implementing the No Surprises Act (the Act), a federal statute enacted in 2020 to protect patients from the often-devastating effects of surprise medical bills. Each party prevailed in part before the district court, and the parties cross-appealed. A unanimous panel of this Court issued a balanced opinion upholding several of the challenged provisions but agreeing with plaintiffs that one provision was inconsistent with the statute. Plaintiffs now ask the en banc Court to consider their challenges to two regulatory provisions upheld by the panel. The rehearing petition should be denied because the panel correctly upheld the two challenged provisions, which were reasonable exercises of an express grant of rulemaking authority. Moreover, the panel's decision does not conflict with any decision of this Court, any other court of appeals, or the Supreme Court, nor does it present any question of exceptional importance that would warrant review by the full Court.

This case concerns the implementation by the Department of Health and Human Services (HHS), the Department of the Treasury, and the Department of Labor (collectively, the Departments) of the Act's protections against surprise medical billing and in particular the Departments' establishment of a methodology for calculating the "qualifying payment amount" or "QPA," a figure that approximates the total amount that a provider would have received for a particular service under the terms of a patient's health plan had the provider been in-network. That amount is

used under the statute both to cap the liability a patient can face for covered items and services and as one factor to be considered by an arbitrator when the value of a service is disputed between the provider and a health plan. The statute contains a definition of the QPA, specifying that it is generally "the median of the contracted rates recognized by" the health plan on January 31, 2019 (before the Act was enacted), adjusted for inflation. 42 U.S.C. § 300gg-111(a)(3)(E)(i). But Congress understood that this definition was incomplete and set a deadline for the Departments to "establish through rulemaking" the "methodology" that plans "shall use to determine the [QPA]." *Id.* § 300gg-111(a)(2)(B)(i).

Plaintiffs challenge the panel's rejection of their assertions that two aspects of this methodology are inconsistent with the Act. But the panel correctly recognized that both challenged provisions—directing plans to include all contracted rates and to exclude retrospective payment adjustments from the calculation in a manner that tracks how patient cost-sharing is typically calculated—are consistent with the statute's plain terms and reasonable in light of its nature and purpose to protect patients from surprise medical bills. Plaintiffs fail to identify any error, much less a question warranting en banc review.

STATEMENT

1. Medical services are not provided under uniform pricing models, and different providers may charge a given patient significantly different amounts for the same service. While health plans and providers commonly pre-negotiate rates, where

a patient receives care from a provider outside a plan's "network," the provider generally will not have agreed to accept a particular negotiated rate, and the patient's plan may decline to pay the provider or may pay an amount lower than the provider's billed charges. *See Requirements Related to Surprise Billing; Part I*, 86 Fed. Reg. 36,872, 36,874 (July 13, 2021) (ROA.768-881). In that circumstance, the patient may be personally responsible for the balance of the bill, which may represent a sum that is immensely more than the cost-sharing amount based on a pre-negotiated rate that would have applied if the same service had been in-network. *See id.* This "balance billing" may come as a surprise to an individual, particularly when a patient receives care from a provider whom the patient could not have chosen in advance, like in emergencies, or when a patient has chosen an in-network facility but did not know that at least one provider involved in the care would be out of network. *Id.*

2. The No Surprises Act was designed to address this problem and the market distortion that may result where providers have little incentive to negotiate fair prices in advance for their services or to moderate their charges for out-of-network care. *See* 86 Fed. Reg. at 36,874. Where it applies, the Act caps a patient's share of liability to an out-of-network provider at an amount comparable to what the patient would have owed had she received care from an in-network provider, and the Act also creates procedures allowing the provider to seek further compensation from the patient's health plan.

