United States Court of Appeals
for the
Fifth Circuit

Case No. 23-40605

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 his 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 his official capacity,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF TEXAS IN NOS. 6:22-CV-450 AND 6:22-CV-453, HONORABLE JEREMY DANIEL KERNODLE, U.S. DISTRICT JUDGE

BRIEF OF PLAINTIFFS-APPELLEES/CROSS-APPELLANTS LIFENET, INC., EAST TEXAS AIR ONE LLC, ROCKY MOUNTAIN HOLDINGS LLC, AND AIR METHODS CORPORATION

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CERTIFICATE OF INTERESTED PERSONS

Number and Style of Case: 23-40605, *Texas Medical Association, et al. v. United States Dep't of Health and Human Services et al.*; *LifeNet, Inc. et al. v. United States Dep't of Health and Human Services et al.*

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

Undersigned counsel respectfully incorporates, here, the list of interested persons and entities provided in the principal brief of the Texas Medical Association.

In addition, undersigned counsel also provides the following list:

* All providers of emergency healthcare medical services in the United States. These providers benefit from the District Court's ruling under review.

* All group health plans and individual health insurance plans in the United States. These entities benefited from the agencies' regulations which the District Court vacated.

Federal Rule of Appellate Procedure 26.1:

1. LifeNet, Inc. has no parent corporation, subsidiaries, and/or affiliates, and no publicly held corporation owns 10% or more of its stock.

2. East Texas Air One, LLC hereby certifies that East Texas Air One, LLC is wholly-owned by AHS East Texas Health System, LLC. No publicly held corporation owns more than 10% of East Texas Air One, LLC.

3. Air Methods Corporation hereby certifies that it has no parent corporation and no publicly held corporation owns 10% or more of its stock.

4. Rocky Mountain Holdings, LLC hereby certifies that it is a wholly owned subsidiary of Air Methods Corporation and no publicly held corporation owns more than 10% of its stock.

Dated: March 13, 2024

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REQUEST FOR ORAL ARGUMENT

Plaintiffs respectfully request oral argument. This case presents important questions regarding the proper interpretation and implementation of the No Surprises Act governing, among other things, reimbursement disputes between out-of-network healthcare providers and health insurers. The issues involved will benefit from airing at oral argument, during which counsel can address any questions the Court might have. Because the decisional process will be significantly aided by oral argument, it is appropriate here under Fed. R. App. P. 34(a)(2).

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86 Fed. Reg. 55,996 31

86 Fed. Reg. 56,060 31

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Rate, n., Oxford English Dictionary (online ed.) 25, 26, 38

Rate, Webster's Third New International Dictionary, 1884 (2002) 38

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INTRODUCTION

The Air Ambulance Plaintiffs[1] join the Opening Brief filed by the Texas Medical Association (the "TMA") as to all common issues. This separate brief defends two rulings by the District Court that are not addressed in the TMA's brief.

First, the District Court correctly found that the July Rule impermissibly restricts the definition of "contracted rates" included in the Qualifying Payment Amount ("QPA"). The July Rule excludes "single-case agreements"—which are common in the air ambulance industry—even though those agreements are plainly "contracts," and even though the rates contained in them are highly probative of the market rate for medical air transport. The District Court vacated that exclusion because it is contrary to the plain and ordinary meaning of "contracted rate." It is also arbitrary and capricious because it is contrary to the Departments' stated purpose for the QPA (which was to approximate the market rate for the services in question) and because it is inconsistent with the Departments' interpretation of the very similar statutory term

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[1] The Air Ambulance Plaintiffs are Plaintiffs-Appellees/Cross-Appellants LifeNet, Inc., East Texas Air One, LLC, Air Methods Corporation, and Rocky Mountain Holdings, LLC.

"contractual relationship," which the Departments read to *include* single-case agreements.

Second, the District Court was also correct when it struck down the July Rule's amorphous and indefinite deadline. The No Surprises Act is clear: an insurer must send an "initial payment" or "notice of denial of payment" to a provider "not later than 30 calendar days after the *bill* for such services is *transmitted* by such provider." 42 U.S.C. § 300gg-112(a)(3)(A) (emphasis added). The July Rule replaces this clear deadline with a 30-day clock which starts "on the date the plan or issuer receives the information necessary to decide a claim for payment for the services." 45 C.F.R. § 149.130(b)(4)(i). This new deadline "rewrite[s] clear statutory terms to suit [the Departments'] own sense of how the statute should operate." *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 328 (2014). The new deadline is also arbitrary and capricious because it is vague, unenforceable, and defeats the NSA's purpose. This Court should uphold the District Court's decision vacating this provision of the July Rule.

The Air Ambulance Plaintiffs also challenged, in the District Court, certain of the provisions of the July Rule that are addressed in the TMA's brief. As to those provisions, the TMA's arguments apply in full to the Air

Ambulance Plaintiffs, notwithstanding some minor differences in certain statutory and regulatory provisions that are explained at the end of this brief.

JURISDICTIONAL STATEMENT

The Air Ambulance Plaintiffs respectfully incorporate the TMA's jurisdictional statement.

STATEMENT OF ISSUES

This brief addresses two issues:

I. Whether the Departments may, consistent with the NSA, promulgate rules that require an insurer to exclude, from the "contracted rates" used in the QPA calculation, the rates that the insurer agreed to in "single-case agreements" even though single-case agreements are "contracts."

II. Whether the Departments may replace the statutory deadline for an insurer to make an "initial payment" or issue a "notice of denial" "30 calendar days after the bill for such services is transmitted by such provider," 42 U.S.C. § 300gg-112(a)(3)(A), with a rule that starts the 30-calendar-day clock "on the date the plan or issuer receives the

information necessary to decide a claim for payment for the services," 45 C.F.R. § 149.130(b)(4)(i).

The Air Ambulance Plaintiffs respectfully adopt the TMA's statement of issues regarding all issues addressed in the TMA's brief.

STATEMENT OF THE CASE

The Air Ambulance Plaintiffs respectfully incorporate the TMA's statement of the case. In addition, the Air Ambulance Plaintiffs add the following background and context relating to air ambulances, the No Surprises Act ("NSA"), the July Rule, and the related guidance materials.

A. The Air Ambulance Plaintiffs

Air ambulances play a vital role in responding to medical emergencies. When air ambulances rush to administer lifesaving care, they typically have little information regarding the patient, including the patient's insurance or whether the patient has insurance at all. More than 85 million Americans—over a quarter of the U.S. population—live farther than a one-hour drive from a Level 1 or Level 2 trauma center. *See* ROA.821, 2274. Without air ambulances, many critically ill and injured patients—particularly in rural areas—would not have timely access to necessary medical care. *See* ROA.821, 2274. The Air Ambulance

Plaintiffs' planes and helicopters serve their communities by transporting thousands of critically ill and injured patients each year. *See* ROA.2271-85.

B. The IDR Process

The NSA forbids emergency healthcare providers from sending "balance bills" to their patients—meaning, bills for the "balance" due to the provider after the patient's insurer[2] pays part of the provider's bill.

The NSA created the Independent Dispute Resolution ("IDR") process to ensure that patients' insurers pay fair compensation to emergency providers. The IDR process is, in essence, a private right of action that providers may use to obtain payment from insurers. Although the statute does allow an insurer to initiate an IDR, in actual practice it is almost always the provider that does so. The IDR process is providers' only mechanism to obtain payment. Prompt IDR outcomes are essential to providers' cash flow.

IDR is a "baseball-style" arbitration in which the provider and insurer submit offers for the out-of-network rate to an independent entity—the

[2] The NSA uses the term "group health plan" or "health insurance issuer" when referring to health insurers. Except for when quoting directly from the statute, this brief uses the term "insurer(s)" to refer to collectively to both "group health plans" and "health insurance issuers."

"certified IDR entity." *See* 42 U.S.C. § 300gg-111(c)(4).[3] The arbitration is conducted solely on the papers—there is no hearing. Moreover, each party is permitted just one written submission—called its "offer"—and neither side is given the right to see the "offer" the other side sends to the arbitrator.

The "IDR entities" are private firms which apply to the Departments for certification. To be qualified to serve as an IDR entity, the firm must demonstrate that it has relevant medical and legal expertise. Once certification is granted, it is valid for five years unless earlier revoked by the Departments for good cause. There are currently 13 IDR entities. *See* CMS.gov, *List of certified independent dispute resolution entities* (last visited March 9, 2024), https://perma.cc/97KP-HKFU. These firms charge between $375 and $800 for a single-dispute IDR. *See id.*

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[3] The relevant statutory and regulatory provisions are codified in three places—the Public Health Service Act, enforced by the Department of Health and Human Services ("HHS"); the Internal Revenue Code ("IRC"), enforced by the Department of the Treasury; and the Employee Retirement Income Security Act ("ERISA"), enforced by the Department of Labor. For ease of reference, this brief—like the TMA's brief—cites the PHS Act provisions. The parallel statutory codifications are found at 26 U.S.C. § 9816(c) *et seq.* (IRC), and 29 U.S.C. § 1185e(c) *et seq.* (ERISA). The parallel regulations are codified at 26 C.F.R. § 54.9816-1T *et seq.* (IRC) and 29 C.F.R. § 2590.716-1 *et seq.* (ERISA).

Essentially, the IDR entity's job is to select between the two written "offers" submitted by the parties, based on the information provided by the parties and the IDR entity's consideration of the factors set forth in the NSA. The IDR entity's judgment is final and binding; there is no right of appeal. [4]

C. The July Rule Excludes Case-Specific Contracted Rates From the QPA

One of the factors that the arbitrator "shall consider" in choosing between the two offers is the "Qualifying Payment Amount" ("QPA"). 42 U.S.C. § 300gg-112(b)(5)(C)(i). Congress defined the QPA as the "median of contracted rates recognized by the plan or issuer . . . for the same or similar item or service . . . provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the [Departments]." *Id.* § 300gg-111(a)(3)(E)(i)(I); *see also id.* § 300gg-112(c)(2) (stating that the QPA for air ambulance IDRs has the meaning set forth in 42 U.S.C. § 300gg-111(a)(3)).

