Multiple Documents

Part	Description
1	22
2	Exhibit HHS reconsideration Ex A
3	Exhibit HHS Motion for Reconsideration Exh B
4	Exhibit HHS motion for reconsideration Exh C
5	Exhibit HHS Motion for Reconsideration Exh D
6	Exhibit HHS motion for reconsideration EXh E

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

NEUROLOGICAL SURGERY PRACTICE OF LONG ISLAND, PLLC,

Plaintiff,

vs

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF THE TREASURY; UNITED STATES DEPARTMENT OF LABOR; XAVIER BECERRA, in his official capacity as Secretary, United States Department of Health and Human Services; JANET YELLEN, in her official capacity as Secretary, United States Department of the Treasury; and JULIE A. SU, in her official capacity as Acting Secretary, United States Department of Labor,

Defendants.

AMENDED COMPLAINT

Case No. 23-cv-02977-BMC

(Judge Cogan)

Plaintiff, Neurological Surgery Practice of Long Island, PLLC, by its attorneys, Harris Beach PLLC, for its Amended Complaint against the Defendants, United States Department of Health and Human Services; United States Department of the Treasury; United States Department of Labor; Xavier Becerra, in his official capacity as Secretary, United States Department of Health and Human Services; Janet Yellen, in her official capacity as Secretary, United States Department of the Treasury; and Julie A. Su, in her official capacity as Acting Secretary, United States Department of Labor (collectively, the Defendants will be referred to as the "Departments", alleges as follows:

PRELIMINARY STATEMENT

1. Plaintiff, Neurological Surgery Practice of Long Island, PLLC (the "Practice"), is one of the largest private neurosurgery practices in New York. It regularly provides medically necessary services on an out-of-network basis to enrollees of all the major health plans. The Practice's provision of these services since January 2022 has been governed in most cases by the No Surprises Act ("NSA"), 42 U.S.C. §§ 300gg-111, et seq.

2. Under the NSA, out-of-network providers are prohibited from billing patients for their services. Rather, health plans have the authority to initial determine whether, and what amount, to pay. Because health plans, if they pay at all, have decided to pay at rates far below what they historically paid – and far below the providers' costs for rendering the services – out-of-network providers have become heavily dependent on the independent dispute resolution ("IDR") process established by the NSA to resolve disputes between plans and out-of-network providers, such as the Practice, regarding the appropriate reimbursement amount.

3. The NSA set forth tight time limits and deadlines for the IDR process to ensure that there is a predictable and efficient process designed to enable providers to be timely and appropriately reimbursed for the medically necessary, and often lifesaving treatment, they provide health plan beneficiaries. One extremely important component of the IDR process is the Departments' selection and certification of third-party IDR entities – essentially dispute resolution neutrals – charged with resolving disputes through a "baseball-style" arbitration proceeding in a tight timeframe. In the NSA, Congress specifically required that Defendants "shall ensure that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations. 42 U.S.C. § 300gg-111(c)(4)(E).

4. As alleged in detail below, the Departments have utterly failed to honor this statutory mandate regarding the certification of IDR entities. Indeed, the Departments' have *admitted* – as recently as just last month – that they have only 1/4th of the IDR entities required to timely and efficiently process the volume of IDR proceedings. This is despite the NSA having been enacted 30 months ago, and in effect for over 18 months.

5. This is not the only NSA provision that the Departments have violated. As we allege in detail below, the Departments have wrongly determined that New York has a "Specified State Law" that overrides the NSA for non-emergency services rendered by out-of-network providers to enrollees of New York-state-regulated health plans at in-network hospitals and ambulatory surgery centers. This determination violates the NSA's definition of "Specified State Law" and has resulted in a category of out-of-network reimbursement disputes that are neither eligible for NSA IDR process nor the New York IDR process, creating significant delays in NSA IDR proceedings involving New York providers.

6. These failures by the Departments have been a significant factor in the breakdown of the NSA IDR process. Nationally, as of March 2023, more than 91% of the 2022 IDR claims remained unadjudicated, with over 95% of open IDR claims more than five months old. This is despite the NSA's statutory mandate that the IDR process take only 30 days to complete.

7. The Practice's specific experience with the IDR process is similar: Through March 15, 2023, the Practice submitted 1,050 claims to NSA IDR. Of these, only 204 have been decided, with the remaining 81% undecided.

8. These delays, and other processing issues have placed the Practice in serious financial jeopardy. The expenses of providers such as the Practice to provide medically necessary, lifesaving services to patients do not abate because the providers are waiting to be paid. In fact, if anything, because of current inflationary trends, supply chain issues, and staff shortages, these costs have soared. Accordingly, providers such as the Practice are heavily dependent on the fair, effective, and efficient operation of the No Surprises Act's IDR process to balance the playing field and provide them sufficient reimbursement. Without this, the Practice and other similarly situated out-of-network providers have been placed in serious financial jeopardy.

9. To avoid catastrophic consequences to the American healthcare system, this Court must exercise its statutory authority to compel the Departments to honor their specific statutory obligations under the No Surprises Act with respect to the establishment and operation of a fair, quick, and inexpensive federal IDR process. The Practice also asks this Court to remedy the Departments' deprivation without due process in receiving compensation for the medically necessary services they provide without due process. . Without this relief, the Practice, and many other similarly situated out-of-network health care providers, will be forced out of business, thereby denying healthcare access to millions of Americans.

PARTIES

10. Plaintiff, Neurological Surgery Practice of Long Island, PLLC, is a New York professional service limited liability medical company with its principal place of business located at 100 Merrick Road, Suite 128W, Rockville Centre, New York.

11. Neurological Surgery Practice of Long Island, PLLC was formed in August 2020, and, because of a merger in December 2020, is the corporate successor of Neurological Surgery, P.C.

12. Defendant United States Department of Health and Human Services is one of the three federal executive departments that Congress charged with implementing and administering the No Surprises Act.

13. Defendant United States Department of the Treasury is another one of the three federal executive departments that Congress charged with implementing and administering the No Surprises Act.

14. Defendant United States Department of Labor is the final one of the three federal executive departments that Congress charged with implementing and administering the No Surprises Act.

15. Defendant Xavier Becerra is the presidentially nominated and senatorially confirmed Secretary of the United States Department of Health and Human Services. Secretary Becerra is sued in his official capacity only.

16. Defendant Janet A. Yellen is the presidentially nominated and senatorially confirmed Secretary of the United States Department of the Treasury. Secretary Yellen is sued in her official capacity only.

17. Defendant Julie A. Su is the duly appointed Acting Secretary of the United States Department of Labor. Acting Secretary Su is sued in her official capacity only.

JURISDICTION AND VENUE

18. The Court has jurisdiction over this action under 28 U.S.C. § 1331 and the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 701–06. The Practice is entitled to the requested declaratory and injunctive relief under the APA and the Declaratory Judgment Act, 28 U.S.C. §§ 2201–02.

19. Venue is proper in this judicial district under 28 U.S.C. § 1391(e) because this is an action against officers and agencies of the United States, the plaintiff resides in this district, and no real property is involved in this action.

FACTS COMMON TO ALL CAUSES OF ACTION

NSPC

20. Neurological Surgery Practice of Long Island, PLLC (the "Practice"), is one of the largest private neurosurgery practices on Long Island and in the New York metropolitan area. Its award-winning specialists are among the best neurosurgeons in New York City and on Long Island and serve as chiefs of neurosurgery in the most prestigious hospitals on Long Island.

21. Historically, the Practice, like many other independent medical specialty groups, has chosen in most cases not to join health plan networks, because its small size makes it impossible to negotiate acceptable rates. Accordingly, neither the Practice nor its neurosurgeons are health plan participating providers in most cases. Notwithstanding this, the Practice regularly provides medically necessary, covered services on an "out of network" and often emergency basis to beneficiaries of all health plans.

NSA Overview

22. In December 2020, the United States Congress enacted the NSA, which was signed into law as part of the Consolidated Appropriations Act of 2021 (Public Law 116-260; Division BB § 109) on December 27, 2020. It took effect on January 1, 2022.

23. NSA § 103 amends 42 U.S.C. §§ 300gg *et seq*. to establish an IDR process for non-emergency services performed by non-participating physicians at in-network hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers and out-of-network emergency services in the emergency department of a hospital or independent freestanding emergency department.

24. The NSA provides that the federal IDR process will apply and may be used by physicians and health plans to determine the out-of-network rate for emergency services in the emergency department of a hospital or independent freestanding emergency department and non-emergency items and services furnished by non-participating providers during a visit to a participating health care facility when a "specified state law" does not apply (42 U.S.C. § 300gg-111).

NSA Balance Billing Ban

25. Since the NSA became effective on January 1, 2022, the Practice's reimbursement for many of these services has been governed by the provisions of the Act.

26. The NSA prohibits out-of-network providers, such as the Practice, from balance billing or otherwise pursuing payments from health plan members. *See* 42 U.S.C. §§ 300gg-131(a)

(emergency services), 300gg-132 (non-emergency services performed by nonparticipating providers at participating facilities).

27. Given this balance billing ban imposed on out-of-network providers, the Act requires health plans, within 30 calendar days after the out-of-network provider transmits its bill to the health plan, to either make an initial payment to the provider or issue a notice of denial of payment. *See id.* §§ 300gg-111(a)(1)(C)(iv) (emergency services), 300gg-111(b)(1)(C) (non-emergency services).

28. Since the NSA became effective in January 2022, the health plans have completely failed to comply with this 30-day period. When the plans do make initial payments – oftentimes beyond the statutory period – to the Practice as required by 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv) and 300gg-111(b)(1)(C), those initial payments are abysmally low, far below the out-of-network reimbursement payments that the Practice received in the months before the No Surprises Act became effective for the same services at the same location.

29. There is no incentive for the health plans to provide anything but a *de minimis* initial payment, because, given the current delays in the IDR process (as we detail below), it will be many months, if not years, before there is any realistic chance for them to be held to account for their initial low payment. It is no doubt in their view that it far better to retain the appropriate reimbursement funds in their coffers – and thereby pressure the Practice and other similarly situated providers to accept low in-network rates – than to pay an appropriate amount in the first instance to providers such as the Practice.

30. Of course, the obligations of the Practice to render medically necessary care and to incur and pay for the ever-increasing costs of providing that care continue unabated during

this process; the only thing that has changed is that the Practice is not receiving anything more than far-below cost, minimal reimbursement for providing that care.

NSA Open Negotiations Period

31. One of the biggest problems facing the Practice and other similarly situated providers is the long delays and uncertainty in the IDR process. Congress established an open negotiation period between health plans and providers coupled with a balanced IDR process employing tight time limits and deadlines to ensure that there is a predictable and efficient process designed to enable providers to be reasonably and appropriately reimbursed. However, this is not what has occurred.

32. For example, it has been the Practice's consistent experience during the 18 months that the No Surprises Act has been in effect that health plans have steadfastly refused to engage in meaningful open negotiations with it regarding reimbursement rates, as required by the Act. 42 U.S.C. § 300gg-111(c)(1)(A). Accordingly, every reimbursement claim submitted to the health plans has been forced into the IDR process.

General IDR Process Problems

33. There has been a complete failure by the Departments to follow and observe the tight time limits established in the NSA for the IDR process. The NSA specifically states:

> Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the certified IDR entity shall—
>
> (i) Take into accout the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount

> of payment for such item or service determined under this subsection for purposes of subsection (a)(1) or (b)(1), as applicable; and
>
> (ii) notify the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination of the offer selected under clause (i).

42 U.S.C. § 300gg-111(c)(5)(A).

34. Since the IDR process became mandatory in January 2022, this statutory time limit has been routinely ignored. Indeed, it took months *after* the IDR process became mandatory in January 2022 for the Departments to set up and open the portal that enabled the Practice to initiate the process and submit the required documents.

35. Even after the portal opened, there were months on end when the entire process ground to a halt because of successful challenges that were made to the IDR determination methodology established by the Department's regulations.[2] These decisions are *Texas Medical Association. v. United States Department of Health and Human Services*, Case No. 6:21-cv-425 (E.D. Tex. Feb. 23, 2022) (*TMA* I); *LifeNet, Inc. v. United States Department of Health and Human Services*, Case No. 6:22-cv-162 (E.D. Tex. Jul. 26, 2022) (*LifeNe*t I), and *Texas Medical Association v. United States Department of Health and Human Services*, Case No. 6:22-cv-372 (E.D. Tex. Feb. 6, 2023) (*TMA* II).

Departments Failure To Certify Sufficient Number Of IDR Entities

36. These delays, unfortunately, were only the tip of the iceberg. Even when the IDR process was up and running globally, the overloading of the IDR system – due in significant part to the Department's failure to have sufficient IDR entities on board to meet the demand – has meant that the time from submission of all documentation to decision has not even remotely met the statutorily required 30-day deadline.

37. No doubt concerned about the potential for these delays and its negative consequences to out-of-network providers, Congress expressly and specifically commanded that the Departments "*shall ensure* that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations." 42 U.S.C. § 300gg-111(c)(4)(E).

38. The entire statutory provision states:

> Sufficient number of entities. The process described in subparagraph (A) [1] shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (5).[2]

Id.

39. The Departments have failed to honor this clear statutory mandate. Indeed, the Departments have admitted – *in this lawsuit* –that they have certified only 26% of the IDR entities they needed based on estimated volume, and actual volume is 15.2 times what they anticipated. Thus, the Departments' original estimate was that it needed one certified IDR entity for every 440 IDR proceedings, but currently, it has only certified enough IDR entities to have one certified IDR entity for every 25,756 proceedings.