In both circumstances, Congress determined that a relevant consideration would be what the statute terms the "qualifying payment amount" or "QPA," which is generally "the median of the contracted rates recognized by" a health plan on January 31, 2019, for a particular 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," adjusted for inflation. 42 U.S.C. § 300gg-111(a)(3)(E)(i). The QPA essentially approximates the total amount that the provider would have received under the terms of the patient's plan had the provider been in-network. A patient's cost-sharing requirement in most circumstances must be calculated as if the total charge was no greater than the QPA, and it cannot exceed the requirement that would apply if the service had been provided by an in-network provider. *Id.* § 300gg-111(a)(1)(C)(ii)-(iii), (3)(H)(ii), (b)(1)(A)-(B).[1]

The Act's procedures for determining a health plan's payment obligation to providers include additional steps, while also using the QPA as a required consideration. After a provider transmits a bill for a covered out-of-network service to the health plan, the plan must respond within 30 days by issuing an initial payment

[1] For ease of reference, this response cites the Act's amendments to the Public Health Service Act and the regulations implemented by HHS. The Act made parallel amendments to the Employee Retirement Income Security Act (administered by the Department of Labor) and the Internal Revenue Code (administered by the Department of the Treasury), and the implementing regulations likewise contain parallel provisions implemented by the different Departments.

or a notice of denial of payment; either party then has 30 days to initiate a further 30-day period of "open negotiation." 42 U.S.C. § 300gg-111(a)(1)(C)(iv), (b)(1)(C), (c)(1)(A). If the dispute remains unresolved, the parties may proceed to an independent dispute resolution process, where an arbitrator working for an entity certified under a government-established process will determine the appropriate out-of-network rate. *Id.* § 300gg-111(c)(1)(B), (4)(A). The Act relies on "baseball-style" arbitration: the provider and the health plan each offer a payment amount, and the arbitrator is required to select one of the two offers. *Id.* § 300gg-111(c)(5)(A)(i). In determining which offer to select, arbitrators "shall consider—(I) the [QPAs] for the applicable year for items or services that are comparable" to the item or service at issue; "and (II) . . . information on any circumstance described in" a list of "[a]dditional circumstances," as well as any information "relating to" a party's offer requested by the arbitrator or submitted by the party. *Id.* § 300gg-111(c)(5)(B)(i)(II), (B)(ii), (C)(i)-(ii).

The Act directs the Departments to issue regulations implementing the Act's provisions, including in particular to establish through rulemaking the methodology plans must use in determining the QPA. 42 U.S.C. § 300gg-111(a)(2)(B)(i).

3. The Departments promulgated an interim final rule pursuant to this statutory directive in July 2021, which, among other things, set the methodology for calculating the QPA. *See* 86 Fed. Reg. at 36,876. In doing so, the Departments resolved two issues relevant to this petition.

First, the Departments concluded that, in determining the rates that a plan has contracted to accept, plans should treat each rate negotiated under a contract as a single contracted rate "regardless of the number of claims paid at that contracted rate." 86 Fed. Reg. at 36,889. Thus, for this purpose, the QPA calculation is based on a consideration only of the four corners of a plan's contracts, with each contracted rate receiving equal weight, regardless of how many claims (if any) a given provider may ultimately submit for the service in question. The Departments recognized, however, that a plan's contracted rates may vary based on provider specialty, including because providers in a particular specialty do not perform a particular service, in which case the QPA must be calculated separately for each provider specialty. *See FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55*, at 16-17 (Aug. 19, 2022) (Aug. FAQs) (ROA.413-14); *see also* 45 C.F.R. § 149.140(b)(3)(i) (similar).[2] The Departments further clarified that, to the extent that some plans may enter "$0" in a fee schedule as a placeholder "for covered items and services that a provider or facility is not equipped to furnish," that does not represent a contracted rate that should be included in the QPA calculation. Aug. FAQs at 17 n.29 (ROA.414).

[2] The district court vacated this guidance and regulatory provision, concluding, in a holding that the government did not challenge on appeal, that the statute requires QPAs to be calculated separately based on provider specialty regardless of whether a plan varies its rates on this basis. *See* ROA.13209-11, 13239-40.

Second, the Departments directed health plans to consider the "full contracted rate applicable" to the relevant service code, but to exclude from the QPA calculation "risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments." 45 C.F.R. § 149.140(b)(2)(ii), (iv). The Departments explained that this approach was "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 not subject to retrospective adjustment based on such payments. 86 Fed. Reg. at 36,894.

4. Two sets of plaintiffs brought suit challenging various provisions of the rule. With respect to the two provisions discussed above, the district court granted summary judgment to plaintiffs and issued a universal vacatur as to these provisions. ROA.13238-40.