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[4] The IDR entity's determination is not subject to judicial review absent circumstances described in the Federal Arbitration Act codified at 9 U.S.C. § 10(a)(1)–(4). 42 U.S.C. § 300gg-111(c)(5)(E)(i) (as to non-air ambulance providers); *id.* § 300gg-112(b)(5)(D) (incorporating this provision for air ambulance IDRs); *see also* 45 C.F.R. § 149.510(c)(4)(vii)(A).

Each insurer is responsible for calculating the QPA for each NSA-covered emergency service provided to its beneficiaries. The insurer does this in secret, based on its own "contracted rate" data.[5] The insurer must then send the QPA to the provider as part of the insurer's initial "Explanation of Benefits" ("EOB"). 45 C.F.R. § 149.140(d)(1). Both parties then send the QPA to the arbitrator for consideration.[6]

Congress directed the insurer to calculate each QPA as the median of the insurer's "contracted rates" as of "January 31, 2019."42 U.S.C. § 300gg-111(a)(3)(E)(i)(I). Although the insurer must then adjust that median amount for inflation, *see id.* § 300gg-111(a)(3)(E)(i)(II), the underlying "contracted rates" remain the same for all time. In other words, ten years from now the QPA will still be calculated using 2019 "contracted rates," and will then be adjusted based on the inflation recorded between 2019 and 2034.

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[5] If the insurer lacks three rates (the minimum necessary to calculate a median) for the relevant service in the relevant geographic region, then the insurer may instead use a third-party database. *See* 45 C.F.R. § 149.140(c)(3).

[6] 42 U.S.C. § 300gg-112(b)(5)(C); 45 C.F.R. § 149.510(b)(2)(iii)(A)(7) (requiring parties to include the QPA in their notice of IDR initiation); 45 C.F.R. § 149.520(b)(1) (incorporating this requirement for air ambulance IDRs).

In the July Rule, "Requirements Related to Surprise Billing; Part I," 86 Fed. Reg. 36872 (July 13, 2021) (ROA.768), the Departments repeatedly stated that they believed the QPA's purpose was to approximate the "rates" reflecting "typical market negotiations" and "true market dynamics" for the service at issue in the IDR. *See, e.g.,* 86 Fed. Reg. at 36,896 (ROA.792) ("[F]or a database to be used to calculate the QPA, the database should contain sufficient data to reflect the true market dynamics in a given geographic region."); *id.* ("[T]hree contracted rates … represents the minimum number of contracts necessary to reasonably reflect typical market negotiations."). The Departments also attempted to prioritize the QPA over all the other applicable factors in IDR. That attempt was twice struck down by the District Court in separate litigation; the District Court's final order vacating the Departments' most recent attempt to improperly prioritize the QPA is now before this Court in a separate appeal. *See Texas Medical Association et al v. United States Dep't Health and Hum. Servs. et al*, No. 23-40217 (5th Cir.).

The typical market rate for air ambulance services is an *out-of-network* rate. As the Departments recognized in the July Rule, the great majority of air ambulance transports have historically been provided by out-of-network

providers. *See* 86 Fed. Reg. at 36,923 (ROA.819) (noting that "in 2012, 75 percent of [air ambulance] transports were out-of-network and in 2017, 69 percent were out-of-network."). These out-of-network air transports often resulted in "case-specific" or "single-case" agreements negotiated between the air ambulance provider and the insurer. *See id.* at 36,882 (describing a "single case agreement" as an agreement "between a health care facility and a plan or issuer, used to address unique situations in which a participant, beneficiary, or enrollee requires services that typically occur out-of-network . . ."). Elsewhere in the July Rule, the Departments recognized that such agreements "constitute[] a contractual relationship." *See id.* at 36,882; 45 C.F.R. § 149.30 (defining the terms "participating emergency facilit[ies] and "participating health care facilit[ies]").

But when it came to implementing Congress's definition of the QPA, the Departments narrowly defined the statutory term "contracted rate" to mean only the insurer's *in-network* rates. This had the intended effect of excluding, from the QPA calculation, the vast majority of market rates for emergency air-ambulance services in 2019 which were documented in "single case" agreements between the provider and the insurer.

Specifically, the July Rule expressly excludes, from the QPA calculation, any "single case agreement, letter of agreement, or other similar arrangement." 45 C.F.R. § 149.140(a)(1). According to the Departments, these agreements "do[] not constitute a contract" and therefore do not count as "contracted rates" that the insurer must include when calculating the median of its "contracted rates." *Id.*

D. The July Rule Re-Writes the Insurers' Deadline for Making an "Initial Payment" or "Notice of Denial"

The NSA requires a series of detailed steps to be taken before a provider may submit its dispute to the arbitrator. Recognizing that providers require *prompt* resolution of their disputes with insurers, Congress set specific deadlines by which each step must occur.

The very first step is the one at issue in this appeal, and it can only be taken by the insurer. Specifically, the insurer must send the provider an "initial payment" or a "notice of denial of payment." 42 U.S.C. §§ 300gg-112(a)(3)(A); (b)(1)(A); (b)(1)(B). The insurer must do this no later than 30 calendar days after the provider "transmit[s]" its "bill" to the insurer. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I); *id.* § 300gg-111(b)(1)(C); *id.* § 300gg-112(a)(3)(A) (same, for air ambulances). (This is the only statutory deadline in the NSA that is measured in *calendar* days, which

underscores its importance.[7]) Congress did not expressly delegate authority to the Departments to make interpretive rules governing this deadline, even though Congress made other express delegations to the Departments regarding other aspects of the NSA.

Once the provider receives from the insurer the "initial payment or a notice of denial of payment," then the provider has 30 business days in which to "initiate" an "open negotiation" with the insurer over the

[7] *Compare* 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv)(I), 300gg-111(b)(1)(C) (the "initial payment" or "notice of denial of payment" is due within "30 *calendar* days" after the provider submits the bill) (emphasis added), and *id.* § 300gg-112(a)(3)(A) (same, for air ambulances), *with id.* § 300gg-111(c)(1)(A) ("the *30-day period*" to initiate open negotiations and the "*30-day-period*" which open negotiation lasts after initiation) (emphasis added), *id.* § 300gg-112(b)(1)(A) (same, for air ambulances), *id.* § 300gg-111(c)(1)(B) (the IDR process must be initiated "during the *4-day period*" after the open negotiation period closes) (emphasis added), *id.* § 300gg-112(b)(1)(B) (same, for air ambulances), *id.* § 300gg-111(c)(3)(A)(iv) ("*30[-]day period*" applicable to certain batched submission requirements) (emphasis and alteration added), *id.* § 300gg-112(b)(3) (same, for air ambulances), *id.* § 300gg-111(c)(4)(F) (deadlines to select IDR entities based on "*business days*") (emphasis added), *id.* § 300gg-112(b)(4)(B) (same, for air ambulances), *id.* 300gg-111(c)(5)(A), (B) ("*10 day[]*" offer deadline in IDR and "*30 day[]*" decision deadline in IDR) (emphasis added), *id.* § 300gg-112(b)(5)(A), (B) (same, for air ambulances), *id.* § 300gg-111(c)(5)(E)(ii) ("*90-day period*" applicable for "cooling-off period") (emphasis added), *id.* § 300gg-112(b)(5)(D) (same, for air ambulances), *id.* § 300gg-111(c)(6) ("*30 day[]*" post-determination deadline for additional payments) (emphasis added), and *id.* § 300gg-112(b)(6) (same, for air ambulances).

appropriate amount of payment. *Id.* § 300gg-112(b)(1)(A); *see also* 45 C.F.R. §§ 149.510(b)(1)(i), (b)(1)(ii)(B), (b)(2)(i) (regulatory provisions implementing these statutory deadlines); 45 C.F.R. § 149.520(b)(1) (incorporating these provisions and deadlines for air ambulance IDRs).

The "open negotiation" period then lasts for an additional 30 business days. *See* 42 U.S.C. § 300gg-111(c)(1)(A); 45 C.F.R. § 149.510(b)(1)(i). The provider is finally authorized to initiate an IDR "during the 4-day period beginning on the day after [the] open negotiation period" ends. 42 U.S.C. § 300gg-112(b)(1)(B). If any of the prior steps were delayed, then that would also have the effect of delaying the date on which the provider finally obtains a binding payment decision from the arbitrator, requiring the insurer to pay the provider's bill.

In the July Rule, the Departments effectively eliminated the deadline by which the insurer must take the first step in this pre-IDR process. Congress mandated that the insurer send its "initial payment" or "notice of denial of payment" no later than 30 calendar days after the provider "transmit[s]" its "bill" to the insurer. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I); *id.* § 300gg-111(b)(1)(C); *id.* § 300gg-112(a)(3)(A) (same, for air ambulances). In the July Rule, the Departments rewrote

that deadline as follows: "the 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services." 45 C.F.R. § 149.130(b)(4)(i).[8]

The July Rule does not define what "information" an insurer can demand from the provider (or from others), does not require the insurer to take any affirmative steps to obtain the "information" it claims to need, and does not place any limits whatsoever on how long an insurer can delay. *See generally id.*

The Departments acknowledged that their re-write of Congress's 30-calendar-day deadline created the possibility for "abuse and gaming where plans and issuers are unduly delaying making an initial payment or sending a notice of denial to providers on the basis that the provider has not submitted a clean claim." 86 Fed. Reg. at 36,900 (ROA.796). However, the Departments failed to give providers any regulatory rights to stop such "abuse and gaming." *Id.*

The "abuse and gaming" by insurers, which the Departments foresaw, came to pass. For example, before the District Court below,

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[8] Similar provisions apply to non-air-ambulance providers. 45 C.F.R. §§ 149.110(b)(3)(iv)(A); 149.120(c)(3).