40. A true and correct copy of the Departments' Memorandum of Law in Opposition to Plaintiff's Motion for a Preliminary Injunction and in Support of Defendants' Motion to Dismiss

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[1] Subparagraph (A) provides that : "(A) In general. The Secretary, in consultation with the Secretary of Labor and Secretary of the Treasury, shall establish a process to certify (including to recertify) entities under this paragraph. Such process shall ensure that an entity so certified—(i) has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to make determinations described in paragraph (5) on a timely basis; (ii) is not— (I) a group health plan or health insurance issuer offering group or individual health insurance coverage, provider, or facility; (II) an affiliate or a subsidiary of such a group health plan or health insurance issuer, provider, or facility; or (III) an affiliate or subsidiary of a professional or trade association of such group health plans or health insurance issuers or of providers or facilities; (iii) carries out the responsibilities of such an entity in accordance with this subsection; (iv) meets appropriate indicators of fiscal integrity; (v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations; (vi) does not under the IDR process carry out any determination with respect to which the entity would not pursuant to subclause (I), (II), or (III) of subparagraph (F)(i) be eligible for selection; and (vii) meets such other requirements as determined appropriate by the Secretary." 42 U.S.C. § 300gg-111(c)(4)(A).

[2] Paragraph (5) sets forth the IDR procedure that the entities must follows. *See* 42 U.S.C. § 300gg-111(c)(5).

[Dkt 15-1] is annexed hereto as Exhibit A and incorporated herein by reference. The Departments' admissions are set forth at pages 7 and 8 of the Memorandum.

41. The NSA became law in December 2020 and became effective in January 2022. Despite the time that has elapsed – 30 months from enactment and 18 months from effective date – the Departments have not resolved these issues and have therefore breached this clear and expressional Congressional mandate.

42. This failure to have sufficient IDR entities in place has been a major contributing factor to the incredible delays that the IDR process has experienced. In March 2023, for example, the Emergency Department Practice Management Association surveyed more than 220,000 IDR reimbursement claims during the first year that the No Surprises Act became effective.

43. A true and correct copy of the EDPMA survey is annexed hereto as Exhibit B and incorporated herein by reference.

44. As of March 2023, of the 220,000+ IDR claims surveyed, more than 91% remained unadjudicated. 95.6% of open IDR claims surveyed were more than five months old. (Exhibit A.)

45. The experience of the Practice, unfortunately, is very similar to what reported in the EDPMA survey. For example, from January 1, 2022, when the No Surprises Act became effective, through March 15, 2023, the Practice submitted 1,050 claims to No Surprises Act IDR. Of those submitted IDR claims, only 204 have been decided, with the remainder – 81% -- remaining undecided.

Departments' Violation of NSA Specified State Law Provisions

46. The NSA's IDR process does not apply when a state has a specified state law that meets certain criteria regarding the provision of an alternative IDR process. 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

47. The NSA defines a "specified State law" as:

> The term "specified State law" means, with respect to a State, an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 514 of the Employee Retirement Income Security Act of 1974 [29 USCS § 1144]) in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility

42 U.S.C. § 300gg-111(a)(3)(I).

48. Since 2015, New York has had in effect its Surprise Bill and Emergency Medical Services Law, which is codified at article 6 of the New York Financial Services Law. It applies primarily to fully insured health plans in New York where the care underlying the dispute is rendered under circumstances that would meet the definition of a surprise bill or emergency medical services. *See* N.Y. Financial Services Law §§ 601-08. Disputes involving surprise bills and emergency medical services are submitted to a New York IDR process overseen by the New York Department of Financial Services.

49. Elective non-emergency procedures, performed in a hospital or ambulatory surgery center, by an out-of-network provider, on a fully insured health plan beneficiary, who was aware before he or she came to the in-network hospital or ambulatory surgery center that the provider was out-of-network, but chose to proceed anyway, do not fall within the definition of a surprise bill or emergency medical services under article 6 of the Financial Services Law.

50. Indeed, Section 603(h) of Financial Services Law states that a "'Surprise bill' means a bill for health care services, other than emergency services, with respect to":

> an insured for services rendered by a non-participating provider at a participating hospital or ambulatory surgical center, where a participating provider is unavailable or a non-participating provider renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered; *provided, however, that a surprise bill shall not mean a bill received for health care services when a participating provider is available and the insured has elected to obtain services from a non-participating provider*,

N.Y. Financial Services Law § 603(h)(1); *see also* New York State Department of Financial Services, Circular Letter No. 10 (2021) (issued Dec. 17, 2021) (annexed hereto as Exhibit C).

51. Applying this provision, the New York State Department of Financial Services has expressly stated in its Surprise Bill Guidelines that, for non-emergency services provided by out-of-network providers in an in-network hospital or ambulatory surgery center, "[i]t will not be a surprise bill if the out-of-network service was preauthorized in advance and the patient received notice that the service was out-of-network and other disclosures required by the Insurance Law. . . ."

52. A true and correct copy of the New York State Department of Financial Services current Surprise Bill Guidelines are annexed hereto as Exhibit C and incorporated herein by reference.

53. Based on the foregoing, there is no specified state law that applies in New York for elective non-emergency procedures, performed in a hospital or ambulatory surgery center, by an out-of-network provider, on a fully insured health plan beneficiary, who was aware before he or she came to the in-network hospital or ambulatory surgery center that the provider was out-of-network, but chose to proceed anyway.

54. Accordingly, under the No Surprises Act, those disputes are therefore subject to federal IDR because there is not a specified state law that applies. 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

55. However, the Departments have specifically found – and publicly stated on their website – that the New York Surprise Bill Law is specified state law for all "non-emergency services provided by an out-of-network provider at an in-network facility or surgical center."

56. A true and correct copy of the Department's finding is annexed as Exhibit E and incorporated herein by reference.

57. This finding is incorrect and in violation of the NSA's definition of specified state law. As alleged above, a state law is a specified state law for purposes of the NSA only if it "provides for a method for determining the total amount payable . . . in the case of a participant, beneficiary, or enrollee covered . . . and receiving such item or service from such a nonparticipating provider. . ." 42 U.S.C. § 300gg-111(a)(3)(I).

58. As also alleged above, the New York Surprise Bill Law does not cover, and therefore does not provide for a method determining the total amount payable, for elective non-emergency procedures, performed in a hospital or ambulatory surgery center, by an out-of-network provider, on a fully insured health plan beneficiary, who was aware before he or she came to the in-network hospital or ambulatory surgery center that the provider was out-of-network, but chose to proceed anyway.

59. Thus, contrary to the Department's finding annexed as Exhibit E, these types of elective non-emergency procedures are not covered by a specified state law, as that term is defined

in the NSA. Accordingly, disputes involving these services are subject to NSA IDR. 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I)

60. The Department's incorrect finding has caused significant issues for the Practice and other similarly situated out-of-network providers in New York. IDR entities and health plans have relied upon this incorrect finding to find disputes involving these elective non-emergency procedures to be ineligible for NSA IDR because, based on the Departments' erroneous finding, they conclude a specified state law applies.

61. However, when disputes involving these elective non-emergency procedures are referred to New York IDR under the Surprise Bill Law – the specified state law that the Defendants refer to – the New York IDR entities and the New York Department of Financial Services find those disputes ineligible for New York IDR because these disputes, as alleged above, do not meet the definition of a surprise bill under New York law.

62. Thus, the Departments' erroneous interpretation has placed the Practice and other similarly situated out-of-network providers in an endless loop of failed IDR attempts and a classic Catch-22. This has increased the IDR process delays, and denied them proper – and in some cases, any – reimbursement for medically necessary elective non-emergency procedures that they performed.

Refusal to Honor Additional Payment Obligations

63. Additionally, even in cases where the IDR process has come to decision – long after the required 30-day time limit – the Practice and other similarly situated out-of-network providers still have not received their reimbursement.

64. For example, under the NSA, when the IDR entity has decided the IDR dispute by selecting the Practice's offer, the plans have 30 days from the date on which the IDR entity makes its determination to pay the additional reimbursement due the Practice. Specifically, 42 U.S.C. § 300gg-111(c)(6) provides:

> The total plan or coverage payment required pursuant to subsection (a)(1) or (b)(1), with respect to a qualified IDR item or service for which a determination is made under paragraph (5)(A) or with respect to an item or service for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made.

42 U.S.C. § 300gg-111(c)(6).

65. There have been numerous claims involving medical services provided by the Practice to enrollees of the plans for which (a) an IDR proceeding was commenced; (b) the duly appointed IDR entity, after reviewing the parties' offers and submissions, selected the Practice's offers, resulting in an additional reimbursement due from the plans to the Practice; (c) more than 30 days have elapsed since the IDR entity made these determinations; yet (d) the plans have breached their statutory obligation under 42 U.S.C. § 300gg-111(c)(6) to pay these additional reimbursement amounts.

66. Making matters worse, the plans have persisted in failing to pay these additional, statutorily ordered reimbursement amounts notwithstanding numerous attempts by the Practice to have the plans honor their obligations. (And, in many cases, they have attempted to satisfy their obligations by sending the additional reimbursement to the patient/beneficiaries.)

67. These failures have been brought to the attention of the Departments, but nothing has been done to redress these statutory violations.

Irreparable Harm Suffered by the Practice and the Public At Large

68. By reason of all the foregoing, the Practice, and other similarly situated out-of-network providers, have been grievously and irreparably harmed.

69. As alleged above, under the NSA, out-of-network providers are forbidden from balance billing patients after providing those patients with medically necessary health care services. Relatedly, the NSA allows health plans to unilaterally determine the amount of reimbursement they pay in the first instance to those providers for the medically necessary health care services that the providers render to the plans' members. Abusing this unilateral power, many health plans are initially reimbursing the Practice, and other similarly situated out-of-network providers, at minimal rates far below what these providers received before the effective date of the NSA. These reimbursement rates are also significantly below the providers' costs of delivering the medically services, as well as far below the usual, customary, and reasonable rates for the services established by the industry standard benchmarking services.

70. Given these circumstances, the Practice, and other similarly situated out-of-network providers, are heavily dependent upon the effectiveness, timeliness, and efficiency of the federal IDR process established by the NSA to "level the playing field" with the plans and ensure that the providers receive if not reasonable compensation for their services, at least compensation for their services that covers the costs for providing those services.

71. Unfortunately, as outlined above, the Departments have failed to honor their statutory obligations under the NSA and have thereby destroyed the timeliness, effectiveness, and efficiency of the federal IDR process. Consequently, the Practice, and other similarly situated out-of-network providers, have been forced to wait now for more than a year to receive anything but

minimal, far-below-cost reimbursement for the medically necessary services that they provided. The inefficiencies of the federal IDR process – created by the Departments' inactions and actions outlined above – have also greatly increased the providers' revenue cycle costs, at a time when reimbursements have been drastically cut.

72. As a result of the foregoing, the Practice, and other similarly situated out-of-network providers, have suffered significant and irreparable injury. They have been forced to confront a situation where, result from the Departments' actions, their reimbursements have been drastically reduced and delayed, while their costs for providing their medically necessary services have significantly risen.

73. No business – much less an independent medical practice in one of the most expensive regions of the country – can long sustain such financial difficulties. The Practice, and other similarly situated out-of-network providers, accordingly, have been forced to curtail and, in many cases, eliminate services and hold off hiring additional or replacement clinicians and support personnel.

74. Some out-of-network providers have already gone out of business. If the current situation regarding the timeliness, effectiveness, and efficiency of the federal IDR process is allowed to continue, many more providers will have their businesses and livelihoods destroyed due to the Departments' actions and inactions, as outlined above.

75. In addition to damaging the providers, this will have the far greater impact of reducing the availability of high-quality and timely medically necessary health care services for the public.

76. There is no adequate remedy at law for these irreparable injuries.

FIRST CAUSE OF ACTION

77. Plaintiff repeats and re-alleges the allegations set forth above as if more fully set forth herein.

78. When implementing and administering the No Surprises Act, and particularly the federal IDR process established by the Act, the Departments are subject to the express provisions of the Act as well as the requirements of the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 1 *et seq.*

79. Pursuant to the provisions of the No Surprises Act and the requirements of the APA, the Departments are prohibited from:

a. Unlawfully withholding or unreasonably delaying agency action, 5 U.S.C. § 706(1).

b. Acting arbitrarily, capriciously, in abuse of discretion, or otherwise not in accordance with law, *id.* § 706(2)(A).

c. Acting contrary to constitutional right, power, privilege, or immunity, *id.* § 706(2)(B).

d. Acting in excess of statutory jurisdiction, or limitations, *id.* § 706(2)(C).

e. Acting without observance of procedure required by law, *id.* § 706(2)(D).

80. By reason of all the foregoing, and as specifically alleged in detail above, the Departments have violated these obligations under the NSA and the APA by undertaking a series of inappropriate and illegal actions and inactions including, but not limited to, the following:

a. Failing to obey the Congressional mandate that the Departments "*shall ensure* that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations." 42 U.S.C. § 300gg-111(c)(4)(E).

b. Wrongfully determining that the New York Surprise Bill Law is specified state law under the NSA for all "non-emergency services provided by an out-of-network provider at an in-network facility or surgical center," in direct violation of the NSA, . 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

81. By reason of all the foregoing, the Practice is entitled to a judgment under the Declaratory Judgment Act, 38 U.S.C. §§ 2201-02, declaring that the Departments have violated these obligations under the No Surprises Act and the APA by undertaking a series of inappropriate and illegal actions and inactions including, but not limited to, the following:

a. Failing to obey the Congressional mandate that the Departments "*shall ensure* that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations." 42 U.S.C. § 300gg-111(c)(4)(E).

b. Wrongfully determining that the New York Surprise Bill Law is specified state law under the NSA for all "non-emergency services provided by an out-of-network provider at an in-network facility or surgical center," in direct violation of the NSA, . 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

82. By reason of the all the foregoing, the Practice is entitled to an order under 5 U.S.C. § 706 directing that the Departments:

a. Take all steps necessary to obey the Congressional mandate that the Departments "*shall ensure* that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations." 42 U.S.C. § 300gg-111(c)(4)(E).

b. Withdraw the Departments' erroneous determination that the New York Surprise Bill Law is specified state law under the NSA for all "non-emergency services provided by an out-of-network provider at an in-network facility or surgical center," which is in direct violation of the NSA, . 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

c. Direct the Departments to immediately issue a determination (and publish same on their websites) that there is no specified state law under 42 U.S.C. §§ 300gg-111(a)(3)(H)(i) and 300gg-111(a)(3)(I).that applies in New York for elective non-emergency procedures, performed in a hospital or ambulatory surgery center, by an out-of-network provider, on a fully insured health plan beneficiary, who was aware before he or she came to the in-network hospital or ambulatory surgery center that the provider was out-of-network, but chose to proceed anyway.