5. The government appealed several of the district court's rulings, including the invalidation of the two provisions discussed above, and plaintiffs cross-appealed from the district court's rejection of another of their challenges. A unanimous panel of this Court reversed the district court's invalidation of certain regulatory provisions, including the two at issue in this petition. It also affirmed the invalidation of another provision and rejected plaintiffs' cross-appeal.

As relevant here, the panel held that the Departments' determination that "contracted rates" should be included in the QPA calculation regardless of the number of claims paid at each rate was consistent with the Act. It explained that,

while the statute specified that the rates be for services "provided by a provider in the same or similar specialty," 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I), the Departments' rule was consistent with the plain meaning of "provide" as "to make available," reasoning that a service may be "available" "regardless of whether, or how many times, it has actually been performed." Op. 10 (quotation marks omitted). The panel also noted that the statutory requirement that the QPA be based on contracted rates of providers in the same or similar specialty and geographic region addressed plaintiffs' concern about including rates for a service that a given provider would not perform, as did the Departments' guidance directing that $0 placeholder rates be excluded from the calculation. Op. 10-11. And the panel recognized that plaintiffs provided no basis for performing the line-drawing for within-specialty services that they asserted the Act required. Op. 11.

The panel held that the rule's exclusion of retrospective payment adjustments was consistent with the statute as well. It noted the Departments' explanation that this approach was consistent with how cost-sharing is typically calculated for in-network services at the time a service is performed. Op. 14. And it concluded that the statute granted the Departments discretion in addressing such retrospective payment adjustments, highlighting a provision delegating rulemaking authority to the Departments regarding how to take account of payments that are not made on a fee-for-service basis, including certain payment adjustments taking into account quality or facility type. Op. 15 (citing 42 U.S.C. § 300gg-111(a)(2)(B)).

ARGUMENT

I. The Panel Decision Is Correct.

A. The panel correctly rejected plaintiffs' challenge to the Departments' determination that plans must include all contracted rates for a particular service in the QPA calculation, without considering whether, or how often, a claim had been paid at that rate. Plaintiffs argue (Pet. 11) that that decision is inconsistent with the Act's directive that the QPA be based on the rates for a service "provided by a provider in the same or similar specialty and provided in the geographic region" as the service for which a QPA is being calculated. But, as the panel recognized, the ordinary understanding of "provide" encompasses making available a particular service, regardless of how many times, if any, the service then happens to be performed. Op. 10. That understanding is consistent, moreover, with the general industry practice of negotiating contracts prospectively at a time when a plan or provider will not know how many times a service will actually be performed. *See, e.g.*, Blue Cross Blue Shield Ass'n Amicus Br. 8-9 (explaining particular relevance of prospective agreement on contracted rates to emergency-medicine providers). And especially where the statute directs plans to calculate the QPA based on rates "recognized" as of a particular statutorily specified date—January 31, 2019—the natural way to determine the contracted rates for services that have been made available is to look at the rates for a particular service reflected in a plans' contracts with providers as of that date, as the rule does.

Plaintiffs argue that some providers may contract to provide a service at a particular rate without really expecting to perform the service in question over the term of the contract. Pet. 11-12. But, as the panel correctly recognized, the statute addresses that concern via the requirement that the QPA be based on the rates of providers in the same or similar specialty and geographic region as the service for which the QPA is being calculated. Op. 10-11. And the panel noted that plaintiffs themselves offer no mechanism for plans to determine which rates reflected in contracts with in-specialty providers as of January 31, 2019, represent rates that a provider might perform versus those they would never perform for purposes of determining which rates to include.

Plaintiffs' only response is to assert that the in-specialty requirement Congress adopted may insufficiently address plaintiffs' concerns and to disclaim any responsibility for offering a theory as to how a plan could calculate a QPA on their reading of the statute. *See* Pet. 13. Indeed, to the extent plaintiffs had suggested in their brief before the panel that one mechanism the Departments could use to implement their preferred approach would be to base the determination on data regarding "items and services providers have provided," TMA Pls.' Br. 37, they disclaim in the en banc petition any "historical-provision test." Pet. 12 (quotation marks omitted). That concession makes sense, since any such test is both unadministrable given the limits on the data plans have available to determine whether a particular service has been performed and completely untethered from the statutory

directive that QPAs be calculated using rates applicable on a particular statutorily specified date. The fact that plaintiffs cannot identify any plausible method by which, for example, plans are to determine which obstetrician-gynecologists with contracted rates for performing deliveries truly mean to perform such services and which do not (*see* Pet. 13) underscores that the panel correctly rejected their effort to engraft an additional requirement onto the text Congress enacted, which focuses only on a plan's contracted rates.