Plaintiff-Appellee Air Methods demonstrated that approximately 53% of its transmitted bills did not receive an initial payment or denial within 30 calendar days of the bill being transmitted to the insurer. ROA.248 ¶ 2 (Declaration of Christopher Brady). Sometimes the delays are extreme: Air Methods' records show that some claims have languished in the insurer's hands, without any initial payment or denial, for more than 325 days. *Id.* ¶ 3. Air Methods' records further indicate an average of 104 calendar days between the time it submits a bill to the date insurers make initial payments—a 346% increase from the 30-calendar-day deadline set by Congress. *Id.*

Plaintiff-Appellee East Texas Air One has had similar experiences: the record before the District Court demonstrates that approximately 67% of the bills which East Texas Air One transmits do not receive an initial payment or denial within 30 calendar days. ROA.253 ¶ 5 (Declaration of Marc Mariani). Here again, some delays are extreme, with some claims languishing in the insurer's hands, without any initial payment or denial, for 253 days. *Id.* ¶ 4. As of the date of that declaration—January 16, 2023—some of East Texas Air One's claims

from March 2022 had still not received an "initial payment" or "notice of denial." *Id.*

E. The Decision Below

In December 2022, the Air Ambulance Plaintiffs sued the Departments under the APA, arguing that the challenged provisions of the July Rule violated the NSA's unambiguous terms and were arbitrary and capricious. The District Court consolidated the Air Ambulance Plaintiffs' suit with the TMA's challenge. ROA.128. On August 24, 2023, the District Court ruled in favor of both sets of plaintiffs in a consolidated opinion and order. *See* ROA.13196. The TMA's brief sets forth the District Court's holdings as to the common issues of (1) ghost rates, (2) bonus/incentive payments, and (3) QPA disclosure requirements.

1. The Case-Specific Rates Agreed to In "Single-Case Agreements" Must Be Included in the QPA

The District Court struck down the Departments' exclusion of the case-specific rates, agreed to in single-case agreements, from the "contracted rates" that must be included in the QPA. The District Court held that "case-specific or single-case agreements are contracts between insurers and providers under a plan or policy providing coverage for air ambulance transports" and therefore these agreements' rates are

included in the plain meaning of the statutory term “contracted rates.” ROA.13229. The District Court rejected the Departments’ arguments that such rates were excluded from the QPA because they were “not ‘contracted for under the generally applicable terms of a health plan or health insurance policy.’” ROA.13228-29. The District Court rejected that argument because “the Act does not say to include only rates ‘contracted for under the generally applicable terms of a health plan or health insurance policy,’” rather “[t]he Act says to include ‘contracted rates recognized by [the insurer] . . . under the plans or coverage.’” *Id.* (quoting 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I)).

The District Court similarly rejected the Departments’ arguments that contracted rates must be negotiated “in advance.” ROA.13229-30. The District Court explained that “the Act does not say anything about when the rates are negotiated, providing instead that the QPA should include all ‘contracted rates recognized by [an insurer under its] plans or coverage.’” ROA.13229 (quoting 42 U.S.C. § 300gg-111(a)(3)(E)(i)). Because the July Rule’s exclusion of such rates from the QPA calculation “conflict[ed] with the Act,” the Court held that it “must be set aside.” ROA.13230.

2. The Insurer's Deadline to Provide an "Initial Payment" or "Notice of Denial" Begins When the Insurer Receives the Provider's Bill

As for the 30-calendar-day deadline by which insurers must provide either an "initial payment" or "notice of denial," the District Court agreed with the Air Ambulance Plaintiffs that the challenged provision of the July Rule "conflict[ed] with the [No Surprises Act] and must be set aside." ROA.13225. The District Court rejected the Departments' arguments that the July Rule was a permissible attempt to implement a "clean claim" requirement. ROA.13224-25. After all, "the statute uses the term 'bill,' not 'clean claim' [a]nd elsewhere, Congress specified 'clean claim' when it wanted to refer to clean claim.'" ROA.13224 (citing 42 U.S.C. § 1395w-112(4)(A)(ii); 10 U.S.C. § 1095c(a)(1); *id.* § 1095c(3); 38 U.S.C. § 1703D(d)(2)(A); and *id.* § 1703D(f)(1)). The District Court held that the "Departments cannot adopt a meaning of a statutory term where Congress used the same meaning in the same Title because, '[i]f Congress had intended that narrow meaning, it knew how to say so.'" *Id.* (quoting *Wallaesa v. FAA*, 824 F.3d 1071, 1083 (D.C. Cir. 2016)).

The District Court also rejected the Departments' arguments that the word "'bill' as used in the Act is 'a technical term.'" *Id.* The District

Court explained that "'[b]ill' is a common term with an ordinary meaning—'[a]n itemized list or statement of fees or charges.'" ROA.13224-25 (quoting Am. Heritage Dictionary 180 (5th ed. 2011)). "By deleting 'bill' and replacing it with 'the information necessary to decide a claim' (or 'clean claim')," the District Court held, "the Departments have improperly rewritten the statute," in effect turning "a firm 30-day deadline essential to an efficient process into an indefinite delay at the mercy of the insurer." ROA.13223.

3. Non-Appealed Issues

Two of the Air Ambulance Plaintiffs' challenges to the July Rule are no longer at issue. The District Court also ruled in favor of the Air Ambulance plaintiffs regarding whether a single air ambulance transport constituted a single "item or service" for IDR purposes. ROA.13225-27. The Departments do not challenge this holding on appeal. Op. Br. at 22 n.9. The District Court ruled in favor of the Departments regarding the July Rule's definitions of the "geographic regions" used to determine the QPA. ROA.13230-33. The Air Ambulance Plaintiffs do not challenge this holding on appeal.

STANDARD OF REVIEW

The Air Ambulance Plaintiffs respectfully incorporate the TMA's statement of the standard of review.

SUMMARY OF ARGUMENT

The District Court correctly held that "single-case agreements" are contracts between providers and insurers; therefore, the case-specific rates agreed to in those contracts are "contracted rates" within the plain meaning of that statutory term. The Departments themselves acknowledged this in other provisions of the July Rule. Even if the Departments' rule were a permissible interpretation of the statutory term "contracted rates" (and it is not), this Court should still affirm because the exclusion of case-specific rates from the QPA is arbitrary and capricious. By excluding these rates from the QPA, the Departments defeated the QPA's purpose, which was to approximate "typical market negotiations" and "true market dynamics" for the item or service at issue. *See, e.g.,* 86 Fed. Reg. at 36,896 (ROA.792).

The District Court was also correct to strike down the Departments' re-writing of the statutory provision that requires the insurer to send the provider an "initial payment" or "notice of denial" within 30 calendar

days of the date that the provider "transmits" its "bill." The statute is unambiguous and the Departments were not expressly delegated any authority to re-interpret it. The Departments' attempt to graft the concept of "clean claim" onto the statutory word "bill" does great violence to the plain and ordinary meaning of "bill." Congress has repeatedly used the words "clean claim" when it meant "clean claim." Congress deliberately chose not to do so, here. The Departments' rule is also arbitrary and capricious because it is wholly unenforceable.

The Air Ambulance Plaintiffs incorporate the TMA's arguments as to all other issues.

ARGUMENT

I. The July Rule's Exclusion of Single-Case Agreements from the "Contracted Rates" Included in the QPA is Unlawful

The No Surprises Act requires insurers to calculate the QPA based on the "median of the *contracted rates* recognized by the plan or issuer . . . as the total maximum payment . . . under such plan or coverage . . . for the same or a similar item or service." 42 U.S.C. § 300gg-111(a)(3)(E) (emphasis added). A single-case agreement—also called a "case-specific agreement"—is a contract in which an insurer recognizes the rate to be paid to a provider for a service under the patient's plan or

coverage. Single-case agreements thus set "contracted rates." Insurers must include such rates when calculating the QPA.

Single-case agreements are particularly important in the air ambulance industry, where in-network contracts have been comparatively rare. Prior to the No Surprises Act, network participation by air ambulance providers was "low." 86 Fed. Reg. at 36,923 (ROA.819). The Departments themselves reported that out-of-network transports constituted 69% of all emergency medical transports in 2012; by 2017, out-of-network transports were up to 77% of the total. *Id.* As the declaration of Air Methods attests, out-of-network transports were very common before the NSA took effect, and a large number of them resulted in "single-case agreements" that documented the agreed-upon case-specific rate negotiated between providers and insurers. ROA.13127-28 ¶ 3 (Declaration of Sandra Copenhaver) (81% of transports of patients with commercial insurance were performed out-of-network by Air Methods in 2018); ROA.13129 ¶ 8 (in 2018, approximately 25% of commercially insured transports by Air Methods resulted in a single case agreement).

The statute does not exclude any contracted rates from the QPA calculation. Yet the Departments' July Rule limits the rates used to determine the QPA to those established through one specific type of contract: network agreements. "Solely for purposes" of calculating the QPA, the Departments declare that such an agreement "does not constitute a contract." 86 Fed. Reg. at 36,889 (ROA.785). The July Rule thus excludes from the QPA calculation any "single case agreement, letter of agreement, or other similar arrangement . . . for a specific participant or beneficiary in unique circumstances." 45 C.F.R. § 149.140(a)(1).