83. By reason of all the foregoing, awarding such other and further relief under the No Surprises Act and the APA that the Court deems just, proper, and equitable.

SECOND CAUSE OF ACTION

84. Plaintiff repeats and re-alleges the allegations set forth above as if more fully set forth herein.

85. By reason of all the foregoing, and as specifically alleged in detail above, the Departments have violated their obligations under the NSA and the APA by undertaking a series of inappropriate and illegal actions and inactions including, but not limited to, the following:

a. Failing to obey the Congressional mandate that the Departments "*shall ensure* that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations." 42 U.S.C. § 300gg-111(c)(4)(E).

b. Wrongfully determining that the New York Surprise Bill Law is specified state law under the NSA for all "non-emergency services provided by an out-of-network provider at an in-network facility or surgical center," in direct violation of the NSA, . 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

86. These actions, as alleged above, have significantly, grievously, and irreparably harmed the Practice.

87. The Practice has no adequate remedy at law.

88. The Departments have no defense or explanation for their illegal, unauthorized, and *ultra vires* actions and inactions outlined above.

89. By reason of the foregoing, the Practice is entitled to a writ of prohibition or mandamus, as appropriate, under the All-Writs Act, 28 U.S.C. § 1651(a), directing that the Departments:

a. Take all steps necessary to obey the Congressional mandate that the Departments "*shall ensure* that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations." 42 U.S.C. § 300gg-111(c)(4)(E).

b. Withdraw the Departments' erroneous determination that the New York Surprise Bill Law is specified state law under the NSA for all "non-emergency services provided by an out-of-network provider at an in-network facility or surgical center," which is in direct violation of the NSA, . 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

c. Direct the Departments to immediately issue a determination (and publish same on their websites) that there is no specified state law under 42 U.S.C. §§ 300gg-111(a)(3)(H)(i) and 300gg-111(a)(3)(I).that applies in New York for elective non-emergency procedures, performed in a hospital or ambulatory surgery center, by an out-of-network provider, on a fully insured health plan beneficiary, who was aware before he or she came to the in-network hospital or ambulatory surgery center that the provider was out-of-network, but chose to proceed anyway.

90. By reason of all the foregoing, awarding such other and further relief that the Court deems just, proper, and equitable.

THIRD CAUSE OF ACTION

91. Plaintiff repeats and re-alleges the allegations set forth above as if more fully set forth herein.

92. Since the NSA became effective on January 1, 2022, the Practice has provided medically necessary services to thousands of patients.

93. The Practice provided many of these medically necessary services to patients under circumstances that rendered those services subject to the provisions of the NSA.

94. Indeed, it is well recognized under New York law that, even in the absence of an express contractual agreement, a physician is entitled to be reimbursed when the services have been rendered at the request of the patient. *See McGuire v Hughes*, 207 N.Y. 516, 521-22, 101 N.E. 460 (1913); *Crouse Irving Hosp. v City of Syracuse*, 283 App. Div. 394, 128 NYS2d 433 (4th Dept 1954), *aff'd*, 308 N.Y. 844, 126 N.E.2d 179 (1955); *UnitedHealthcare Servs., Inc. v. Asprinio*, 49 Misc. 2d 985, 993, 16 N.Y.S.3d 139 (Sup. Ct. Westchester County 2015); *Mercy Flight Cent., Inc. v Kondolf,* 41 Misc. 3d 483, 973 N.Y.S.2d 521 (Canandaigua City Ct 2013).

95. The legal principle in New York that a physician is entitled to be reimbursed for medically necessary services rendered at the request of the patient is so fundamental and longstanding under New York law to amount to more than just a unilateral expectation, but from a legitimate claim of entitlement under New York law.

96. For these reasons, the Practice has a cognizable property interest in being reimbursed for medically necessary services rendered at the request of the patient.

97. This cognizable property interested is protected against federal government interference, without due process of law, pursuant to the Fifth Amendment of the United States Constitution.

98. Through the Departments' actions, the Practice has been deprived of this federally cognizable property right to be reimbursed for medically necessary services rendered at the request of a patient, without due process of law.

99. Specifically, as alleged above, for services governed its provisions, the NSA prohibits out-of-network providers, such as the Practice, from balance billing or otherwise pursuing payments from health plan members. *See* 42 U.S.C. §§ 300gg-131(a), 300gg-132.

100. Given this balance billing ban, the NSA requires health plans, within 30 days to either make an initial payment to the provider or issue a notice of denial of payment. *See id.* §§ 300gg-111(a)(1)(C)(iv), 300gg-111(b)(1)(C).

101. Since the NSA became effective in January 2022, in many circumstances, the health plans have simply denied payment to the Practice.

102. Accordingly, the only way that the Practice can receive payments the medically necessary services it provided to patients is through the IDR process established by the NSA. No doubt recognizing this, Congress established tight time limits and deadlines for the IDR process.

103. However, as alleged above, the Departments have taken a series of actions and inactions that has rendered the IDR process untimely, ineffective, and inefficient, including but not limited to:

a. Failing to compel health plans subject to the NSA to either make an initial payment to the provider or issue of notice of denial of payment within 30 calendar days after the out-of-network provider transmits its bill to the health plan. *See* 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv) (emergency services), 300gg-111(b)(1)(C) (non-emergency services).

b. Failing to adopt procedures to monitor health plans' compliance with their obligations under the NSA to either make an initial payment to the provider or issue of notice of denial of payment within 30 calendar days after the out-of-network provider transmits its bill to the health plan. *See id.*

c. Failing to follow and observe the tight time limits established by the No Surprises Act for the IDR process. *See* 42 U.S.C. § 300gg-111(c)(5)(A).

c. Failing to obey the Congressional mandate that the Departments "*shall ensure* that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations." 42 U.S.C. § 300gg-111(c)(4)(E).

d. Wrongfully determining that the New York Surprise Bill Law is specified state law under the NSA for all "non-emergency services provided by an out-of-network provider at an in-network facility or surgical center," in direct violation of the NSA, . 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

d. Failing to require health plans to pay additional reimbursement due providers, as determined through the IDR process, within 30 days, as required by the NSA. *See* 42 U.S.C. § 300gg-111(c)(6).

e. Failing to adopt procedures to monitor health plans' compliance with their obligations to require health plans to pay additional reimbursement due providers, as determined through the IDR process, within 30 days, as required by the NSA. *See id*.

104. As a result of all the foregoing, the Departments' actions and inactions have deprived the Practice, and other similarly situated out-of-network providers, of their property without due process of law.

105. The Practice has no adequate remedy at law.

106. By reason of all the foregoing, the Practice is entitled to a judgment under the Declaratory Judgment Act, 38 U.S.C. §§ 2201-02, declaring that the Departments have deprived the Practice, and other similarly situated out-of-network providers, of their property without due process of law in violation of the Fifth Amendment of the United States Constitution.

107. By reason of all the foregoing, the Practice is entitled to a permanent injunction directing that the Departments:

a. Compel health plans subject to the NSA to either make an initial payment to the provider or issue of notice of denial of payment within 30 calendar days after the out-of-network provider transmits its bill to the health plan. *See* 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv) (emergency services), 300gg-111(b)(1)(C) (non-emergency services).

b. Adopt procedures to monitor health plans' compliance with their obligations under the NSA to either make an initial payment to the provider or issue of notice of denial of payment within 30 calendar days after the out-of-network provider transmits its bill to the health plan. *See id.*

c. Follow and observe the tight time limits established by the NSA for the IDR process. *See* 42 U.S.C. § 300gg-111(c)(5)(A).

d. Take all steps necessary to obey the Congressional mandate that the Departments "*shall ensure* that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations." 42 U.S.C. § 300gg-111(c)(4)(E).

e. Withdraw the Departments' erroneous determination that the New York Surprise Bill Law is specified state law under the NSA for all "non-emergency services provided by an out-of-network provider at an in-network facility or surgical center," which is in direct violation of the NSA, . 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

f. Direct the Departments to immediately issue a determination (and publish same on their websites) that there is no specified state law under 42 U.S.C. §§ 300gg-111(a)(3)(H)(i) and 300gg-111(a)(3)(I).that applies in New York for elective non-emergency procedures, performed in a hospital or ambulatory surgery center, by an out-of-network provider, on a fully insured health plan beneficiary, who was aware before he or she came to the in-network hospital or ambulatory surgery center that the provider was out-of-network, but chose to proceed anyway.

d. Require health plans to pay additional reimbursement due providers, as determined through the IDR process, within 30 days, as required by the NSA. *See* 42 U.S.C. § 300gg-111(c)(6).

e. Adopt procedures to monitor health plans' compliance with their obligations to require health plans to pay additional reimbursement due

providers, as determined through the IDR process, within 30 days, as required by the NSA. *See id*.

108. By reason of all the foregoing, awarding such other and further relief that the Court deems just, proper, and equitable.

WHEREFORE, for all the reasons set forth above, the Plaintiff demands judgment against the Defendants, as follows:

1. Declaring, pursuant to the Declaratory Judgment Act, 38 U.S.C. §§ 2201-02, that the Departments have violated their obligations under the No Surprises Act and the APA by undertaking a series of inappropriate and illegal actions and inactions including, but not limited to, the following:

a. Failing to obey the Congressional mandate that the Departments "*shall ensure* that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations." 42 U.S.C. § 300gg-111(c)(4)(E).

b. Wrongfully determining that the New York Surprise Bill Law is specified state law under the NSA for all "non-emergency services provided by an out-of-network provider at an in-network facility or surgical center," in direct violation of the NSA, . 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

2. An order under 5 U.S.C. § 706 directing that the Departments:

a. Take all steps necessary to obey the Congressional mandate that the Departments "*shall ensure* that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations." 42 U.S.C. § 300gg-111(c)(4)(E).

b. Withdraw the Departments' erroneous determination that the New York Surprise Bill Law is specified state law under the NSA for all "non-emergency services provided by an out-of-network provider at an in-network facility or surgical center," which is in direct violation of the NSA, . 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

c. Immediately issue a determination (and publish same on their websites) that there is no specified state law under 42 U.S.C. §§ 300gg-111(a)(3)(H)(i) and 300gg-111(a)(3)(I).that applies in New York for elective non-emergency procedures, performed in a hospital or ambulatory surgery center, by an out-of-network provider, on a fully insured health plan beneficiary, who was aware before he or she came to the in-network hospital or ambulatory surgery center that the provider was out-of-network, but chose to proceed anyway.

3. A writ of prohibition or mandamus, as appropriate, under the All-Writs Act, 28 U.S.C. § 1651(a), directing that the Departments:

a. Take all steps necessary to obey the Congressional mandate that the Departments "*shall ensure* that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations." 42 U.S.C. § 300gg-111(c)(4)(E).

b. Withdraw the Departments' erroneous determination that the New York Surprise Bill Law is specified state law under the NSA for all "non-emergency services provided by an out-of-network provider at an in-network facility or surgical center," which is in direct violation of the NSA, . 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

c. Immediately issue a determination (and publish same on their websites) that there is no specified state law under 42 U.S.C. §§ 300gg-111(a)(3)(H)(i) and 300gg-111(a)(3)(I).that applies in New York for elective non-emergency procedures, performed in a hospital or ambulatory surgery center, by an out-of-network provider, on a fully insured health plan beneficiary, who was aware before he or she came to the in-network hospital or ambulatory surgery center that the provider was out-of-network, but chose to proceed anyway.

4. Declaring, pursuant to the Declaratory Judgment Act, 38 U.S.C. §§ 2201-02, that the Departments have deprived the Practice, and other similarly situated out-of-network providers, of their property without due process of law in violation of the Fifth Amendment of the United States Constitution.

5. A permanent injunction directing that the Departments:

f. Compel health plans subject to the NSA to either make an initial payment to the provider or issue of notice of denial of payment within 30 calendar days after the out-of-network provider transmits its bill to the health plan. *See* 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv) (emergency services), 300gg-111(b)(1)(C) (non-emergency services).

g. Adopt procedures to monitor health plans' compliance with their obligations under the NSA to either make an initial payment to the provider or issue of notice of denial of payment within 30 calendar days after the out-of-network provider transmits its bill to the health plan. *See id.*

h. Follow and observe the tight time limits established by the NSA for the IDR process. *See* 42 U.S.C. § 300gg-111(c)(5)(A).

g. Take all steps necessary to obey the Congressional mandate that the Departments "*shall ensure* that a sufficient number of [IDR] entities are certified . . . to ensure the timely and efficient provision of [IDR] determinations." 42 U.S.C. § 300gg-111(c)(4)(E).

h. Withdraw the Departments' erroneous determination that the New York Surprise Bill Law is specified state law under the NSA for all "non-emergency services provided by an out-of-network provider at an in-network facility or surgical center," which is in direct violation of the NSA, . 42 U.S.C. §§ 300gg-111(a)(3)(H)(i), 300gg-111(a)(3)(I).

i. Direct the Departments to immediately issue a determination (and publish same on their websites) that there is no specified state law under 42 U.S.C. §§ 300gg-111(a)(3)(H)(i) and 300gg-111(a)(3)(I).that applies in New York for elective non-emergency procedures, performed in a hospital or ambulatory surgery center, by an out-of-network provider, on a fully insured health plan beneficiary, who was aware before he or she came to the in-network hospital or ambulatory surgery center that the provider was out-of-network, but chose to proceed anyway.

i. Require health plans to pay additional reimbursement due providers, as determined through the IDR process, within 30 days, as required by the NSA. *See* 42 U.S.C. § 300gg-111(c)(6).