B. The panel also correctly concluded that the rule's directive that plans exclude from the QPA calculation risk-sharing, bonus, penalty, and other retrospective payments or payment adjustments was reasonable and consistent with the Act. As the Departments explained, calculating the QPA without reference to such adjustments is consistent with how a patient's cost-sharing amount is customarily determined at or near the time a service is furnished, before any such retrospective payment adjustment has been made. *See* Op. 14 (citing 86 Fed. Reg. at 36,894). Such industry practice represents a "prime source[]" for determining what interpretation best comports with congressional intent in this regard, *City of Dallas v. FCC*, 118 F.3d 393, 395 (5th Cir. 1997), and the Departments reasonably aligned their understanding of this provision with the manner in which cost-sharing payments are determined generally, particularly given the QPA's determinative role in setting patient cost-sharing responsibilities under the Act.

As the rule also explained, bonus and incentive payments are rarely tied to specific contracted rates for particular items and services; they are more often paid in the context of a non-fee-for-service payment model as an annual lump-sum, based on the overall performance of a provider or a facility over time. *See* 86 Fed. Reg. at 36,893-94. The panel thus recognized that, in excluding such payments from the QPA calculation for a particular item or service, the Departments reasonably exercised discretion the Act gave them in establishing a QPA methodology, including specifically with respect to determining how to treat such payments made on a non-fee-for-service basis in establishing the methodology for calculating the QPA. Op. 15.

As they did before the panel, plaintiffs assert that the Departments' approach is inconsistent with the statutory directive that the QPA be based on the "total maximum payment" for a particular service. Pet. 14 (quoting 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I)). But in context, the "total maximum payment" referenced is the highest value a plan has contracted to pay for a given "item or service," including both the cost-sharing amount to be paid by the patient and the amount to be paid by the plan. 42 U.S.C. § 300gg-111(a)(3)(E)(i). Given the reality that bonus and incentive payments are rarely tied to specific contracted rates for particular items and services, the Departments reasonably adopted a methodology for calculating the QPA that excludes those adjustments. *See* 86 Fed. Reg. at 36,893-94*; see also* America's Health Ins. Plans Amicus Br. 11-15 (noting such models may encompass things like adjustments based on a provider group's overall performance or savings generated

across multiple patients and services); Blue Cross Blue Shield Ass'n Amicus Br. 18-22 (similarly noting alternative payment models often incorporate performance-based payments tied to outcomes across numerous patients and services as well as payments for things like general infrastructure investments or performing data-reporting services). Plaintiffs suggest that there may be some bonuses that can in some way be attributed to a particular service (*see* Pet. 15), but as with their challenge to the rule's inclusion of all contracted rates, they make no effort to show how it would be possible to calculate the impact of any such payments on the rate for a particular service when the provider and plan have agreed to rates established on a fee-for-service model.

Plaintiffs also argue (Pet. 15) that the Departments' approach to addressing retrospective payment adjustments is inconsistent with the statutory directive that the Departments "shall take into account" payments made on a non-fee-for-service basis, 42 U.S.C. § 300gg-111(a)(2)(B), as these retrospective adjustments generally are. But the panel correctly recognized that the statute does not direct the Departments as to how they must account for such payments. Op. 15. The Departments exercised their expressly delegated authority to adopt an approach based on a health plan's underlying fee schedule rate or a similar "derived amount" that a plan may have established for a particular service for cost-sharing or other internal accounting purposes, again excluding retrospective adjustments that cannot naturally be tied to a particular service. 86 Fed. Reg. at 36,893. Here too, the Departments acted

reasonably in establishing a QPA-calculation methodology that comports with the general manner in which both fee-for-service and non-fee-for-service payment models treat retrospective adjustments.