This exclusion is unlawful and must be set aside. It is contrary to the plain meaning of the statutory term "contracted rate" and is also arbitrary and capricious.[9]

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[9] The Departments have not asked the Court to defer to their interpretation under *Chevron, USA, Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). They have thus forfeited any such deference. *See Texas v. Biden*, 20 F.4th 928, 960–61 (5th Cir. 2021), *vacated on other grounds* 142 S. Ct. at 2548; *see Data Mktg. P'Ship, LP v. Dep't of Labor*, 45 F.4th 846, 856 n.2 (5th Cir. 2022). Regardless, to the extent *Chevron* applies, the Departments' rules fail at step one because "the intent of Congress is clear." *Chevron*, 467 U.S. at 843. And they fail at step two for the same reasons the rules are arbitrary and capricious. *See infra*, § I.B; *Sw. Elec. Power Co. v. EPA*, 920 F.3d 999, 1028–29 (5th

A. <u>The Departments' Exclusion of Single-Case Agreements Contravenes the Unambiguous Meaning of "Contracted Rates"</u>

The District Court correctly held that case-specific rates, agreed to in single-case agreements, come within the plain meaning of the statutory term "contracted rates" "because they are contracts to pay a specific rate for an air ambulance transport for the insurers' beneficiaries, participants, or enrollees." ROA.13228.

In the absence of a statutory definition of "contracted rate," the Court "must give [the] term its ordinary meaning." *Petit v. U.S. Dep't of Educ.*, 675 F.3d 769, 781 (D.C. Cir. 2012) (citing *FCC v. AT&T, Inc.*, 562 U.S. 397, 403 (2011)); *see also United States v. Lowe*, 118 F.3d 399, 402-04 (5th Cir. 1997) (using the plain meaning of undefined statutory terms to find such terms unambiguous); *Thompson v. Goetzmann*, 337 F.3d 489, 501-502 (5th Cir. 2003) (finding undefined term unambiguous, in part through recourse to dictionary).

This Court recently interpreted the word "contract" to include a "letter of agreement." *Lexon Ins. Co., Inc. v. Fed. Deposit Ins. Corp.*, 7

Cir. 2019) (describing how "analysis under the two standards proceeds similarly").

F.4th 315, 322-24 (5th Cir. 2021). The Court did so by relying on the definitions of "contract" contained in Black's Law Dictionary, the Restatement (Second) of Contracts, comments to the Uniform Commercial Code, and the Williston on Contracts treatise. *Id.* "[A]bsent contrary indications, Congress intends to adopt the common law definition of statutory terms." *Id.* (quoting *United States v. Shabani*, 513 U.S. 10, 13 (1994)).

A single-case agreement is a "contract" because it is "[a]n agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law." *Contract*, Black's Law Dictionary (11th ed. 2019); *Lexon*, 7 F.4th at 323 (citing 5th ed. of Black's Law Dictionary).[10] A single-case agreement contains a promise by the insurer to pay, and a promise by the provider to accept, an agreed amount

[10] *See also Contract, n.*, Oxford English Dictionary (online ed.) ("An agreement enforceable by law"); Restatement (Second) of Contracts § 1 (1981) ("A contract is a promise or a set of promises for the breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty."); Williston on Contracts § 1:1 (4th ed.) ("The traditional definition of the term 'contract' is 'a promise or set of promises for breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty.' … As commonly used, and as here defined, 'contract' includes varieties described as voidable, unenforceable, formal, informal, express, implied, unilateral, bilateral.")

for the provider's services. *Cf. Robert O. v. Harvard Pilgrim Health Care, Inc.*, No. 2:17-CV-1251-TC, 2019 WL 3358706, at *3 n.5 (D. Utah July 25, 2019) ("Single case agreements are contracts between the insurer and the out-of-network provider . . . ." (citation omitted)). The Departments even *admitted*, in another portion of the July Rule, that "***a single case agreement*** between a health care facility and a plan or issuer . . . ***constitutes a contractual relationship***." 45 C.F.R. § 149.30 (defining "participating health care facility" and "participating emergency facility") (emphasis added).[11]

A "rate" is "[a]n amount paid or charged for a good or service." *Rate*, Black's Law Dictionary (11th ed. 2019); *see also Rate, n.*, I.3 Oxford English Dictionary (online ed.) ("Price, cost; the sum paid or asked for a single thing"). A single-case agreement sets the "amount" to be "paid" by the insurer for the provider's services. Therefore, the amount agreed to in a single-case agreement is a "rate."

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[11] As shown below, the Departments' own contradictory treatment of single-case agreements—treating them as contracts for purposes of defining "participating facilities" but defining them as *not* contracts for purposes of the QPA—is strong evidence that the Departments' QPA definition is arbitrary and capricious. *See infra* § I.B.

Congress combined these two unambiguous terms—"contract" and "rate"—into the statutory phrase "contracted rate." The meaning of that combined phrase is also unambiguous. A "contracted rate" is simply the "amount paid" pursuant to a contract. The Departments admitted as much in the July Rule, where they wrote (correctly) that the phrase "contracted rate" means "the total amount" that "an [insurer] has *contractually agreed to pay*." 45 C.F.R. § 149.140(a)(1) (emphasis added). Exactly so. Precisely because a "single-case agreement" plainly qualifies as a "contracted rate" under that definition, the Departments had to write another sentence, immediately following the one just quoted, which removed "single-case agreements" from that definition. *Id.* In that next sentence, the Departments declared by fiat (without any explanation) that "solely for purposes of the definition of contracted rate, a single case agreement, letter of agreement, or other similar arrangement … does not constitute a contract." 86 Fed. Reg. at 36,889 (ROA.785).

The Departments were obviously aware of the common practice in the health-care industry of entering into single-case agreements. After all, elsewhere in the July Rule the Departments explicitly *included* such agreements in their understanding of the term "contractual

relationship." 45 C.F.R. § 149.30. At no point have the Departments ever disputed that an insurer, when entering into a single-case agreement, has "contractually agreed to pay" the "total amount" that is set forth in that agreement. 45 C.F.R. § 149.140(a)(1). Indeed, the Departments implicitly acknowledged that this is exactly what the insurer does in a single-case agreement. That is why the Departments had to follow the just-quoted regulatory definition of "contracted rate" with a second sentence that declares, by executive fiat, that a "single-case agreement" does not qualify *even though* the insurer that signs such an agreement has obviously "contractually agreed to pay" the "total amount" set forth in the agreement.

The rates set by single-case agreements are unambiguously "contracted rates" according to both the plain and ordinary meanings of "contract" and "rate" and also according to the Department's own interpretation of the combined phrase. Because the July Rule contradicts the plain meaning of the statute, the District Court properly vacated it.

B. The July Rule's QPA Calculation Methodology Unlawfully and Arbitrarily Excludes Case-Specific Contracted Rates from the QPA

Even if the term "contracted rates" were ambiguous, the Court should still affirm because the Departments' exclusion of single-case agreements, from the QPA calculation, was arbitrary and capricious. Although the District Court did not reach plaintiffs' arbitrary-and-capricious challenge to the methodology rules, ROA.13216 n.5, this Court can "affirm on any basis supported by the record," *In re: Deepwater Horizon*, 48 F.4th 378, 385 (5th Cir. 2022).

Here, the exclusion of single-case agreements from the QPA has no "rational connection" to the agency's stated goal for the QPA, which was to approximate market rates. And the exclusion is inconsistent with the Departments' reading of the NSA's very similar phrase "contractual relationship," which the Departments (correctly) interpreted to *include* single-case agreements.

1. *Excluding the Single-Case Agreements from QPA Calculations Cannot Achieve the Agencies' Stated Goal of Approximating Market Rates*

An agency's interpretation is arbitrary and capricious where it lacks any "rational connection" to the agency's stated goal. *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43, 52-57 (1983). Earlier this year, this Court invalidated the Department

of Energy's appliance efficiency standards because that agency failed to grapple with evidence that those standards would "likely do the opposite" of achieving DOE's stated goal of conserving water and energy. *Louisiana v. DOE*, 90 F.4th 461, 472 (5th Cir. 2024). In *Louisiana*, "the administrative record contain[ed] ample evidence" that appliances that complied with the regulations would be ineffective, which would drive an offsetting increase in handwashing that would *waste* water and energy. *Id.* at 472. Because the DOE did not explain how its regulation could nonetheless achieve its stated goals of conserving water and energy, this Court held that the DOE had failed to "articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Id.* at 473 (quoting *State Farm*, 463 U.S. at 43).

Here, the Departments repeatedly stated, throughout the July Rule, that the purpose of the QPA was to approximate the "rates" reflecting "typical market negotiations" and "true market dynamics" for the item or service at issue. *See, e.g.,* 86 Fed. Reg. at 36,896 (ROA.792) ("[F]or a database to be used to calculate the QPA, the database should contain sufficient data to reflect the true market dynamics in a given

geographic region."); *id.* ("[T]hree contracted rates … represents the minimum number of contracts necessary to reasonably reflect typical market negotiations."); *see also* 86 Fed. Reg. 55,980, 55,996, "Requirements Related to Surprise Billing; Part II," (Oct. 7, 2021) ("Generally, the QPA should reflect standard market rates arrived at through typical contract negotiations"); *id.* at 56,060 ("The QPA generally is based on the median of contracted rates, which are the product of contract negotiations between providers and facilities and plans (and their service providers) and issuers, and therefore generally reflect market rates.").

The administrative record demonstrates that excluding case-specific rates from the QPA *defeats* the Departments' stated goal of making the QPA an approximation of the market rate in the air ambulance industry. In the air ambulance industry, *in-network* rates are comparatively rare. The Departments conceded, in their rulemaking, that the vast majority (69%) of air-ambulance transports are *out-of-network*. 86 Fed. Reg. at 36,923 (ROA.819) (admitting that just 25% of air ambulance transports in 2012, and just 31% air ambulance transports in 2017, were paid under traditional in-network contracts). The

Departments also concede this point in their opening brief, when they acknowledge that "a substantial majority" of air ambulance transports, prior to the passage of the No Surprises Act in 2019, were "furnished by out-of-network providers." Op. Br. at 47. In-network rates are consistently much *lower* than out-of-network rates. *E.g.*, 86 Fed. Reg. at 36,923 (ROA.819) (noting insurers paid the entirety of billed charges in 48% of out-of-network transports, but paid the entirety of billed charges in just 7% of in-network transports).