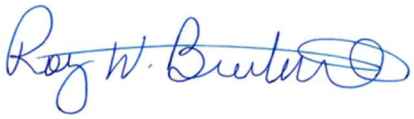
j. Adopt procedures to monitor health plans' compliance with their obligations to require health plans to pay additional reimbursement due providers, as determined through the IDR process, within 30 days, as required by the NSA. *See id*.

6. Awarding attorney's fees to the Plaintiff in accordance with the provisions of the Equal Access to Justice Act, 28 U.S.C. § 2412(d).

7. Awarding such other and further relief that the Court deems just, proper, and equitable including, but not limited to, costs, disbursements, and other allowances.

Dated: Uniondale, New York
July 31, 2023

HARRIS BEACH, PLLC
Attorneys for Plaintiff



By:_____
Roy W. Breitenbach
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Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

NEUROLOGICAL SURGERY PRACTICE OF LONG ISLAND, PLLC, Plaintiff, v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	Civil Action No.1:23-cv-2977-BMC

DEFENDANTS' MEMORANDUM OF LAW IN OPPOSITION TO PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION AND IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Federal Rules of Civil Procedure

Rules and Regulations

Other Authorities

INTRODUCTION

Millions of Americans, at one time or another, may face a critical decision whether to seek health care services "in network" or "out of network," in other words, from a provider that has a contract with the patient's health plan, or from a provider that does not. As anyone familiar with health insurance can attest, the cost difference between receiving care from an in-network versus an out-of-network provider can be substantial. And, in many cases, a patient might not be able to avoid extra costs by choosing an in-network provider.

For example, in an emergency, the patient might be taken to an emergency department at a hospital that turns out not to be in-network. Or the patient might carefully schedule a procedure at an in-network facility but, unbeknownst to him or her, a portion of the services could be performed by an out-of-network provider. Cases like these have often led to staggering, and sometimes ruinous, medical bills. What is more, this phenomenon of surprise billing has also inflated the cost of in-network care, because many providers have simply refused to negotiate for fair payment rates in advance, knowing that they could fall back on the option of demanding exorbitant out-of-network payments.

In late December 2020, Congress enacted the No Surprises Act ("NSA" or the Act). The principal aim of the Act is to address this "surprise billing" problem at a nationwide level. The Act limits a patient's share of the cost of emergency services delivered by out-of-network providers, or of the cost of certain non-emergency services provided by out-of-network providers at in-network facilities. The Act also addresses how a payment dispute in these situations between an out-of-network provider or facility and a group health plan or issuer will be resolved. If no applicable state law or All-Payer Model Agreement applies to the claim, and if the parties are unable to reach an agreement through negotiation, the Act creates an arbitration mechanism, called the Independent Dispute Resolution ("IDR") process, whereby each party submits its proposed

payment amount and an independent private arbitrator, known as a "certified IDR entity," will select between the two.

The principal provisions of the Act went into effect on January 1, 2022, and claims began to reach the arbitration process in April 2022. The Defendants here—the Departments of Health and Human Services, Labor, and the Treasury (the "Departments")—have worked tirelessly over the past two years to build, from the ground up, the regulatory framework needed to implement the Act. This has been a tremendous, multifaceted undertaking. The Departments have, for example, issued regulations and guidance setting forth how to calculate patient cost-sharing, explaining how payers and providers can negotiate out-of-network payments and participate in the IDR process, and implementing other provisions of the law. And these efforts have been paying off for patients every month. *See* Press Release, Am. Health Ins. Plans, *New Study: No Surprises Act Protects 9 Million Americans from Surprise Medical Bills*, (Nov. 17, 2022) (the Act protects patients from one million surprise medical bills every month).

Plaintiff here makes a variety of vague and unsupported allegations that the Departments' efforts to implement the Act and oversee regulated entities have been insufficient. It requests a sweeping injunction ordering the Departments to take a long list of actions, including devoting more financial resources to the IDR process, and asks the Court to oversee the Departments' compliance with that injunction through intrusive weekly status reports. Plaintiff's claims fail, however, because its alleged injuries result from delays by health plans and arbitrators, not the Departments, and it therefore lacks standing to pursue these claims against the Departments. Plaintiff's claims also fail because it cannot point to any specific and unequivocal statutory command requiring the Departments to take the requested actions, as is required in a case challenging agency inaction. Furthermore, to the extent Plaintiff alleges that the Departments have

inadequately exercised their enforcement authority to compel these third parties to comply with statutory deadlines, an agency's enforcement discretion is not subject to judicial review. What Plaintiff ultimately appears to seek is wholesale improvement of a government program by court order. But the APA does not permit such claims, and for good reason. The implementation of the No Surprises Act requires a careful balancing of limited resources and complex policy choices that Congress charged the Departments, not courts, to make. For these reasons, the Court should deny Plaintiff's Motion for a Preliminary Injunction and dismiss this case for failure to state a claim.

BACKGROUND

I. Congress enacted the No Surprises Act to protect patients from devastating surprise medical bills.

Congress passed the No Surprises Act in December 2020 to combat the growing crisis of surprise medical billing. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182, 2758-2890 (2020). Most health plans and health insurance issuers "have a network of providers and health care facilities (participating providers or preferred providers) who agree by contract to accept a specific amount for their services." *Requirements Related to Surprise Billing; Part I*, 86 Fed. Reg. 36,872, 36,874 (July 13, 2021).[1] When an individual receives care from a provider outside of their plan network, however, the plan could decline to pay for the services, or could pay an amount lower than the provider's billed charges, leaving the patient responsible for the balance of the bill. *Id.* This practice, where the provider bills the patient for the difference between the charges the provider billed and the amount paid by the patient's health plan, is known as balance billing or, where the patient did not select the provider, surprise billing. This out-of-network billing phenomenon had been rapidly growing before Congress acted, indeed, "becoming

[1] For ease of reference, this brief uses "health plan" to refer to group health plans and health insurance issuers, and "provider" to refer to both providers and facilities.

more common and potentially more costly in both the emergency department and inpatient settings." Eric C. Sun et al., *Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals*, 179 JAMA INTERN. MED. 1543, 1544 (2019) (finding mean potential liability to patients from balance bills increased from $804 to $2040 between 2010 and 2016).

The Act protects insured patients from unexpected liabilities arising from the most common forms of balance billing. If an insured patient receives emergency care, or receives care that is scheduled at certain types of in-network facilities, health care providers are generally prohibited (absent, in certain circumstances, the patient's consent) from balance billing the patient for any part of their care that is furnished by an out-of-network provider or facility. *See* 42 U.S.C. §§ 300gg-131, 300gg-132, 300gg-135.[2] Likewise, the patient's cost-sharing responsibilities for out-of-network services may not exceed their financial responsibilities "that would apply if such services were provided by a participating provider or a participating emergency facility[.]" *Id.* § 300gg-111(a)(1)(C)(ii), (b)(1)(A). For example, if the patient's health insurance policy would require them to pay coinsurance of 20% of the cost of an in-network service, the patient's responsibility for any out-of-network service would be limited to the same 20% co-insurance. *Id.* § 300gg-111(a)(1)(C)(ii), (iii), (b)(1)(A), (B).

In addition to setting the rules to determine a patient's payment obligations for a particular

[2] The Act makes parallel amendments to the Public Health Service Act ("PHSA") (administered by the Department of Health and Human Services ("HHS")), the Employee Retirement Income Security Act ("ERISA") (administered by the Department of Labor), and the Internal Revenue Code (administered by the Department of the Treasury). In addition, the Act requires the Office of Personnel Management to ensure that that its contracts with Federal Employees Health Benefits Program carriers require compliance with applicable provisions in the same manner as group health plans and health insurance issuers. 5 U.S.C. § 8902(p). For ease of reference, except where otherwise noted, this brief cites only to the Act's amendments to the PHSA.

out-of-network medical service, the Act also establishes a procedure to resolve disputes between providers and plans over the amount of payment for such a service when no specified state law or All-Payer Model Agreement applies.[3] The Act specifies that a plan will issue an initial payment, or notice of a denial of payment, to a provider within 30 calendar days after the provider submits a bill to the plan for an out-of-network service. *Id.* § 300gg-111(a)(1)(C)(iv), (b)(1)(C). If the provider is not satisfied with this determination, either party may initiate a 30-day period of open negotiation over the claim. *Id.* § 300gg-111(c)(1)(A). If those negotiations do not resolve the dispute, the parties may then proceed to the IDR process. *Id.* § 300gg-111(c)(1)(B).

The Act specifies that the Departments "shall establish by regulation," no later than December 27, 2021, "one independent dispute resolution process . . . under which[]" a private, independent arbitrator, known in the statute as a "certified IDR entity," "determines, . . . in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such item or service furnished by such provider or facility." *Id.* § 300gg-111(c)(2)(A). The Act further instructs the Departments to "establish a process" to certify arbitrators, *id.* § 300gg-111(c)(4)(A), under which such an entity "meets such other requirements as determined appropriate by the Secretary," such as sufficient medical, legal, and other expertise and sufficient staffing, *id.* § 300gg-111(c)(4)(A). IDR entities' certifications may be revoked by the Departments for noncompliance with statutory requirements. *Id.* § 300gg-111(c)(4)(C).

The Act employs a system of "baseball-style" arbitration under which the provider and the health plan will each submit an offer for a proposed payment amount and the arbitrator will, within 30 business days, select one or the other offer as the amount of payment for the item or service in

[3] In New York, the Emergency Medical Services and Surprise Bill Law, N.Y. Fin. Serv. Law § 601 *et seq.*, prohibits balance billing under certain circumstances and provides a dispute resolution process to resolve payment disputes over certain out-of-network medical bills.

dispute, taking into account the considerations specified in the statute and additional information submitted by the parties. *Id*. § 300gg-111(c)(5)(A)(i), (c)(5)(B)(i)(II). Among these considerations are the QPA which is generally defined as the median of the in-network contracted rates for a given item or service from 2019, adjusted for inflation, the provider's training, and the patient's acuity, among other things. *Id*. § 300gg-111(a)(3)(H)(ii); (a)(2)(B). The arbitrator's decision is binding on the parties and is not subject to judicial review except under certain circumstances described in the Federal Arbitration Act. *Id*. § 300gg-111(c)(5)(E). Following an arbitrator's decision, a plan has 30 days to make the necessary payment. *Id*. § 300gg-111(c)(6). State and federal authorities share enforcement authority over provisions of the No Surprises Act. *See, e.g.*, Letter from Ellen Montz, Director, Center for Consumer Information and Insurance Oversight to Governor Hochul, at 2 (July 29, 2022), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA-Enforcement-Letters-New-York.pdf (explaining spheres of enforcement authority). The Act went into effect on January 1, 2022, and the first IDR proceedings began three months later.

II. The Departments issued rules to establish the IDR process.

Congress instructed the Departments to issue one set of rules no later than July 1, 2021, addressing the No Surprises Act's patient protections, and to issue a second set of rules no later than December 27, 2021, addressing the procedures for resolving payment disputes. 42 U.S.C. § 300gg-111(a)(2)(B), (c)(2)(A). This second set of rules exercises Congress's delegation of authority to the Departments to "establish by regulation one independent dispute resolution process," *id*. § 300gg-111(c)(2)(A), for the resolution of disputes between providers and health plans over the amount of payment for out-of-network services. In particular, the rules set forth procedures for IDR entities to be certified, and for providers and health plans to invoke the Act's IDR system. *See Requirements Related to Surprise Billing; Part II*, 86 Fed. Reg. 55,980, 55,985

(Oct. 7, 2021) ("September 2021 IFR"). The September 2021 IFR also established regulations governing the batching of multiple items or services into a single dispute to be resolved by an IDR entity. 45 C.F.R. § 149.510(c)(3)(i)(A)-(D).

In August 2022, the Departments issued final rules providing guidance to the IDR entities in deciding between the competing offers to be submitted by providers and health plans and setting the out-of-network payment amount for a given medical service.[4] Under the final rules, the certified IDR entity "must select the offer that the certified IDR entity determines best represents the value of the qualified IDR item or service as the out-of-network rate." *Id.* § 149.510(c)(4)(ii)(A). After certain portions of the August 2022 final rules were vacated in separate litigation, the Departments issued updated guidance to certified IDR Entities that reflected that court's order. *See* March 2023 Guidance, at 5.

The Departments originally estimated that 22,000 disputes would be initiated in the Federal IDR process each year and 50 IDR entities would be certified. *See* 86 Fed. Reg. 56,002 n.41, 56,056, 56,069-70. However, between April 15, 2022 and March 31, 2023, disputing parties initiated 334,828 disputes through the Federal IDR portal, exponentially greater than the initial estimates, and only 13 IDR entities have been certified. Ctrs. For Medicare & Medicaid Servs., Federal Independent Dispute Resolution Process—Status Update (April 27, 2023),

[4] Several provisions of the September 2021 interim final rule and subsequent August 2022 final rules were vacated by the Eastern District of Texas on February 23, 2022 and February 6, 2023, respectively. *See Tex. Med. Ass'n v. U.S. Dep't of Health & Hum. Servs.*, 587 F. Supp. 3d 528 (E.D. Tex. 2022) *appeal dismissed*, No. 22-40264, 2022 WL 15174345 (5th Cir. Oct. 24, 2022); *Tex. Med. Ass'n v. U.S. Dep't of Health & Hum. Servs.*, _F Supp. 3d _ , 2023 WL 1781801 (E.D. Tex. Feb. 6, 2023), *appeal filed*, No. 23-40217, 2023 WL 1781801 (5th Cir. Apr. 11, 2023). After portions of the final rules were vacated, there was a pause on payment adjudications for several weeks while the Departments drafted new guidance for arbitrators. *See* Ctrs. for Medicare & Medicaid Servs., Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities (updated March 2023), https://www.cms.gov/files/document/federal-idr-guidance-idr-entities-march-2023.pdf ("March 2023 Guidance").

https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf; Ctrs. for Medicare & Medicaid Servs., List of Certified Independent Dispute Resolution Entities, https://www.cms.gov/nosurprises/help-resolve-payment-disputes/certified-idre-list (last visited May 25, 2023). Although the certified IDRE entities have closed 106,615 disputes as of March 31, 2023, the Departments have recognized that there remains a growing backlog of disputes awaiting resolution. Federal Independent Dispute Resolution Process—Status Update at 2. To address this issue, the Departments announced their intention to devote more resources to the IDR process to assist overburdened arbitrators and help alleviate the backlog. *See* Ctrs. for Medicare & Medicaid Servs., Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act: Change in Administrative Fee, 3-4 (Dec. 23, 2022), https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/Amended-CY2023-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf (explaining goal of increased resources was to "ensure more timely processing of disputes assigned to certified IDR entities").[5] The Departments are continuing to listen to public input and make improvements to the IDR process.