The reasonableness of this approach is bolstered, moreover, by the Departments' recognition that the QPA may be used not just to determine cost-sharing but as a consideration in the open-negotiation period between plans and providers and any subsequent arbitration. The rule thus specifies that, upon a provider's request, a plan must inform the provider whether the QPA includes contracted rates not set on a fee-for-service basis and whether the plan's rates include incentive-based or retrospective payments or payment adjustments that were excluded in calculating the QPA, and providers are free to point to bonus and incentive payments not incorporated into the QPA as a reason why the QPA does not reflect the full value of their services in negotiating or arbitrating with plans. *See* 45 C.F.R. § 149.140(d)(2)(i), (iv); 86 Fed. Reg. at 36,899; *see also* 42 U.S.C. § 300gg-111(c)(5)(C)(ii) (specifically directing arbitrators to consider "quality and outcomes measurements" of a given provider or facility among the "[a]dditional circumstances" that may be relevant in determining which offer to choose in the Act's dispute resolution process).

II. Plaintiffs Identify No Question Warranting En Banc Review.

Plaintiffs do not suggest that the panel decision conflicts with any decision of this Court, any other court of appeals, or the Supreme Court. Rather, they base their

claim that the petition satisfies the requirements of Rule 40(b)(2) of the Federal Rules of Appellate Procedure solely on the contention that the panel's supposed misinterpretation of the No Surprises Act as it relates to the two challenged regulatory provisions at issue represents a question of exceptional importance. Their claims that the panel's reversal of the district court's vacatur of two regulatory provisions will "undermin[e] the [Act] and jeopardiz[e] the functioning of the U.S. healthcare system," Pet. xiii, are unsubstantiated and do not support en banc review.

Plaintiffs' contention that supposedly deflated QPAs would have drastic effects on the healthcare system warranting en banc review is in any event meritless. While plaintiffs cite amicus briefs asserting that the Departments' implementation of the Act has reduced rates providers in relevant practices are being offered by plans, plaintiffs nowhere mention that the statute was designed to address the market distortion caused by certain providers' ability to engage in surprise billing leading to highly inflated payment rates for these services. *See* H.R. Rep. No. 116-615, pt. 1, at 53 (2020) (ROA.934). The claim that the two challenged provisions are having a meaningful effect in unlawfully reducing the QPA is, moreover, significantly undermined by the fact that plaintiffs have themselves proposed no method to remedy either alleged error in the QPA calculation they highlight.

Finally, while plaintiffs note that, in determining the compensation a provider receives from a plan, an arbitrator must consider the QPA, this Court has emphasized that the QPA is only one of several factors that an arbitrator is directed to consider in

determining which party's offer to choose. *See Texas Med. Ass'n v. HHS*, 110 F.4th 762, 778 (5th Cir. 2024). Where arbitrators conclude that an offer not based on the QPA better represents the value of the service, they can and do select that offer. Plaintiffs have consequently provided no basis to conclude this case presents a question of exceptional importance warranting en banc review.[3]

CONCLUSION

For the foregoing reasons, the petition should be denied.

Respectfully submitted,

BRIAN M. BOYNTON
Principal Deputy Assistant Attorney General

DAMIEN M. DIGGS
United States Attorney

JOSHUA M. SALZMAN

s/ Leif Overvold
LEIF OVERVOLD
KEVIN B. SOTER
Attorneys, Appellate Staff
Civil Division, Room 7226
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530
(202) 305-1754
leif.overvold2@usdoj.gov

[3] Plaintiffs also suggest that the fact that the Departments must respond to the vacatur of other provisions of the rule somehow supports en banc review, but they do not attempt to explain why that reality signifies that the panel's decision presents a question of exceptional importance.

January 2025

CERTIFICATE OF SERVICE

I hereby certify that on January 17, 2025, I electronically filed the foregoing response with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. Service will be accomplished by the appellate CM/ECF system.

s/ Leif Overvold
Leif Overvold

CERTIFICATE OF COMPLIANCE

This response complies with the type-volume limit of Federal Rule of Appellate Procedure 40(d)(3)(A) because it contains 3,896 words. This response also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 40(d)(2) because it was prepared using Word for Microsoft 365 in Garamond 14-point font, a proportionally spaced typeface.

s/ Leif Overvold
Leif Overvold