Because out-of-network transports were so common prior to the NSA's enactment, a QPA that is based solely on the relatively few *in-network* transports will be just the *opposite* of an approximation of market rates. The QPA would be a much better approximation of the true market rate if the Departments had done as Congress directed, and had included the case-specific rates from single case agreements—which, by definition, occur only in out-of-network transports. The July Rule does not address the contradiction between the Departments' stated purpose of approximating market rates and their exclusion of the market rates captured by single-case agreements. The Departments' failure to chart a "rational connection" between their exclusion of single-case agreements

from the QPA and their stated goal of making the QPA an approximation of a market rate means that the exclusion must be struck down as arbitrary and capricious.

The arbitrariness of the Departments' exclusion of case-specific rates is underscored by their decision to *include* in the QPA the "ghost rates" agreed to by in-network providers who *do not even provide air ambulance services*. *See* TMA Resp. Br. at Argument §§ I.A, II.A. The Departments concede that their July Rule requires insurers to include rates agreed to by providers who do not "anticipate ever providing" the service at issue. Op. Br. at 28 (emphasis added). There is no rational basis for concluding that a "ghost" rate accepted by a non-provider, who has no incentive to negotiate, will be relevant evidence of a "market" rate, while at the same time excluding the case-specific rates agreed to in single-case agreements that are negotiated by providers who *are* in the business of emergency air transport. Because the Departments are attempting to include junk "ghost rate" data in the QPA calculation (and artificially reducing the QPA's value as an approximation of a market rate), the Department's exclusion of the far more probative case-specific rates is all the more irrational.

2. The Departments Acted Arbitrarily by Treating Single-Case Agreements Inconsistently in the July Rule

The second reason why the Department's treatment of single-case agreements is arbitrary and capricious is a glaring inconsistency in the July Rule. When an agency interprets the same or similar statutory terms to mean two different things, in the agency's regulations, that inconsistent interpretation renders the agency's decision arbitrary and capricious. It is a "basic canon of statutory construction that identical terms within an Act bear the same meaning." *Lexon Ins. Co.*, 7 F.4th at 324 (quoting *Est. of Cowart v. Nicklos Drilling Co.*, 505 U.S. 469, 479 (1992)); *In re Greenwood*, No. 19-60884, 2022 WL 501393, at *3 (5th Cir. Feb. 18, 2022) (applying same canon). If an agency interprets similar statutory language to mean two *different* things in the agency's regulation, that inconsistency means that the regulation is arbitrary and capricious. *Butterbaugh v. Dep't of Just.*, 336 F.3d 1332, 1339 (Fed. Cir. 2003) (describing inconsistent interpretation of "day" to exclude non-workdays as arbitrary and capricious); *Ne. Hosp. Corp. v. Sebelius*, 699 F. Supp. 2d 81, 95 (D.D.C. 2010) (failure to justify inconsistent interpretation of statutory term held to be arbitrary and capricious). The Departments' July Rule reveals just this kind of inconsistency.

Elsewhere in the NSA, Congress provided separate rules for "participating emergency facilit[ies]" and "participating health care facilit[ies]." 42 U.S.C. § 300gg-111(a)(3)(F)(ii), (b)(2)(A)(i). Congress defined those terms to mean facilities that have "a contractual relationship with" the insurer. *Id.* The Departments then interpreted that statutory term—"contractual relationship"—to *include* a facility that has a single-case agreement with the insurer. 86 Fed. Reg. at 36,882 (ROA.778) ("[A] *single case agreement* between a health care facility and a plan or issuer . . . *constitutes a contractual relationship*."); 42 C.F.R. § 149.30 (same).

If a single-case agreement "constitutes a contractual relationship" for purposes of the NSA, then such an agreement must also logically constitute "contract" for purposes of calculating the QPA. The July Rule's exclusion of single-case agreements from QPA calculations is contrary to the Departments' interpretation of the phrase "contractual relationship" in the statutory definition of "participating facility." The Departments admit—but do not explain or justify—this inconsistency in a footnote to the July Rule. 86 Fed. Reg. 36,882 n.32 (ROA.778) (noting the "contrast" between these approaches).

The Departments cannot have it both ways. They must consistently apply the plain and ordinary meaning of "contract." Their failure to do so—coupled with their failure to even attempt to explain the inconsistency in their rulemaking—is a separate and independent reason why the exclusion of case-specific rates is arbitrary and capricious.

C. The Departments' New Statutory Arguments Fail

1. *Post Hoc Rationalizations Cannot Rescue an Arbitrary Rulemaking*

"[A]n agency's action must be upheld, if at all, on the basis articulated by the agency itself." *Chem. Mfrs. Ass'n v. Env't Prot. Agency*, 899 F.2d 344, 356 (5th Cir. 1990). "*Post hoc* explanations" are "simply . . . inadequate." *Id.* (rejecting an agency's "post hoc" interpretation of the statute because "nothing" in the rule "indicat[es] that the [agency] did in fact apply" that interpretation of the statute when promulgating the rule at issue); *see also State Farm*, 463 U.S. at 50 ("It is well-established that an agency's action must be upheld . . . on the basis articulated by the agency itself," and not "counsel's *post hoc* rationalizations."). Because counsel's new justifications were absent from the Departments' published rulemaking, the Court must disregard them.

The Departments' counsel advances four *post hoc* rationales for excluding single-case agreements. Even if the Court were to consider these rationalizations, each one fails.

2. Single-Case Agreements Set Payment "Rates"

The Departments' first *post hoc* argument is that a single-case agreement cannot contain a "rate" because such an agreement is by definition limited to a specific case (e.g., a specific service for a specific patient). The Departments said just the opposite in the July Rule. In their rulemaking, the Departments described single-case agreements as setting a payment "rate":

> [S]olely for purposes of the definition of contracted rate, a single case agreement, letter of agreement, or other similar arrangement … does not constitute a contract, and ***the rate paid under such an agreement*** should not be counted among the plan's or issuer's contracted rates.

86 Fed. Reg. at 36,889 (ROA.785) (emphasis added). Yet now, the Departments reverse course. Now, the Departments' lawyers insist that a "rate" *cannot* be "paid under such an agreement" because it reflects a "one-off" payment. Op. Br. at 33.

Even if this argument *had* been preserved in the Departments' July rulemaking, it is without any merit. As discussed above, a "rate" is the

"price" of a good or service." *Rate*, Black's Law Dictionary (11th ed. 2019) ("[a]n amount paid or charged for a good or service"); *Rate, n.*, Oxford English Dictionary (online ed.) ("Price, cost; the sum paid or asked for a single thing"). Neither of the Departments' hand-selected definitions defeat this common-sense understanding. The Departments cherry-pick definition II.6.a of "rate" from the Oxford English Dictionary. Op. Br. at 33 (quoting *Rate, n.*, II.6 Oxford English Dictionary (online ed.)). This citation fails to prove the Departments' point because this is the *thirteenth* such definition and the earlier definitions in this dictionary favor the Air Ambulance Plaintiffs. *See, e.g., Rate, n.*, I, Oxford English Dictionary ("[a]n *amount*, quantity, or value." (emphasis added)); *id.* I.3 ("[p]rice, cost; *the sum paid or asked for a single thing*" (emphasis added). And even the Departments' cherry-picked definition states that "rate" means "the amount paid or asked for a certain quantity of a particular commodity, service, etc." *Id.* at II.6.a.

The Departments' definition from Merriam-Webster's Dictionary also fails to prove their point: by specifying the sum to be paid for a transport, a single-case agreement establishes "a charge, payment, or

price fixed according to a ratio, scale, or standard." Op. Br. at 33 (quoting *Rate*, Webster's Third New International Dictionary, 1884 (2002)).

The Departments' own brief demonstrates that the Departments do not actually believe that the word "rate" does not include a "one-off" payment. Elsewhere in their brief, the Departments use the word "rate" to refer to an amount of money that will *never* be paid. When defending the decision to include, in the QPA, "ghost rates" in the QPA calculation (that is, "contracted rates for items or services that a provider has not provided"), the Departments argue that an in-network contract sets a "rate" *regardless of how frequently (or whether) that rate is ever paid*. Op. Br. at 27-30. The inconsistency is glaring. According to the Departments, the word "rate" must *exclude* amounts agreed to in single-case agreements (because those amounts are only paid once) but must *include* amounts agreed to by providers who never perform the service (even though those amounts will never be paid).

In defense of their inclusion of "ghost rates" in the QPA, the Departments give away their game. They write: "[T]he statute *does not impose any minimum number of times* an item or service must be provided under a contract for the rates agreed to in that contract to be

considered 'contracted rates.'" Op. Br. at 27-28 (emphasis added). Exactly so. So long as the provider does "provide" the service in question, there is no "minimum number of times" that the provider must be paid a contracted-for amount in order for that amount to be considered a "contracted rate." A case-specific rate agreed to in a single-case agreement is, therefore, a "rate" even though it is only paid once.

3. Case-Specific Agreements Set Rates Paid "Under Such Plan or Coverage"

The Departments next turn to the word "under" in the statutory definition of the QPA. The statutory text states that, "with respect to a sponsor of a group health plan and health insurance issuer offering group or individual health insurance coverage" the QPA is "the median of the contracted rates recognized by the plan or issuer . . . *under* such plans or coverage." 42 U.S.C. § 300gg-111(a)(3)(E)(i). The Departments contend that when insurers agreed to the case-specific rates contained in single-case agreements, they did not do so "under" the "plans or coverage," but instead did so as a "business decision" to "spare their members" from out-of-network charges. *Id.* at 34. This is another *post hoc* justification that was never made in the July Rule and should be disregarded for that reason alone. *Chem. Mfrs. Ass'n*, 899 F.2d at 356.