III. This litigation is brought.

Plaintiff is an independent neurosurgery practice group. Compl. ¶ 1, ECF 1. It has chosen to remain out-of-network with most health plans, and accordingly some of the items and services it provides are subject to the provisions of the Act. *Id*. ¶ 3. Plaintiff alleges that its practice relies

[5] Because the Departments' funding for carrying out the IDR process comes from the administrative fees paid by parties who participate in the IDR process, 42 U.S.C. § 300gg-111(c)(8)(B), the Departments increased the administrative fee to fund these additional expenditures. That fee increase is currently being challenged in the Eastern District of Texas. *See Tex. Med. Ass'n v. U.S. Dep't of Health & Hum. Servs*., No. 23-cv-59-JDK (E.D. Tex. Jan 30, 2023).

on the reimbursement from health plans subject to the Act's processes and that it is being injured by low and delayed reimbursement from these payers which it attributes to a failure to better implement and enforce the Act. *Id*. ¶ 8. Plaintiff's complaints fall into three general categories: (1) "The Departments are not processing IDR claims in the required timeframe"; (2) "The Departments are routinely allowing IDR eligible claims to be rejected"; and (3) "The Departments are allowing health plans to avoid paying claims they lose at IDR." *Id*. ¶ 9.

The day after it filed this case, Plaintiff filed five lawsuits against various health plans claiming that they violated the No Surprises Act by failing to pay claims after losing at IDR.[6] In those lawsuits, Plaintiff seeks to enforce the arbitration award and compel the insurers to make payments to Plaintiff. *See, e.g., Empire Blue Cross Blue Shield*, 2:23-cv-3050-JS-LGD, Compl. ¶ 1, ECF No. 1 ("Defendant violated federal law by failing to timely pay hundreds of thousands of dollars in out-of-network payment awards issued to the Practice . . . under the No Surprises Act.").

In this lawsuit, Plaintiff alleges that the Departments have failed to appropriately implement the No Surprises Act in 13 ways and seeks an injunction and writ of mandamus ordering the Departments to take 13 actions. Compl. ¶¶ 86, 87, 88, 91, 95, 108, 112, 125, 129. Plaintiff generally alleges that the Departments have violated their statutory obligations by failing to compel health plans to comply with the statutory deadlines for making payments imposed by the Act and failing to adopt procedures to monitor health plans' compliance with those deadlines; failing to compel health plans to comply with the statutory obligation to make payments to providers directly

[6] *See Neurological Surgery Prac. of Long Island, PLLC v. UnitedHealthCare Ins. Co. of N.Y.*, No. 1:23-cv-3007-NRM-PK (E.D.N.Y. Apr. 21, 2023); *Neurological Surgery Prac. of Long Island, PLLC v. Emblemhealth, Inc*., No. 1:23-cv-3029-JS-SIL (E.D.N.Y. Apr. 21, 2023); *Neurological Surgery Prac. of Long Island, PLLC v. Cigna Health & Life Ins. Co*., No. 2:23-cv-3047-GRB-SIL (E.D.N.Y. Apr. 21, 2023); *Neurological Surgery Prac. of Long Island, PLLC v. Cigna Health & Life Ins. Co*., No. 2:23-cv-3048-GRB-JMW (E.D.N.Y. Apr. 21, 2023); *Neurological Surgery Prac. of Long Island, PLLC v. Empire Blue Cross Blue Shield*, No. 2:23-cv-3050-JS-LGD (E.D.N.Y. Apr. 21, 2023).

and failing to adopt procedures to monitor health plans' compliance with that requirement; failing to institute certain requirements for information that health plans must include on their explanation of benefits ("EOB") forms; failing to require health plans to engage in "meaningful" negotiations during the 30-day open negotiation period; failing to compel IDR entities to comply with the statutory deadlines imposed by the Act; failing to establish a standardized process for IDR entities to determine eligibility issues and failing to impose requirements on IDR entities to provide explanations for eligibility determinations; failing to issue a "reasonable" batching regulation; and failing to require IDR entities to adjudicate claims for non-emergency services for which a patient was provided notice and consented to out-of-network care. *Id.* In addition to bringing claims under the APA and the All-Writs Act, Plaintiff alleges that the health plans' delays in making payments after an IDR decision is entered have deprived it of property without due process of law and constitute a taking, in violation of the Fifth Amendment to the Constitution. Compl. ¶¶ 111, 128-29.

The motion for a preliminary injunction seeks an order requiring the Departments to take 10 actions that largely cover the same ground, and also asks this Court to order the Departments to "[d]evote sufficient monetary and other resources required to ensure that the IDR process time frames established by the No Surprises Act are complied with" and to "[r]equire Defendants to provide a status report to the Court weekly regarding compliance with this Order." Pl.'s Mem. of Law in Supp. of Injunctive Relief at 1-2, ECF No. 11, at 1-2 ("Pl.'s Mot. for PI").

LEGAL STANDARDS

"The preliminary injunction 'is one of the most drastic tools in the arsenal of judicial remedies.'" *Doe v. U.S. Merch. Marine Acad.*, 307 F. Supp. 3d 121, 142 (E.D.N.Y. 2018) (citations omitted). It is "is an extraordinary remedy never awarded as of right," *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008), "one that should not be granted unless the movant, *by a clear*

showing, carries the burden of persuasion," *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (per curiam) (citation omitted). A plaintiff must establish that four factors have been met: "that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *N.Y. Progress & Prot. PAC v. Walsh*, 733 F.3d 483, 486 (2d Cir. 2013) (quoting *Winter*, 555 U.S. at 20).

A plaintiff that seeks a mandatory injunction—that is, an injunction that disrupts the status quo—must "meet a heightened legal standard by showing 'a clear or substantial likelihood of success on the merits.'" *N. Am. Soccer League, LLC v. U.S. Soccer Fed'n*, 883 F.3d 32, 37 (2d Cir. 2018). Additionally, where a party seeks injunctive relief that "will affect government[al] action taken in the public interest pursuant to a statutory or regulatory scheme, the injunction should be granted only if the moving party meets the more rigorous likelihood-of-success standard." *Sussman v. Crawford*, 488 F.3d 136, 140 (2d Cir. 2007) (citations omitted). This heightened requirement "reflects the idea that governmental policies implemented through legislation or regulations developed through presumptively reasoned democratic processes are entitled to a higher degree of deference and should not be enjoined lightly." *Otoe-Missouria Tribe of Indians v. N.Y. State Dep't of Fin. Servs.*, 769 F.3d 105, 110 (2d Cir. 2014) (quoting *Able v. United States*, 44 F.3d 128, 131 (2d Cir.1995)).

On a motion to dismiss under Rule 12(b)(1), "the plaintiff[] bear[s] the burden of demonstrating that [it] ha[s] standing." *TransUnion LLC v. Ramirez*, 141 S. Ct. 2190, 2207 (2021). "The plaintiff must have (1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision." *Spokeo, Inc v. Robins*, 578 U.S. 330, 338 (2016) (quoting *Lujan v. Defs. of Wildlife*, 504 U.S. 555,

560-61 (1992)).

Dismissal under Rule 12(b)(6) for failure to state a claim is proper when the complaint does not "contain sufficient factual matter . . . to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citation omitted). "[T]he tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions. Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." *Id.*

ARGUMENT

I. The Court should dismiss the Complaint for lack of subject-matter jurisdiction because Plaintiff lacks standing to pursue claims against Defendants where its injuries were caused by third parties.

Standing requires that Plaintiffs demonstrate an injury-in-fact that is "fairly traceable to the challenged action of the defendant" and that "it is likely," not merely speculative, "that the injury will be redressed by a favorable decision." *Friends of the Earth, Inc. v. Laidlaw Env't Servs.*, 528 U.S. 167, 180-81 (2000). Given that Plaintiff does not allege that the Departments have harmed it directly—for example, by issuing a specific regulation that harms Plaintiff—but instead that it has failed to regulate third parties in a way that indirectly affects Plaintiff, standing will be "'substantially more difficult' to establish." *Lujan*, 504 U.S. at 562 (quoting *Allen v. Wright*, 468 U.S. 737, 758 (1984)). As always, it is "the burden of the plaintiff to adduce facts showing that those choices have been or will be made in such manner as to produce causation and permit redressability of injury." *Id.*

Here, Plaintiff cannot establish causation or redressability because its claimed injury—health plans' and arbitrators' failure to meet statutory deadlines—"results from the independent action of some third party not before the court," namely, the health plans and arbitrators themselves. *Simon v. E. Ky. Welfare Rts. Org.*, 426 U.S. 26, 41-42 (1976). The Complaint is replete

with complaints of health plans' and arbitrators' failure to meet statutory deadlines, and of health plans' failure to engage in good faith negotiations, make payments to the proper entities, and otherwise comply with *their* obligations under the Act. *See* Compl. ¶¶ 32, 36, 37, 38, 43, 44, 49, 57, 58, 70, 71, 74. The only injury that Plaintiff identifies in the Complaint is financial harm from delayed payments and delayed IDR arbitration decisions. *Id*. ¶¶ 73-80. Plaintiff has also failed to establish that its alleged injuries are redressable by the Departments—*even if* the Departments fined every health plan or revoked the certification of every IDR entity that has failed to meet statutory deadlines, Plaintiff could not demonstrate that these actions would result in payment disputes getting resolved faster or its claims getting paid sooner.

Indeed, seemingly recognizing that its injuries were caused by health plans, the day after filing this suit, Plaintiff filed five other cases against the allegedly offending health plans—cases now pending before four other judges of this Court. *See supra* n.6 (citing cases). Plaintiff's filing of these lawsuits effectively concedes that it is these third parties, not the Departments, that are causing its alleged injuries. And it is likewise fatal to Plaintiff's request for mandamus, which requires a showing that Plaintiff has no other available remedy at law. *In re United States*, 10 F.3d 931, 933 (2d Cir.1993) (petitioner must show "the inadequacy of other available remedies").

II. The Court should dismiss the Complaint for failure to state a claim upon which relief can be granted.

A. Plaintiff fails to identify an unambiguous statutory obligation that the Departments have violated.

Even if Plaintiff could establish standing, its Complaint would fail on several independent grounds. To start, Plaintiff's Complaint challenges not agency action, but *in*action. Plaintiff brings claims under the APA, 5 U.S.C. § 706(1) and the All-Writs Act, 28 U.S.C. § 1651(a). To meet the high burden under either of these statutes, Plaintiff must show that Defendants failed to take a discrete action that they are unambiguously required to take. Plaintiff cannot make that showing.

Plaintiff argues that the Departments failed to compel health plans to comply with their statutory payment deadlines and failed to adopt procedures to monitor health plans' compliance with those deadlines; failed to compel health plans to make payments directly to providers and failed to adopt procedures to monitor health plans' compliance with that requirement; failed to require health plans to include certain information on their EOB forms; failed to require health plans to engage in "meaningful" negotiations during the negotiation period; failed to compel IDR entities to decide payment disputes within the statutory deadline, failed to establish a "streamlined process" for IDR entities' eligibility determinations and failed to require IDR entities to provide an explanation for eligibility decisions; failed to "allow a reasonable batching" of claims for resolution in a single IDR dispute; and failed to require the federal IDR process to adjudicate claims for non-emergency services where the patient consented to out-of-network care. *See* Compl. ¶¶ 86, 87, 88, 91, 95, 108, 112, 125, 129.

While the APA authorizes courts to "compel agency action unlawfully withheld or unreasonably delayed," 5 U.S.C. § 706(1), it does so "only within strict limits," *Anglers Conservation Network v. Pritzker*, 809 F.3d 664, 668, 670 (D.C. Cir. 2016). Courts can compel only "*discrete* agency action that [an agency] is *required to take*," *Norton v. S. Utah Wilderness All.* ("*SUWA*"), 542 U.S. 55, 64 (2004)—that is, where a statute or regulation imposes a "ministerial or non-discretionary" duty amounting to a "specific, unequivocal command," *id*. at 63-64; *see also Benzman v. Whitman*, 523 F.3d 119, 131 (2d Cir. 2008) (holding general duties imposed by statute or regulation failed to constitute a discrete legal obligation). This standard reflects the common-law writ of mandamus, which the APA "carried forward" in Section 706(1). *Id*. at 63 ("The mandamus remedy was normally limited to . . . the ordering of a precise, definite act . . . about which [an official] had no discretion whatever[.]") (citation omitted); *see Indep.*

Mining Co. v. Babbitt, 105 F.3d 502, 507 (9th Cir. 1997) (relief authorized by mandamus statute and under APA Section 706(1) "is essentially the same"). "[W]here an alleged 'duty is not . . . plainly prescribed, but depends on a statute or statutes the construction or application of which is not free from doubt, it is regarded as involving the character of judgment or discretion which cannot be controlled by mandamus.'" *Power v. Barnhart*, 292 F.3d 781, 786 (D.C. Cir. 2002) (quoting *Consol. Edison Co. of N.Y. v. Ashcroft*, 286 F.3d 600, 605 (D.C. Cir. 2002)).