The argument fails even under the Departments' own proposed definitions of the word "under." The Departments concede that the word can mean "by reasons of the authority of," "in accordance with," "in compliance with," or "required by" the plan or policy. Op. Br. at 33. Under those definitions, an insurer *does* act "under" the "plan or coverage" when the insurer enters a binding single-case agreement to pay for a patient's air ambulance transport. By entering into that contract, the insurer necessarily acts "in accordance with" the group health plan or insurance policy.

If the Departments really were correct that group health plans, by entering into single-case agreements, were acting *outside* of the "authority" granted to them by the terms of those plans, then this would mean that these group health plans were in violation of their fiduciary duties to all the other plan beneficiaries. A group health plan is *only* allowed to make payments that are authorized by the plan terms. An ERISA plan must be "established and maintained pursuant to a written instrument" that "specif[ies] the basis on which payments are made to and from the plan." 29 U.S.C. §1102(a)(1), (b)(4). Plan administrators are only allowed to make payments "*in accordance with* the documents and

instruments governing the plan." 29 U.S.C. §1104(a)(1) (emphasis added); *see also* 29 C.F.R. § 2560.503-1(b)(5) (requiring that administrators make benefits determinations "in accordance with governing plan documents").[12]

If this Court were to accept the Departments' argument that single-case agreements are not made "under" the plan documents, then the Court would also be holding that this very common practice (of entering into single-case agreements) is a violation of plan administrators' ERISA duties. The Air Ambulance Plaintiffs pointed this out in their briefing below, but the Departments still have nothing to say about the serious real-world consequences that their made-for-litigation argument would have on the administrators of ERISA plans.

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[12] Plans subject to the No Surprises Act via its incorporation in the Public Health Services Act or Internal Revenue Code must comply with comparable requirements. *See, e.g.,* 42 U.S.C. § 300gg-19(a)(2)(A) & 45 C.F.R. § 147.136(b)(2)(i) (PHSA requirement that group health plans and issuers offering group health insurance coverage must comply with claims and appeals provisions in 29 C.F.R. § 2560.503-1); 42 U.S.C. § 300gg-19(a)(2)(B) & 45 C.F.R. § 147.136(b)(3)(i) (same for individual coverage); 26 U.S.C. § 9815(a)(1) (requiring group health plans and group health insurance coverage to comply with PHSA mandate); 26 C.F.R. § 54.9815-2719(b)(2)(i) & 26 C.F.R. § 54.9815-2719T(b)(2)(i) (IRC requirement that group health plans and issuers offering group health insurance coverage must comply with claims and appeals provisions in 29 C.F.R. § 2560.503-1).

4. *Any Ambiguity Concerning the Dates of the Single-Case Agreements Included in the QPA Does Not Justify Excluding These Agreements Entirely*

Finally, the Departments provide the *post hoc* justification that their exclusion of single-case agreements "makes sense" because "the Act directs health plans to look at rates recognized on a single specified date," January 31, 2019. Op. Br. at 34. But any ambiguity (if it exists) as to *which* case-specific rates should be included (as being "recognized . . . on" January 31, 2019) does not mean that there is any ambiguity about the threshold question of *whether* case-specific rates are included in the plain meaning of the phrase "contracted rates"—they are. Even if the Departments had authority to resolve any ambiguity as to time (that is, how far back in time should the insurer go, in gathering the single-case agreements) through notice-and-comment rulemaking, the Departments could *not* have resolved that temporal ambiguity by excluding single-case agreements altogether, since case-specific rates contained in single-case agreements are plainly "contracted rates."

II. The July Rule Impermissibly Extends the 30-Calendar-Day Deadline Congress Imposed on Insurers to Make Payment Determinations

The insurer's "initial payment" or "notice of denial" is a critical event in the NSA's new dispute-resolution process. The provider is

entirely unable to initiate the IDR process until the insurer completes this step in the NSA's carefully designed framework. *See supra* Statement of the Case § D.[13]

Congress set an unambiguous deadline for when an insurer must send an "initial payment" or "notice of denial of payment" to a provider: "not later than 30 calendar days after the bill for such services is transmitted by such provider." 42 U.S.C. § 300gg-112(a)(3)(A). Although Congress elsewhere made express delegations of rulemaking authority to the Departments, those delegations did *not* include the grant of any authority to alter this clear deadline.

As the District Court correctly held, "[t]he statutory text is unambiguous and provides no exceptions" to the 30-calendar-day deadline by which the insurer must send its "initial payment" or "notice of denial of payment." ROA.13223. Yet the Departments modified this deadline in a manner that completely wipes away Congress's intentional design. The July Rule effectively erases the statute's 30-calendar-day deadline, stating that the 30-calendar-day period within which the

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[13] This is the *only* statutory deadline in the NSA to which Congress assigned specific measurement in *calendar* days, underscoring its importance. *See supra* Statement of the Case § D & n.10.

insurer must send an initial payment or notice of denial of payment begins, *not* on the date Congress specified—the date on which a provider "transmit[s]" its "bill"—but instead on an alternative unknowable date preferred by the Departments—"the date the plan or issuer receives the information necessary to decide a claim for payment for the services." 45 C.F.R. § 149.130(b)(4)(i).

The District Court correctly concluded that the July Rule turned a "firm 30-day deadline essential to an efficient process into an indefinite delay at the mercy of the insurer" and "improperly rewr[ote] the statute" by "deleting 'bill' and replacing it with 'the information necessary to decide a claim' (or 'clean claim') . . . ." ROA.13223–25 (citing *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 328 (2014); *Benjamin v. United States*, 932 F.3d 293, 300 (5th Cir. 2019)).

The Departments now ask this Court to arrive at a different conclusion, recycling largely the same arguments the District Court rejected. The Departments justify their modifications to Congress's clear directive on the ground that it makes "little sense" for the 30-calendar-day clock to begin when a provider transmits a "bill," as Congress expressly provided in the NSA. Op. Br. at 42–43. And all the July Rule

does, according to the Departments, is "reasonably suppl[y] meaning to the otherwise undefined statutory term 'bill for such services.'" *Id.* at 43.

This Court should reject the Departments' theory for the same reasons given by the District Court. The Departments may not "rewrite clear statutory terms to suit [their] own sense of how the statute should operate." *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 328 (2014). *See infra* § II.A. And, in any event, Congress did not grant the Departments any rulemaking authority to alter the clear deadline that Congress established. *See infra* § II.B. Finally, the Departments' modification to the 30-calendar-day deadline is arbitrary and capricious because it replaces a clear rule with a hopelessly vague, and entirely unenforceable, standard. *See infra* § II.C.

A. The Departments' Modification of the 30-Calendar-Day Deadline Conflicts with the NSA's Unambiguous Text

The "preeminent canon" courts must follow when interpreting a statute is to "presume that [the] legislature says in a statute what it means and means in a statute what it says there." *BedRoc Ltd., LLC v. U.S.*, 541 U.S. 176, 183 (2004) (internal quotation marks and citation omitted). In the NSA, Congress said that the date by which an insurer must make an "initial payment" or a "notice of denial" is the date that is

30 calendar days after the date that the provider "transmit[s]" its "bill." 42 U.S.C. § 300gg-112(a)(3)(A).

But Congress's choice did not "make sense" to the Departments. Op. Br. at 42 (asserting that the way Congress expressly defined the deadline "make[s] little sense"). So, the Departments "rewr[o]te clear statutory terms to suit [their] own sense of how the statute should operate," and thereby violated a "core" principle of administrative law. *Util. Air Regul. Grp.*, 573 U.S. at 328. Rather than start the 30-calendar-day clock when the provider "transmit[s]" its "bill," as Congress required, the Departments believed it made more sense to bestow upon an insurer the power to delay making an "initial payment," or sending a "notice of denial," until the insurer believed that it had obtained whatever "information" the insurer thought "necessary" to that determination. 45 C.F.R. § 149.130(b)(4)(i). This creates a regulatory loophole that contravenes the unambiguous statutory text. It permits insurers to delay for months and even years, as proven by the declarations submitted to the District Court by the air ambulance providers. *See supra* Statement of the Case § D. During all that delay, providers are without any power

under the NSA to bring the insurer before an arbitrator and obtain a binding decision of what the provider is owed.

1. The Word "Bill" is Not Ambiguous

According to the Departments, the regulation "reasonably supplies meaning to the otherwise undefined statutory term 'bill for such services.'" Op. Br. at 43. Not so. It is very clear what a "bill" is; it is deeply *unclear* to everyone involved—and especially to the providers waiting to be paid—what is meant by "the information necessary to decide a claim." 45 C.F.R. § 149.130(b)(4)(i).

The Departments contend that their regulation "aligns" with "general industry practice" regarding a "clean claim." Op. Br. at 43. A "clean claim," the Departments say, is "'a claim that has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment[.]'" *Id.* (emphasis added) (quoting 86 Fed. Reg. at 36,900 (ROA.796); *Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties* 33 (Apr. 2022) (ROA.11586)).

The fatal flaw in the Departments' argument is that Congress was clearly familiar with the term "clean claim." Congress defined and

invoked the term "clean claim" elsewhere within the same Title.[14] But Congress made the deliberate choice to use the term "bill" rather than "clean claim" when setting the triggering event for the 30-calendar-day initial payment determination deadline. *See BedRoc Ltd.*, 541 U.S. at 183.

Accordingly, because there was no ambiguity for the Departments to resolve, the Departments lacked authority to change the trigger for the 30-calendar-day deadline. *See Texas v. U.S.*, 497 F.3d 491, 501 (5th Cir. 2007) ("When, as here, the statute is clear and unambiguous, that is the

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[14] *See, e.g.,* 42 U.S.C. § 1395w-112(4)(A)(ii) (defining "clean claim" to mean "a claim that has no defect or impropriety (including any lack of any required substantiating documentation)…"); *id.* § 1395h(c)(2) (setting forth the requirements for contracts between Medicare administrative contractors and the Department of Health and Human Services ("HHS")); *id.* § 1395u(c)(2) (same, for contracts related to the administration of Medicare Part B benefits); *id.* § 1395w-112(4) (setting forth the requirements for contracts with prescription drug plan sponsors); *accord* 10 U.S.C. § 1095c(a) (permitting the Secretary of Defense to require interest be paid on "clean claims" submitted under the TRICARE program that are not processed within 30 days); 38 U.S.C. §§ 1703D(d)(2)(A) (permitting the Secretary of Veterans' Affairs to require interest be paid "clean claims" submitted to the Department of Veterans' Affairs that are not processed within statutory timeframes); *id.* § 1703D(f) (instructing the Secretary of Veterans' affairs to establish a definition of "clean claim").

end of the matter; for this court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." (cleaned up)).

2. *The July Rule Allows the Insurer to Delay Based on (In)actions By Third Parties Whom the Provider Does Not Control*

The regulation also contravenes the statute because it empowers the insurer to delay paying the provider based on (in)actions by *third parties* over whom the provider exercises no control. Congress deliberately started the initial payment deadline based on an action *within the provider's control*: the "transmi[ssion]" of the provider's "bill" to the insurer. 42 U.S.C. § 300gg-112(a)(3)(A).

The July Rule, by contrast, starts the deadline when the insurer "receives" "information," without specifying *from whom* the insurer might expect to receive that information. 45 C.F.R. § 149.130(b)(4)(i). There are many third parties from whom an insurer might want to receive information. For example, what kind of treatment did the patient receive at the hospital to which the air ambulance transported her? Is there any auto insurance that might pay for the air ambulance trip? *See* ROA.253 ¶ 6 (Mariani Decl.) (describing the most common reasons that insurers have given East Texas Air One for insurers' delays in making

initial payment determinations). An air ambulance provider does not have the answers to these questions and does not have any way to compel third parties to provide the answers. The Departments' regulation therefore contravenes the statute by delaying the provider's right to commence the IDR process—and thus its right to promptly receive adequate payment for lifesaving services—based on the (in)actions of third parties whom the provider does not control.

Without citing any authority, the Departments contend that under their interpretation of their regulation, "a health plan could not . . . withhold initial payment or notice of denial of payment based on a lack of information outside of the provider's control[.]" Op. Br. at 46. But that *post-hoc* contention does not survive contact with the Departments' *own brief*. Later in the same passage, the Departments walk it back, and state that an insurer could only delay the start of the 30-day clock, based on a supposed need for information from third parties, if "*the information provided by the provider is [not] sufficient to decide [the] claim for payment*." *Id.* at 46–47 (emphasis added). In other words—whenever the insurer decides that the information in the provider's control is *not* "sufficient" by itself, and that the insurer would really like to see some

additional information in someone else's possession, then the insurer may delay the 30-calendar-day deadline for as long as it takes for the insurer to obtain that additional information.

3. *Other Statutes' Broad Delegations of Rulemaking Authority Indicate that Congress Did Not Mean to Delegate Authority Here*

The July Rule's departure from the statute is even more clear when the NSA's 30-calendar-day deadline is compared to other nearby statutory provisions. The NSA's directives are codified in three statutes; ERISA, the PHS Act, and the IRC.[15] Prior to the NSA, those statutes did not contain any specific claim-processing deadlines. Instead, the pre-NSA versions of these statutes contained very broad mandates that the claims process be "adequate," "full and fair," or "effective."[16] Those standards

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[15] This brief cites the PHS Act, where the statutory deadline appears at 42 U.S.C. § 300gg-112(a)(3)(A). The same command also appears in ERISA, at 29 U.S.C. § 1185f(a)(3)(A), and in the IRC, at 26 U.S.C. § 9817(a)(3)(A). *See supra* n.1.

[16] ERISA required group health plans to "provide adequate notice" of any denial and "a reasonable opportunity . . . for full and fair review" of the denial. 29 U.S.C. § 1133. The PHS Act broadly required group health plans and health insurance issuers to "implement an effective appeals process for appeals of coverage determinations and claims." 42 U.S.C. § 300gg-19(a)(1). The PHS Act further required group health plans and issuers of group health coverage to follow the ERISA claims processing rules in 29 C.F.R. § 2560.503-1 (as amended). *See* 42 U.S.C. § 300gg-19(a)(2)(A). The PHS Act simply required issuers of individual health

were interpreted, by the Departments, to allow insurers to toll the claims-processing deadlines in ways that are similar to the regulation challenged here and for similar reasons.[17]

The NSA's 30-calendar-day deadline is starkly different from those other statutes' broad directives to enact "adequate" claims-processing procedures. In the NSA, Congress made the deliberate choice to enact a very specific deadline keyed to the date on which the provider "transmits" its "bill." 42 U.S.C. § 300gg-112(a)(3)(A).

The contrast between the NSA's specific deadline, and the preexisting statutory standards, is further evidence that Congress deliberately intended something different here, since "[d]ifferent words

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insurance to "provide an internal claims and appeals process" that met "standards established by the Secretary of Health and Human Services." *Id.* § 300gg-19(a)(2)(B). The IRC incorporated the PHS Act's requirement by reference. *See* 26 U.S.C. § 9815(a).

[17] The Secretary of Labor has interpreted ERISA's broad claims-processing mandate to require the determination of post-service claims "not later than 30 days after receipt of the claim," but the regulation also allows insurers to extend and then toll this deadline, for a discrete period of time, due to "a failure of the claimant to submit the information necessary to decide the claim." 29 C.F.R. §§ 2560.503-1(f)(2)(iii)(B), (f)(4). This ERISA deadline was then incorporated by the Secretaries of HHS and of the Treasury in the corresponding PHSA and IRC regulations. *See* 45 C.F.R. § 147.136(b)(3)(i); 26 C.F.R. § 54.9815-2719(b)(2)(i); 26 C.F.R. § 54.9815-2719T(b)(2)(i).

within the same statute should, if possible, be given different meanings." *Cascabel Cattle Co., LLC v. United States*, 955 F.3d 445, 451 (5th Cir. 2020). The NSA's express statutory deadline contains entirely "different words," *id.*, from the claims-processing standards contained in the pre-existing statutes into which the NSA's deadline provisions were inserted. The textual differences alone prove that the Departments are wrong to interpret the NSA's very specific deadline to be *even more vague and less specific* than the pre-existing claims-processing standards.[18]

B. Congress Did Not Delegate Rulemaking Authority to the Departments to Rewrite the Deadline

Congress did not grant the Departments any rulemaking authority to alter the clear deadline that Congress established. The Departments fail to even address this threshold issue in their Brief.

"Courts recognize an implicit delegation of rulemaking authority *only* when Congress has not spoken directly to the extent of such authority, or has 'intentionally left [competing policy interest] to be

[18] As previously discussed, the Departments' NSA regulation permits the insurer to toll the deadline based on supposed failures by *third parties* to provide information—something that not even the Departments' own prior regulations, implementing the previous broad standards, would allow.

resolved by the agency charged with the administration of the statute.'" *Texas v. United States*, 497 F.3d 491, 503 (5th Cir. 2007) (quoting *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 865–66 (1984)) (alteration in original) (emphasis added). "It stands to reason that when Congress has made an explicit delegation of authority to an agency, Congress did not intend to delegate additional authority *sub silentio*." *Id.*

Here, Congress expressly limited and defined its delegations of rulemaking authority in the NSA. None of those delegations of rulemaking authority gives the Departments discretion to alter the 30-calendar-day deadline for an initial payment, or notice of denial, found in subsection 300gg-112(a)(3)(A).[19] The 30-calendar-day deadline has

[19] *See* 42 U.S.C. § 300gg-111(a)(2)(A) (audits of QPAs); *id.* § 300gg-111(a)(2)(B) (calculation of QPA, required disclosures, and complaints against insurers); *id.* § 300gg-111(a)(3)(C)(ii)(II)(cc)-(dd) (conditions for waiving NSA protections); *id.* § 300gg-111(b)(2)(B) (services included in medical "visit"); *id.* § 300gg-111(c)(1)(A) (date IDR process deemed to have begun); *id.* § 300gg-111(c)(2)(A) ("establish[ing]" the IDR process for non-air ambulance services); *id.* § 300gg-111(c)(2)(A) (criteria for batching IDR disputes); *id.* § 300gg-111(c)(4) (certification and selection of IDR entities); *id.* § 300gg-111(c)(8) (IDR fees); *id.* § 300gg-111(c)(2)(A) (extension of certain IDR deadlines, *i.e.,* not deadline for initial payment or notice of denial); *id.* § 300gg-111(f)(2) (deadline to provide advanced explanation of benefits); *id.* § 300gg-111(c)(2)(A) (confidentiality of

nothing to do with QPA audits or QPA calculations, and it has nothing to do with the IDR process, which cannot even begin until *after* the initial payment or notice of denial is received.

Congress's express delegation of rulemaking authority to the Departments regarding *different* subject matters, but *not* the 30-calendar-day deadline for an initial payment or notice of denial, is powerful evidence that Congress deliberately chose not to empower the Departments to alter that deadline. The Departments' promulgation of 45 C.F.R. § 149.130(b)(4)(i) therefore exceeded the scope of Congress's delegation of rulemaking authority.

C. <u>The Regulation is Arbitrary and Capricious</u>

Although the District Court did not reach plaintiffs' arbitrary-and-capricious challenge, ROA.13216 n.5, this Court can "affirm on any basis supported by the record." *In re: Deepwater Horizon*, 48 F.4th 378, 385 (5th Cir. 2022). This Court can thus similarly reject the Department's regulation as arbitrary and capricious because it is wholly unenforceable.