Here, Plaintiff does not even attempt to cite to specific statutory provisions that it claims mandate the requested actions. *See SUWA*, 542 U.S. at 66 (holding that "general deficiencies in compliance . . . lack the specificity requisite for agency action"). As an initial matter, the bulk of Plaintiff's claims amount to allegations that the health plans and arbitrators failed to comply with *their own* statutory obligations.[7] But to the extent that Plaintiff alleges that the Departments themselves failed to take certain actions, its claims fail because the Departments have fully complied with all of their statutory obligations under the Act. The Act requires the Departments to "establish by regulation one independent dispute resolution process . . . under which . . . a certified IDR entity . . . determines . . . in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such item or service furnished by such provider or facility." 42 U.S.C. § 300gg-111(c)(2)(A). The only constraint Congress imposed on the Departments is that the regulations be "in accordance with" the succeeding

[7] As mentioned above, the Departments have acknowledged that the certified IDR entities have experienced an overwhelming volume of disputes and lack the resources to resolve every dispute within the 30-day statutory deadline. The Departments are in the process of devoting more resources to assist the certified IDR entities to expedite processing of disputes and reduce the backlog. But the backlog affects all parties to the IDR process, and Plaintiff does not allege that it has experienced unique delays that are the result of anything other than overburdened IDR entities. *See Pesantez v. Johnson*, No. 15-cv-1155-BMC, 2015 WL 5475655, at *4 (E.D.N.Y. Sept. 17, 2015) (holding whether petitioner was treated differently than similarly situated parties is an important factor in evaluating whether overburdened government system unreasonably delayed action).

provisions of subsection (c). *Id.* § 300gg-111(c)(2)(A). Consistent with this statutory directive, the Departments did establish an IDR process, and none of the succeeding provisions of that subsection speak to or purport to require the actions that Plaintiff demands, such as establishing a "streamlined process" for deciding eligibility disputes or mandating that IDR entities provide a written explanation for eligibility decisions. *See, e.g.*, Compl. ¶ 86(i).

There are likewise no statutory provisions that require the Departments to adopt specific procedures to monitor health plans' compliance with the statutory payment deadlines. *See, e.g.*, Compl. ¶ 86(b), (m).[8] Although Congress did require the Departments to assess whether health plans "have a pattern or practice of routine denial [or] low payment," it did so in the form of an "interim report" to be submitted by January 1, 2024, with a "final report" to be submitted two years later. 42 U.S.C. § 300gg-111(C)(5)(E)(iv). The Departments have clearly not violated that statutory obligation, which has not yet come due, even in interim form. And although the Act lists several requirements for information that health plans must include on the *advanced* EOB forms (which are different from EOB forms), information about the QPA or whether the claim is eligible for the Federal IDR process are not among them. *Compare* 42 U.S.C. § 300gg-111(f)(1)(A)-(H) *with* Compl. ¶ 86(e), (f); *see also* 45 C.F.R. §149.140(d) (requiring disclosure of QPA elsewhere). Similarly, although Plaintiffs allege that the Departments failed to provide specific guidance to IDR entities, *see, e.g.*, Compl. ¶¶ 60-61, Plaintiff cannot point to an unambiguous statutory command requiring that the specific guidance they request be provided, nor does Plaintiff allege

[8] Congress knows how to require the Departments to monitor health plans' compliance with the Act's requirements. For example, the Act requires the Departments to establish an audit process to monitor health plans' compliance with QPA calculations, and Departments have already established such a process and are in the process of conducting audits. 42 U.S.C. § 300gg-111(A)(2); 86 Fed. Reg. at 36,899. There is no similar requirement that the Departments establish an audit process to monitor health plans' compliance with payment deadlines.

that the guidance provided to IDR entities is legally inaccurate in any way.

Plaintiff's allegation that the Departments have improperly failed to require that claims for non-emergency services, for which a patient "was aware before he or she came to the hospital that the provider was out-of-network, but chose to proceed anyway," be adjudicated in the Federal IDR process, *see* Pl.'s Mot. for a PI at 16, Compl. ¶ 86(k), is also incorrect. When a specified state law, such New York's surprise billing law, applies to a claim, it applies regardless of whether a patient has waived her state law balance billing protections by providing consent to receive out-of-network care, and the Act specifically excludes from its protections, in certain circumstances, patients who have provided notice and consent. *See* 42 U.S.C. § 300gg-111(b)(1). The Departments have provided guidance to assist IDR entities in understanding when the Federal IDR process or a specified state law applies to a claim, guidance which Plaintiff does not contest or even mention. *See* Ctrs. For Medicare & Medicaid Servs., Chart Regarding Applicability of the Federal Independent Dispute Resolution Process in Bifurcated States, (Jan. 13, 2023) https://www.cms.gov/files/document/applicability-federal-idr-bifurcated-states.pdf.

Similarly, Plaintiff's allegation that the Departments failed to promulgate a "reasonable" regulation relating to the batching of claims fails to identify an unambiguous statutory requirement and fails to explain how the current regulation is unreasonable or what Plaintiff thinks a "reasonable" regulation would even look like. *See* Compl. ¶ 54. The statute sets minimum requirements that must be met before any items or services may be considered jointly in a single IDR proceeding, but also authorizes the Secretary to "specify criteria" on top of those minimum requirements. *Id.* § 300gg-111(c)(3)(A). The Secretary issued regulations specifying the criteria for batching, 45 C.F.R. § 149.510(c)(3)(i)(C), and reasonably explained the decision in the September 2021 IFR, 86 Fed. Reg. at 55,994. Plaintiff does not allege that these regulations violate

any *specific* statutory command.

Because Plaintiff fails to identify an unambiguous, non-discretionary statutory obligation that the Departments have failed to comply with, the Court should dismiss Plaintiff's APA and All-Writs Act claims.

B. Plaintiff's claims that the Departments have failed to compel third parties to comply with their obligations under the Act are not reviewable.

To the extent that Plaintiff seeks an injunction requiring the Departments to "enforce" and "monitor" health plans' and arbitrators' compliance with various statutory deadlines and requiring the Departments to "devote sufficient monetary and other resources required to ensure that the IDR process time frames established by the No Surprises Act are complied with," *see* Pl.'s Mot for a PI at 1-2, its Complaint fails for another threshold reason: an agency's enforcement decisions are "committed to [its] discretion," 5 U.S.C. § 701(a)(2), and thus generally immune to judicial review.

In a similar suit seeking to compel the Secretary of Health and Human Services to take specific enforcement actions, the Supreme Court unequivocally held that an agency's enforcement decisions are presumptively unreviewable. *Heckler v. Chaney*, 470 U.S. 821, 832 (1985). Plaintiffs there challenged an agency decision not to take enforcement action against alleged violations, seeking to compel "various investigatory and enforcement actions to prevent these perceived violations," and "the prosecution of all those" who knowingly violated the regulatory scheme. *Id.* 823-24. The Supreme Court rejected that attempt to force the agency's hand, concluding that the decision whether to bring an enforcement action is the paradigmatic example of presumptively unreviewable action committed to agency discretion by law. *Chaney*, 470 U.S. at 828-33 (citing 5 U.S.C. § 701(a)(2)).

As the Court explained, it "has recognized on several occasions over many years that an

agency's decision not to prosecute or enforce, whether through civil or criminal process, is a decision generally committed to an agency's absolute discretion," "attributable in no small part to the general unsuitability for judicial review of agency decisions to refuse enforcement." *Id.* at 831. Such choices "often involve[] a complicated balancing of a number of factors which are peculiarly within [the agency's] expertise." *Id.* at 831-32. Absent a command from Congress directing how an agency will exercise its enforcement authority, "an agency refusal to institute proceedings is a decision 'committed to agency discretion by law' within the meaning of [the APA]." *Id.* at 835. Indeed, an order requiring a federal agency to take enforcement action would trench on the executive's Article II authority and raise significant separation-of-powers concerns. "When the judiciary orders an executive agency to enforce the law it risks arrogating to itself a power that the Constitution commits to the executive branch." *Baltimore Gas & Elec. Co. v. FERC*, 252 F.3d 456, 459 (D.C. Cir. 2001). For that reason, "*Chaney*'s recognition that the courts must not require agencies to initiate enforcement actions may well be a requirement of the separation of powers commanded by our constitution." *Id.*

Heckler v. Chaney thus obligates courts to decline review of an agency's enforcement efforts. Indeed, as the Second Circuit has observed, "it is rare that agencies lack discretion to choose their own enforcement priorities." *Nat. Res. Def. Council, Inc. v. U.S. Food & Drug Admin.*, 760 F.3d 151, 171 (2d Cir. 2014). "The agency is far better equipped than the courts to deal with the many variables involved in the proper ordering of its priorities." *Riverkeeper, Inc. v. Collins*, 359 F.3d 156, 165 (2d Cir. 2004) (quoting *Chaney*, 470 U.S. at 831-32). The Departments have taken enforcement actions against plans and issuers for violations of statutory payment deadlines. *See* Ex. A (Decl. of William Barron); Ex. B (Decl. of Jeff Wu). This is thus far from a case where the agency has "'consciously and expressly adopted a general policy' that is so extreme as to

amount to an abdication of its statutory responsibilities." *Chaney*, 470 U.S. at 833 n.4 (citation omitted).[9] Furthermore, millions of medical bills subject to the No Surprises Act are generated every month, and a monitoring of every single claim, and enforcement of every single statutory violation, would be impossible. *See Chaney*, 470 U.S. at 831 (noting that "an agency generally cannot act against each technical violation of the statute it is charged with enforcing").

Plaintiff's request that the Departments devote additional monetary resources to the IDR process is likewise not reviewable under the APA. *See Lincoln v. Vigil*, 508 U.S. 182, 192 (1993) (holding that an agency's allocation of appropriated funds is typically committed to agency discretion by law because "the very point . . . is to give an agency the capacity to adapt to changing circumstances and meet its statutory responsibilities in what it sees as the most effective or desirable way"). And the IDR process is funded by the administrative fees paid by parties who participate in the IDR process—the Departments do not have an unlimited pool of funding on which to draw. *See* 42 U.S.C. § 300gg-111(c)(8).

C. The APA does not permit claims for wholesale improvement of a government program.

What Plaintiff essentially seeks in this action is the "wholesale improvement of this program by court decree, rather than in the offices of the Department[s] or the halls of Congress, where programmatic improvements are normally made"—precisely the sort of broadside attack on agency operations that the Supreme Court has repeatedly rejected. *SUWA*, 542 U.S. at 64; *Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871, 879 (1990). Plaintiff claims that the Departments have "destroyed the timeliness, effectiveness, and efficiency of the federal IDR process." Compl. ¶ 76. But the list of 13 indistinct actions that it asks this Court to order the Departments to take amounts

[9] There is no formal statutory mechanism for "enforcement" actions against IDR entities other than revoking certification of the IDR entity, which would not alleviate Plaintiff's injuries but result in *fewer* IDR entities available to resolve the backlog of claims.

to little more than a request to generally improve the IDR process and administration of the Act. And Plaintiff even goes so far as to ask this Court to "[r]equire Defendants to provide a status report to the Court weekly regarding compliance with" any injunction." Pl.'s Mot. for a PI at 2. Such a programmatic attack is not permitted under the APA. As the Supreme Court has explained:

> If courts were empowered to enter general orders compelling compliance with broad statutory mandates, they would necessarily be empowered, as well, to determine whether compliance was achieved—which would mean that it would ultimately become the task of the supervising court, rather than the agency, to work out compliance with the broad statutory mandate, injecting the judge into day-to-day agency management.

SUWA, 542 U.S. at 66-67. "The prospect of pervasive oversight by federal courts over the manner and pace of agency compliance with such congressional directives is not contemplated by the APA." *Id*. at 67. The APA's limitations on judicial review "protect agencies from undue judicial interference with their lawful discretion, and . . . avoid judicial entanglement in abstract policy disagreements which courts lack both expertise and information to resolve." *Id*. at 66. Plaintiff's request for the Court to insert itself into the management of the Departments' administration of this large and complex statutory scheme—on a weekly basis, no less—is thus squarely foreclosed by unambiguous Supreme Court precedent.

The proper procedure for pursuit of Plaintiff's grievance is set forth explicitly in the APA: "a petition to the agency for rulemaking, [5 U.S.C.] § 553(e), denial of which must be justified by a statement of reasons, [*id*.] § 555(e), and can be appealed to the courts, [*id*.] §§ 702, 706." *Auer v. Robbins*, 519 U.S. 452, 459 (1997); *see also United States v. L.A. Tucker Truck Lines, Inc.*, 344 U.S. 33, 37 (1952) (objections to how an agency conducts its business should generally be presented to the agency so that it may correct any error). Plaintiff's claims here are thus much like seeking review of a denial of a petition for rulemaking—a petition it never claims to have filed. If it had, any denial would be separately reviewable under the APA, but under a standard of deference

"so high as to be 'akin to non-reviewability.'" *New York v. U.S. Nuclear Regul. Comm'n*, 589 F.3d 551, 554 (2d Cir. 2009) (quoting *Cellnet Commc'n, Inc. v. FCC,* 965 F.2d 1106, 1111 (D.C. Cir. 1992).

D. Plaintiff's constitutional claims fail as a matter of law.

Plaintiff also purports to bring two constitutional claims, under the due process and taking clauses of the Fifth Amendment. *See* Compl. ¶¶ 97-113 (count 3, due process), 114-130 (count 4, taking). Given that the APA likewise supplies the cause of action for these claims, *see* 5 U.S.C. §§ 702 (granting judicial review of agency action), 706(2) (authorizing the review of agency action "contrary to constitutional right, power, privilege, or immunity"), and both seek relief identical to that for Plaintiff's APA and All-Writs Act claims—namely, to compel agency action "unlawfully withheld," *id.* § 706(1); *compare, e.g.*, Compl. ¶ 112 (requested injunction for due process claim) *with id.* ¶ 88 (requested injunction for APA claim)—the constitutional claims are subject to dismissal for the same threshold reasons as the APA and All-Writs Act claims.