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patient information); *id.* § 300gg-112(b)(1)(B) (date IDR process deemed to have begun); *id.* § 300gg-112(b)(2)(A) ("establish[ing]" the IDR process for air ambulance services); *id.* § 300gg-112(b)(8) (IDR fees); *id.* § 300gg-112(b)(9) (extension of certain IDR deadlines, *i.e.,* not deadline for initial payment or notice of denial).

Neither providers nor the Departments have any way to even know what the deadlines are under the Departments' regulation, much less to determine whether the deadlines are being followed.

Indeed, under the Departments' regulation, the event which triggers the 30-calendar-day deadline to provide an initial payment or notice of denial is when the insurer unilaterally determines it has the "information necessary to decide the claim." 45 C.F.R. § 149.130(b)(4)(i). We do not know what this means because the Departments do not define this phrase. In the absence of a clear definition of what it means to have the "information necessary to decide the claim," it is ultimately left open to each insurer to interpret its obligations as broadly as it pleases. Under the Departments' regulation, necessity is left exclusively to the insurer's own determination. By adopting ever more expansive views about what information is "necessary" for it to receive before paying a claim, an insurer may delay indefinitely the date on which the statutory 30-calendar-day period begins to run. The insurer is not even required to tell providers, or the Departments, how it is choosing to interpret the vague phrase "information necessary to decide the claim." *Id.*

But even if the Departments or providers were able to learn how insurers are interpreting the Departments' regulation (and they won't learn this, since insurers aren't required to inform them), the Departments and providers would still be unable to tell whether insurers are actually abiding by the deadline. The Departments and providers have no way to know whether an insurer has actually received whatever information it claims is "necessary." The regulation does not even require the insurer to inform the Departments or the provider of the date on which it has ostensibly received all of this information (whatever it is). In practice, therefore, there is no way for providers or the Departments to tell whether any insurer is obeying this deadline, since no one but the insurer can possibly determine what information is necessary or when it has been received.

The Departments' failure to provide any way for providers or the Departments to determine when the deadline has run is particularly egregious because these problems were foreseen by the Departments when promulgating the July Rule. The Departments acknowledged that their vague regulation created the possibility for "abuse and gaming where plans and issuers are unduly delaying making an initial payment

or sending a notice of denial to providers on the basis that the provider has not submitted a clean claim." 86 Fed. Reg. at 36,900 (ROA.796). The Air Ambulance Plaintiffs have experienced this "abuse and gaming" first-hand, and have suffered the real-world consequences to their cash flows. *See, e.g.,* ROA.253 ¶ 5.

The Departments made no effort to prevent the "abuse" and "gaming" that they foresaw. The July Rule does not define what "information" an insurer can demand. Nor does the regulation set any limitations on *whom* the insurer can demand such "information" from, or require the insurer to take any affirmative steps to obtain the "information" it claims to need. The rule does not even require the insurer to *communicate* with the provider about the reasons why the insurer is delaying. Worst of all, the July Rule puts no time limits at all on how long an insurer may delay its "initial payment" or "denial" for this reason.

The Departments now claim that none of this matters because providers can simply file complaints with the Departments. Op. Br. at 47. But the Departments' own rulemaking failures have made it impossible for providers to make meaningful complaints. Without any communication from the insurer about what information it is waiting for,

there is no way for a provider to tell whether the insurer is delaying for a proper reason or an improper one—even if such a distinction were discernible in the July Rule, which it isn't.

The Departments' amorphous deadline is unlawful both because it is contrary to the plain statutory text and also because it is arbitrary and capricious. The rule is unenforceable and invites "abuse and gaming" which the Departments made no effort to forestall. The Court should affirm the District Court's decision striking the Departments' rule down.

III. The Air Ambulance Plaintiffs Incorporate the TMA's Arguments, Which Apply to Air Ambulance Providers Notwithstanding Minor Differences

The Air Ambulance Plaintiffs respectfully incorporate the merits arguments in the TMA's brief as to (1) the inclusion of "ghost rates" in the "contracted rates" used to calculate the QPA, (2) the exclusion of "risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments," from the "contracted rates" used to calculate the QPAs, and (3) the Departments' wholly inadequate regulation regarding the disclosures that insurers must make to providers regarding their QPAs.

Most of the citations in the TMA's brief apply in full to air ambulance providers. One principal regulation is 45 C.F.R. § 149.140, which contains the QPA calculation methodology and the (very few) disclosures the insurer must make to the provider regarding its secret QPA calculation. This regulation applies equally to all emergency healthcare services—including air ambulances.[20] Similarly, the Departments' August 2022 Frequently Asked Questions ("FAQs")—which supported the inclusion of so-called "ghost rates" into the QPA calculation—also applies with equal force to air ambulance providers. *See* ROA.398, 413-14(August 2022 FAQs at 1, 16-18).

However, the statutory and regulatory provisions governing the *procedure* for conducting IDRs are codified in different places. The TMA's

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[20] *See, e.g.,* 45 C.F.R. § 149.140(a)(1) (defining "contracted rate" for QPA calculation purposes as "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* . . ." (emphasis added)); *id.* § 149.140(b)(1) (setting out the calculation methodology for the "median contracted rate" for all "item[s] or service[s]"); *id.* § 149.140(c) (setting out the calculation methodology for the QPA for all "item[s] or service[s]"); *id.* § 149.140(d) (requiring insurers to make disclosures to, *inter alia*, "provider[s] of air ambulance services . . ."). Although the July Rule sets forth air-ambulance specific rules concerning the inflation adjustments made to QPAs for air ambulance services, those differences are not at issue in this case. *See* 45 C.F.R. §§ 149.140(c)(1)(v), (vi), 86 Fed. Reg. at 36,895 (ROA.791).

brief cites 42 U.S.C. § 300gg-*111*, which governs the IDR process for *non*-air ambulance providers. A separate statute governs the IDR process for air ambulance providers: 42 U.S.C. § 300gg-*112*. The principal substantive difference between them is that in an air ambulance IDR, the arbitrator is directed to consider slightly different factors when choosing between the parties' competing "offers." However, that difference is not relevant to this appeal. As to all the *relevant* provisions, the air ambulance statute (Section 300gg-112) either copies near-verbatim, or else incorporates by reference, the non-air-ambulance statute cited by the TMA's brief (Section 300gg-111). Critically, the "QPA" is defined in the same way, and plays the same role, in all IDRs. *Compare* 42 U.S.C. § 300gg-111(a)(3)(E) (defining the QPA), *with* 42 U.S.C. § 300gg-112(c)(2) (stating that "the term 'qualifying payment amount' has the meaning given such term in section 300gg–111(a)(3) of this title").

Like the statute, the July Rule contains a separate provision governing the procedure to be followed in an air ambulance IDR. The TMA's brief cites 45 C.F.R. § 149.*510*, which governs the process in *non*-air ambulance IDRs. Those rules are incorporated by reference into the

next-door regulation, 45 C.F.R. § 149.*520*, which governs air ambulance IDRs.[21]

Finally, the Air Ambulance Plaintiffs also respectfully incorporate the arguments in the TMA's brief demonstrating that the District Court did not abuse its discretion by vacating the challenged provisions of the July Rule. These arguments apply with equal force to the two challenges addressed in this brief.[22]

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[21] *See* 45 C.F.R. § 149.520(a) (definitions applicable to non-air ambulance IDRs apply to air ambulance IDRs); *id.* § (b)(1) (noting that "[e]xcept as provided in paragraphs (b)(2) and (3) of this section [dealing with the differing statutory factors in air ambulance IDRs], in determining the out-of-network rate to be paid by group health plans and health insurance issuers . . . plans and issuers must comply with the requirements of § 149.510 . . .").

[22] As noted in the TMA's brief, if this Court affirms the air-ambulance-specific challenges on the alternative ground that the rules are arbitrary and capricious, the result (vacatur) should be the same. The Departments failed to grapple with how their rules artificially depress QPAs—contrary to the Departments' own insistence that QPAs should approximate fair market rates—raising "serious doubt over the substantive correctness" of the rules and the Departments' ability to rehabilitate them on remand. *Chamber of Com. of United States v. United States Sec. & Exch. Comm'n,* 88 F.4th 1115, 1118 n.2 (5th Cir. 2023); *see also All. for Hippocratic Med. v. U.S. Food & Drug Admin.*, 78 F.4th 210, 255 (5th Cir.) (remand without vacatur inappropriate where "[t]he record does not tend to show that [the agency] would have arrived at the same decision if it had considered" all important factors).

CONCLUSION

This Court should affirm the District Court's judgment vacating the July Rule's impermissible exclusion of single-case agreements from the "contracted rates" used to calculate the QPA and the July Rule's impermissible re-writing of the 30-calendar-day deadline by which the insurer must send its "initial payment" or "notice of denial." For the reasons set forth in the TMA's brief, this Court should also (1) affirm the District Court's holding regarding the impermissible inclusion of "ghost-rates" in the QPA, (2) affirm the District Court's holding regarding the impermissible exclusion of bonus or incentive payments from the QPA, and (3) remand the QPA disclosure rule to the Departments for further rulemaking.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on March 13, 2024, a copy of the above and foregoing was electronically filed with the Clerk of the Court using the CM/ECF system. Notice of this filing will be sent to all counsel of record by operation of the Court's electronic filing system.

/s/ Steven Shepard
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CERTIFICATE OF COMPLIANCE

This document complies with the type-volume limitation of FED. R. APP. P. 32(a)(7)(B) because, excluding the parts of the document exempted by FED. R. APP. P. 32(f) and Fifth Circuit Rule 32.2, this document contains 13,070 words.

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Dated: March 13, 2024

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