Plaintiff's constitutional claims also fail as a matter of law for other reasons. Plaintiff alleges that health plans' delayed and inadequate payments have deprived it of property without adequate process or compensation. But a court in this district has already rejected the notion that "a health care provider's entitlement to 'reasonable payment' is a cognizable property interest for the purposes of a due process claim" involving the No Surprises Act. *Haller v. U.S. Dep't of Health & Hum. Servs.*, 621 F. Supp. 3d 343, 356-57 (E.D.N.Y. 2022), *appeal filed*, No. 22-3054 (2d Cir. Nov. 30, 2022). To the extent providers have an enforceable property interest *after* an arbitrator's decision ordering a health plan to make a payment, it is the health plans, not the Departments, who are withholding payment to Plaintiff and thus depriving it of property. *See Benzman*, 523 F.3d at 130 (recognizing no constitutional violation for government's failure to interfere when misconduct takes place, "even where such aid may be necessary to secure life, liberty or property interests of

which the government itself may not deprive the individual"); *see also Mehta v. Surles*, 905 F.2d 595, 598 (2d Cir.1990) (per curiam) (plaintiff must show government caused the deprivation).[10]

III. Plaintiff is not entitled to a preliminary injunction.

Even if Plaintiff's Complaint is not dismissed in its entirety, Plaintiff has fallen well short of establishing any entitlement to a preliminary injunction. To start, there is nothing preliminary about the relief Plaintiff seeks. On the contrary, Plaintiff urges the Court to grant the full panoply of relief requested in its Complaint under the guise of an extraordinary, emergency motion. Even if this Court had authority to order such relief at some stage of the litigation, it clearly would not be appropriate in the form of an emergency motion. "[I]t is generally inappropriate for a federal court at the preliminary-injunction stage to give a final judgment on the merits," *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 395 (1981), and a preliminary injunction that effectively would grant full relief accordingly is improper. *See, e.g.*, *Senate of State of Cal. v. Mosbacher*, 968 F.2d 974, 978 (9th Cir. 1992) (explaining that granting "judgment on the merits in the guise of preliminary relief" is "highly inappropriate"). Plaintiff's motion for preliminary relief must fail on this ground alone.[11]

For the reasons given above, the Court should deny Plaintiff's motion for a preliminary injunction and should dismiss the Complaint because Plaintiff cannot establish any likelihood of success on the merits. *See Nken v. Holder*, 556 U.S. 418, 438 (2009) (Kennedy, J., concurring) ("When considering success on the merits and irreparable harm, courts cannot dispense with the

[10] Defendants do not concede that Plaintiff has established any other element of a due process or taking claim.

[11] Plaintiff's broad requests for injunctive relief are also at odds with Rule 65(d), which requires that injunctive relief "state its terms specifically" and "describe in reasonable detail. . . the act or acts restrained or required." Fed. R. Civ. P. 65(d); *see, e.g., Keyes v. Sch. Dist. No. 1*, 895 F.2d 659, 668 & n.4 (10th Cir. 1990) (striking an injunction requiring the defendants "to use their expertise and resources to comply with the constitutional requirement of equal education opportunity for all").

required showing of one simply because there is a strong likelihood of the other."). But even if the Court were to conclude otherwise, it should still deny an injunction because Plaintiff has neither established irreparable harm nor shown that the equities tip in its favor.

A. Plaintiff has not established irreparable harm.

"Irreparable harm is the single most important prerequisite for the issuance of a preliminary injunction[.]" *Freedom Holdings, Inc. v. Spitzer*, 408 F.3d 112, 114 (2d Cir. 2005) (quoting *Rodriguez v. DeBuono*, 175 F.3d 227, 233-34 (2d Cir. 1999)). To satisfy this requirement, Plaintiff "must demonstrate that absent a preliminary injunction [it] will suffer 'an injury. . . that cannot be remedied 'if [the Court] waits until the end of trial to resolve the harm."' *Id.* (quoting *Rodriguez*, 175 F.3d at 234-35). Monetary harm alone is generally insufficient. *See Kamerling v. Masssanari*, 295 F.3d 206, 214 (2d. Cir. 2002).

Plaintiff has failed to substantiate any of its allegations that it will suffer irreparable harm that cannot be remedied by monetary compensation from health plans—compensation which it is already seeking through five other lawsuits. Plaintiff's declarations describe nothing more than financial injuries that are making the practice less profitable, but the purely financial nature of this injury makes injunctive relief inappropriate. *See CRP/Extell Parcel I, L.P. v. Cuomo*, 394 F. App'x 779, 781 (2d Cir. 2010) ("We have long held that an injury compensable by money damages is insufficient to establish irreparable harm."). Because Plaintiff has failed to show that it will suffer non-monetary harm, or that its harm is caused by the Departments, it has failed to meet its burden to show irreparable harm.

B. The equities and the public interest disfavor injunctive relief.

The public interest and the balance of the equities also weigh strongly against granting Plaintiff's motion. *See Nken*, 556 U.S. at 435 (merging these factors merge when the government is a party). As discussed above, Plaintiff does not show any injury, much less irreparable harm,

caused by the Departments. *See supra* III.A. Plaintiff's requested injunction, however, would impose a significant burden on the Defendants and disserve the public.

Where the elected branches have enacted a statute based on their understanding of what the public interest requires, this Court's "consideration of the public interest is constrained . . . for the responsible public officials . . . have already considered that interest." *Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 512 F.3d 1112, 1126-27 (9th Cir. 2008) (internal quotation omitted). Here, pursuant to Congress's directive, the Departments have issued a series of rules faithfully implementing the IDR process that Congress crafted. Plaintiff, however, urges the Court to enjoin the Departments to reallocate resources on a massive scale, without tying those requests to any specific commands in the statutory text. And its request, if granted, would effectively mandate that three federal agencies train their efforts on Plaintiff's preferred policy goals, rather than focusing on their own priorities under the No Surprises Act and other statutes. Redirecting resources to investigation and enforcement actions would mean fewer resources available, for example, to assist the IDR entities to alleviate the backlog of disputes, to ensure that the patient-provider dispute resolution mechanism functions smoothly, 42 U.S.C. § 300gg-137, or to audit health plans' QPA methodologies, *id*. § 300gg-111(a)(2), among the Departments' many other obligations under the Act. Plaintiff's proposed injunction would radically upend the status quo and hamstring the Departments' ability to administer a complex statutory and regulatory framework that is a vital piece of Congress's goal to protect against surprise billing and is decidedly not in the public interest.

CONCLUSION

For the foregoing reasons, this Court should deny Plaintiff's Motion for a Preliminary Injunction and dismiss the Complaint in its entirety.

Dated: May 29, 2023

Respectfully submitted,

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Exhibit B

EDPMA 25 YEARS

Data Analysis

No Surprises Act Independent Dispute Resolution Effectiveness

The Emergency Department Practice Management Association (EDPMA) is a trade association focused on the sustainable delivery of high-quality, cost-effective patient care in emergency departments. Our members deliver or directly support health care for approximately half of the 146 million patients that annually visit U.S. emergency departments.

The Study

EDPMA surveyed its membership to report on issues related to the implementation of the No Surprises Act (NSA) and its Independent Dispute Resolution (IDR) process since its enactment on January 1, 2022. This data documents our members' experiences with the IDR processs and represents a high-level summary of initial findings; additional details are forthcoming.

The Numbers

EDPMA's respondents represented over half of EDPMA's annual emergency department patients.
This accounts for at least one-fourth of all ED visits in the United States.
Respondents filed 220,000+ IDR claims.
Date range: January – December 2022
Antitrust Safe Harbor status maintained[1]

The Findings

91% Of Filed Claims Remain Open and Unadjudicated

Respondents reported almost 200,000 outstanding claims. Payers ignoring claims in the open negotiation period contribute to the significant volume of IDR claims.[2]

95.6% of Outstanding Claims Are 5+ Months Old From 127 Health Plans

If the current NSA implementation goes unchecked, this model will cripple those who staff emergency departments, risking patients' access to quality emergency care. These emergency departments often serve rural and underrepresented communities. Our study reveals outstanding claims by date range:

< 30 days:	0.1%	91-120 days:	0.6%
30-60 days:	0.5%	121-150 days:	44.2%
61-90 days:	3.2%	>151 days:	51.4%

Payers Are Not Participating In 30-Day Open Negotiation Period And IDR Process As Expected By Statute

68% of filed IDR claims did NOT receive replies from health plans during the 30-day open negotiation period. Respondents further reported that 52% of payers did not acknowledge an IDR claim had been filed, and that 75% of payers who actually responded in the IDR process made NO actionable offers.

[1] Redacted data must be at least 3 months old; at least 5 data contributors per published dataset; no group contributing more than 25% of a data set; raw data only reviewed by a third-party independent consultant.
[2] https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf

EDPMA 25 YEARS

Data Analysis

No Surprises Act Independent Dispute Resolution Effectiveness

Rapid and Effective Enforcement Is Not Happening
Physician groups are filing complaints with CMS and CCIIO and issuing demand letters to health plans. Yet despite these efforts, emergency physicians continue to experience a pro-payer process. Respondents reported that CMS responded to about 14% of their complaints.

87% of Payers Did Not Pay In Accordance with the IDR Entity Decision
Payers' blatant disregard of the No Surprises Act's intent and CMS issued guidance undermines the law and guts fair emergency physician reimbursement that underpins emergency care in America. Of the survey respondents, 60% quantified the percentage of payments won in IDR but NOT paid within the prescribed 30 days. Of these, 1/3 reported 100% noncompliance by health plans; 1/3 reported noncompliance from 89% to 98% of the time; and 1/3 reported noncompliance averaging 37% of the time.

The Solutions

To ensure a sustainable healthcare safety net, emergency physicians must be fairly compensated in a timely manner for services already delivered, especially if those services are required under the federal EMTALA law, which provides both a guaranteed network for health plans and a safety net for patients.

Implement the Law as Designed

The Administration should not alter the law Congress passed, should ensure that all parties have fair and appropriate access to the provisions contained in the law, and should enforce compliance with the law by all parties.

Congressional Involvement

Congress should ensure that the bipartisan No Surprises Act not only keeps patients out of the middle of payment disputes but is implemented as intended. This includes aligned implementation policies for health plans and providers, efficient and cost-effective dispute resolution, appropriate transparency, and effective enforcement processes. Congress' continued assistance and involvement is key to achieving the agreed-upon goals of this landmark legislation, while also preventing the NSA from becoming a landmark failure due to its undermining the viability of emergency medicine physician groups—the heart of our national emergency safety net system.

Rapid and Effective Enforcement

The Tri-Departments must uphold the NSA statute and ensure that ALL parties fully participate in the IDR process with a common spirit of fair and timely resolution of disputed claims. Payers who refuse to comply with the IDR process or fail to pay as directed by the IDR entity should be subject to penalties and fees.

EMTALA Must Now Be Funded

Since 1987, the federal law EMTALA mandates emergency physicians to treat all patients regardless of their ability to pay. This requirement is significant and applies to almost all emergency care provided in US hospitals. However beneficial, EMTALA was never funded. Now, the No Surprises Act is causing commercial reimbursement to decrease, upsetting the previous equilibrium. EMTALA-required care, stand-by costs, uninsured care, and underinsured care have no offset in a system that requires care for all patients irrespective of reimbursement. We must now step up to ensure that the U.S. emergency care system is sustainable and that emergency medicine physicians can still supply much-needed care. Without solutions, our nation's healthcare safety net will crumble.

Contact

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Exhibit C

Department of Financial Services

Industry Guidance

TO:	**All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, Health Maintenance Organizations, Student Health Plans Certified Pursuant to Insurance Law § 1124, Municipal Cooperative Health Benefit Plans, Prepaid Health Services Plans, and Health Care Providers**
RE:	**The No Surprises Act, Independent Dispute Resolution Process, and Disclosure of Protections from Balance Billing**

I. Purpose

The purpose of this circular letter is to provide guidance to insurers authorized to write accident and health insurance in New York State, Article 43 corporations, health maintenance organizations, student health plans certified pursuant to Insurance Law § 1124, municipal cooperative health benefit plans, and prepaid health services plans (collectively, "issuers") and health care providers ("providers") regarding the independent dispute resolution ("IDR") process in the federal No Surprises Act ("NSA") and New York's IDR process in Financial Services Law Article 6 and related disclosure requirements.

II. Background

The NSA was signed into law as part of the Consolidated Appropriations Act of 2021 (Public Law 116-260; Division BB § 109) on December 27, 2020 and takes effect on January 1, 2022. NSA § 103 amends 42 U.S.C. § 300gg et seq. to establish an IDR process for non-emergency services performed by non-participating providers at in-network hospitals, hospital outpatient

departments, critical access hospitals, and ambulatory surgical centers (collectively, "facilities") and out-of-network emergency services in the emergency department of a hospital or independent freestanding emergency department.[1] The amendments apply to plan years beginning on or after January 1, 2022.

The NSA provides that the federal IDR process will apply and may be used by providers and issuers to determine the out-of-network rate for emergency services in the emergency department of a hospital or independent freestanding emergency department and non-emergency items and services furnished by non-participating providers during a visit to a participating health care facility when an All-Payer Model Agreement under Social Security Act § 1115A or "specified state law" does not apply. Under 42 U.S.C. § 300gg-111(a)(3)(I), a "specified state law" is a state law that provides for a method of determining the total amount payable in the case of an insured receiving an item or service from a non-participating provider at a participating facility or emergency services in the emergency department of a hospital or independent freestanding emergency department. For a state law to determine the amount upon which cost-sharing is based and the out-of-network rate, the state law must apply to: (1) the plan, issuer, or coverage involved; (2) the non-participating provider or non-participating emergency facility involved; and (3) the item or service involved. When a state has a specified state law, the state law and the state IDR process, rather than the federal IDR process, will apply and the amount upon which cost-sharing is based and the out-of-network rate for emergency and non-emergency services subject to surprise billing protections are calculated based on such specified state law.

New York has an IDR process that applies to out-of-network emergency services,[2] including inpatient services that follow an emergency room visit, in hospital facilities, and surprise bills in participating hospitals or ambulatory surgical centers and for services referred by a participating physician.[3] The IDR process requires issuers, physicians, hospitals and ambulatory surgical centers, and providers to whom the patient was referred by their participating physician, to ensure that the insured incurs no greater out-of-pocket costs for emergency services and surprise bills than the insured would have incurred with an in-network provider. Since New York has a specified state law, the New York IDR process will continue to apply to out-of-network emergency services and surprise bills. However, while the NSA protections are similar to those already provided in New York, there are differences in the federal provisions that expand the New York protections in certain circumstances. The Department of Financial Services ("DFS") will apply the following federal requirements to the New York IDR process beginning on January 1, 2022.[4]

III. Discussion of IDR Process

A. Types of Providers Eligible for IDR

The NSA § 103 IDR process to determine payment for out-of-network emergency services applies to bills for emergency services from providers, hospitals, and independent freestanding emergency departments. In addition, NSA § 103 applies to bills from non-participating providers for non-emergency services performed at participating facilities. The NSA is clear that the IDR process applies to providers, and not just physicians.[5] NSA § 104 also states that such providers may not bill and may not hold insureds liable for payment amounts that are more than the in-network cost-sharing requirement for out-of-network emergency services and for non-emergency services performed by non-participating providers at participating facilities.[6]

Financial Services Law § 605 states that physician and hospital bills for emergency services in hospital facilities (including inpatient services that follow an emergency room visit) are eligible for IDR in New York. Financial Services Law § 607 states that surprise bills for services rendered by non-participating physicians at participating hospitals and ambulatory surgical centers and services referred by participating physicians are eligible for IDR in New York. While New York's Financial Services Law Article 6 meets the federal definition of "specified state law" in most cases, it does not meet the federal definition with respect to providers other than physicians for disputes involving emergency services (including inpatient services that follow an emergency room visit) in hospital facilities and surprise bills at participating hospitals or ambulatory surgical centers.

If the Legislature does not expand the New York IDR process to include providers, along with physicians, the federal IDR process would apply to these disputes for plan years beginning on or after January 1, 2022 because there would not be a "specified state law" that applies. Given the federal requirements, and to minimize potential confusion, issuers and providers may submit disputes involving emergency services rendered by providers (including for inpatient services that follow an emergency room visit) in hospital facilities and surprise bills for the services of non-participating providers at participating hospitals and ambulatory surgical centers through New York's IDR process beginning January 1, 2022. Including providers in New York's IDR process beginning January 1, 2022 will satisfy the federal standards for the state IDR process to apply to these disputes. Providers are also reminded that pursuant to NSA § 104, they must hold insureds harmless for any amounts that are more than the in-network cost-sharing for emergency services (including inpatient services that follow an emergency room visit) in hospital facilities and surprise bills at participating hospitals or ambulatory surgical centers.

B. Types of Services Eligible for IDR

NSA § 102 amends 42 U.S.C. § 300gg-111(b)(2)(B) to define "visit" for purposes of defining the types of items and services furnished to an individual at a facility that are eligible for the federal IDR process. Under this section, "visit" includes, equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and other such services as the Secretary of the U.S. Department of Health and Human Services ("HHS") may specify, regardless of whether the provider furnishing such items or services is at the facility.

Neither the Insurance Law nor the Financial Services Law defines "visit." If the Legislature does not expand the New York IDR process to include the items and services in the federal "visit" definition, the federal IDR process would apply to these disputes for plan years beginning on or after January 1, 2022 because there would not be a "specified state law" that applies. Therefore, the items and services in the federal "visit" definition will be included in the New York IDR process for emergency services and surprise bills regardless of whether the provider furnishing such items or services is at the facility. Providers and issuers are also reminded that pursuant to NSA §§ 102 and 104, Financial Services Law Article 6, and 23 NYCRR Part 400, they must hold insureds harmless for any amounts that are more than the in-network cost-sharing for emergency services (including inpatient services that follow an emergency room visit) in hospital facilities and for surprise bills at participating hospitals or ambulatory surgical centers.

C. Safety Net Hospitals

The federal IDR process for emergency services applies to all hospitals. Financial Services Law § 605(d) exempts hospitals that had at least 60% of inpatient discharges annually that consisted of Medicaid, uninsured, and dual eligible individuals as determined by the New York State Department of Health in its determination of safety net hospitals ("safety net hospitals") from the New York IDR process for hospital bills for emergency services (including inpatient services that follow an emergency room visit). If the Legislature does not expand the New York IDR process to include hospital bills for emergency services at safety net hospitals, the federal IDR process would apply to these disputes for plan years beginning on or after January 1, 2022 because there would not be a "specified state law" that applies. Given the federal requirements, and to minimize potential confusion, issuers and hospitals may submit disputes involving hospital bills for emergency services at safety net hospitals (including inpatient services that follow an emergency room visit) through New York's IDR process beginning on January 1, 2022. The criteria used for determining the reasonable fee in Financial Services Law § 604, and as applicable, the payment amount set

forth in Financial Services Law § 605(e), will be applied to disputes involving safety net hospitals. Including safety net hospitals in New York's IDR process beginning January 1, 2022 will satisfy the federal standards for the state IDR process to apply to these disputes. Safety net hospitals are also reminded that pursuant to NSA § 104 and Financial Services Law § 606(b), they must hold insureds harmless for any amounts that are more than the in-network cost-sharing for emergency services (including inpatient services that follow an emergency room visit) in hospital facilities.

D. Exempt Emergency Services CPT Codes

The federal IDR process for emergency services does not include an exemption for any American Medical Association current procedural terminology ("CPT") codes. Financial Services Law § 602(b) exempts CPT codes 99281 - 99285, 99288, 99291 - 99292, 99217 - 99220, 99224 - 99226, and 99234 - 99236 from the New York IDR process if the bill does not exceed 120% of the usual and customary cost and the fee disputed is $714.64 (adjusted annually for inflation rates) or less after any applicable coinsurance, copayment, and deductible. If the Legislature does not expand the New York IDR process to include these CPT codes, the federal IDR process would apply for emergency services involving these CPT codes beginning on or after January 1, 2022 because there would not be a "specified state law" that applies. Given the federal requirements, and to minimize potential confusion, issuers and providers are advised that they may submit disputes involving these CPT codes for emergency services at hospital facilities through New York's IDR process beginning January 1, 2022. Including these CPT codes in New York's IDR process beginning January 1, 2022 will satisfy the federal standards for the state IDR process to apply to these disputes. Providers are also reminded that pursuant to NSA § 104 and Financial Services Law § 606(b), they must hold insureds harmless for any amounts that are more than the in-network cost-sharing for emergency services (including inpatient services that follow an emergency room visit) in hospital facilities.

E. Insured's Cost-Sharing under the IDR Process

42 U.S.C. § 300gg-111(a)(1)(C)(iii) and (b)(1)(B) and interim final rules promulgated thereunder provide that an insured's cost-sharing for emergency services in the emergency department of a hospital or independent freestanding emergency department, and for nonemergency services furnished by a non-participating provider at a participating facility, must be calculated based on one of the following amounts: an amount determined by an applicable All-Payer Model Agreement under Social Security Act § 1115A; if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or if there is no such applicable All-Payer Model Agreement or specified state law, the lesser of

the billed charge or the plan's or issuer's median contracted rate, the latter referred to as the qualifying payment amount ("QPA"). The determination by the IDR entity of the out-of-network rate does not change the insured's cost-sharing. See 45 C.F.R. §§ 149.110(b)(3) and 149.120(c). The cost-sharing amount remains the same as originally calculated. See id.

Insurance Law § 3241(c) states that when an insured receives emergency services from a non-participating provider, the issuer must ensure that the insured incurs no greater out-of-pocket expenses for the emergency services than the insured would have incurred with a participating provider. Furthermore, under Financial Services Law § 605(a)(1), when an issuer receives a bill for emergency services from a non-participating physician or hospital (including a bill for inpatient services that follow an emergency room visit), the issuer must pay an amount it deems reasonable, except for the insured's copayment, coinsurance, or deductible, if any, and must ensure that the insured incurs no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or hospital. Similarly, with respect to surprise bills, Insurance Law § 607(a)(3) provides that the issuer must pay an amount it deems reasonable, except for the insured's copayment, coinsurance, or deductible, and 23 NYCRR § 400.5(b)(3)(i) provides that the insured shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or provider. Under Financial Services Law § 606(a) and (b), when an insured assigns benefits for a surprise bill or emergency services to a non-participating physician or hospital, the non-participating physician or hospital may not bill the insured except for any applicable copayment, coinsurance, or deductible that would be owed if the insured utilized a participating physician or hospital.

The foregoing sections of the Insurance Law and Financial Services Law set forth that the insured's cost-sharing and out-of-pocket costs must not exceed the amounts the insured would have paid for the services of a participating provider. Given the requirements in the federal law, and the state law language, the insured's cost-sharing amount should not increase in the event the IDR entity determines that the issuer must pay additional amounts for the services rendered. 23 NYCRR § 400.5(a)(3)(ii) and (b)(3)(ii) state that if the issuer pays an amount less than the non-participating physician's or non-participating hospital's charge for emergency services or a surprise bill, the issuer must provide the insured with notice which shall explain that the insured's cost-sharing may increase in the event the IDR entity determines that the issuer must pay additional amounts for the services of the non-participating physician or non-participating hospital. DFS will be amending 23 NYCRR § 400.5, and issuers are advised that the insured's cost-sharing should be calculated based on the issuer's original payment amount and cannot increase based on the IDR entity's

determination beginning on January 1, 2022. In such cases, the issuer would be responsible for paying the additional amount. However, if the IDR entity determines that the issuer must pay a non-participating hospital an amount less than the minimum payment required under Financial Services Law § 605(e), the hospital must refund the overpayment and the insured's cost-sharing should be calculated based on this lower amount.

F. Prohibition on Waiver of Protections from Balance Billing for Emergency Services

NSA § 102 and 45 C.F.R. § 149.410(b) permit insureds to waive their balance billing protections for emergency services after the insured is stabilized if: (1) the provider determines that the insured is able to travel using nonmedical transportation or nonemergency medical transportation; (2) the provider satisfies the notice and consent criteria; (3) the individual is in a condition to receive the information and provide informed consent, in accordance with applicable state law; and (4) the provider satisfies any additional requirements or prohibitions under state law. However, no such waiver exists under New York law. Insurance Law § 3241(c) and Financial Services Law § 605(a) provide that an issuer must ensure that the insured incurs no greater out-of-pocket costs for the emergency services (including inpatient services that follow an emergency room visit) than the insured would have incurred with a participating physician or hospital. Additionally, Financial Services Law § 606(b) provides that when an insured assigns benefits for emergency services (including inpatient services that follow an emergency room visit) to a non-participating physician or hospital that knows the insured is insured under a health care plan, the non-participating physician or hospital may not bill the insured except for any applicable copayment, coinsurance, or deductible that would be owed if the insured used a participating physician or hospital. Neither the Insurance Law nor the Financial Services Law permits a waiver of the insured's rights and protections from balance billing for emergency services. Therefore, issuers and providers are reminded that the NSA provisions relating to notice and consent and the waiver of protections from balance billing for bills for emergency services after the insured is stabilized do not apply in New York.

G. Prohibition on Waiver of Protections from Balance Billing for Surprise Bills

NSA § 102, 42 U.S.C. § 300gg-132, and 45 C.F.R. § 149.420(b) permit insureds to waive their protections from balance billing for bills from non-participating providers at in-network facilities if the notice and consent criteria are met for services that are not ancillary services. Pursuant to 45 C.F.R. § 149.420, the notice and consent must be provided to the insured within set timeframes, use a certain format, contain specified information, including a good faith estimate of the services, and meet language access standards. This waiver is not permitted for ancillary services. Under 45 C.F.R. § 149.420(b)(1), "ancillary services"

mean services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by a non-participating provider if there is no participating provider who can furnish such item or service at such facility.

The Financial Services Law does not permit a waiver of the surprise bill protections when the criteria in Financial Services Law § 603(h) are met. However, Financial Services Law § 603(h)(1) states that a surprise bill does not include a bill received for health care services in a participating hospital or ambulatory surgical facility when a participating physician is available and the insured has elected to obtain services from a non-participating physician.[7] DFS has received questions as to what it means for a participating physician to be considered available for the purposes of a surprise bill. For a participating physician to be considered available, the insured must have a meaningful opportunity to choose an in-network physician in advance of the services. DFS considers notice to the insured at least 72 hours in advance of the services, that otherwise satisfies the requirements of the NSA, to be a meaningful opportunity to choose an in-network physician. DFS does not consider notice on the day of the services as providing the insured with a meaningful opportunity to choose an in-network physician.

In addition, Financial Services Law § 606(a) provides that when an insured assigns benefits for a surprise bill in writing to a non-participating physician who knows the insured is insured under a health care plan, the non-participating physician or hospital may not bill the insured except for any applicable copayment, coinsurance, or deductible that would be owed if the insured used a participating physician. The Financial Services Law does not permit a waiver of the insured's rights and protections from balance billing for surprise bills. Therefore, issuers and providers are reminded that the NSA provisions relating to the waiver of balance billing protections for non-ancillary services do not apply in New York for surprise bills defined under Financial Services Law § 603(h)(1).

H. Provider Hold Harmless for Emergency Services and Surprise Bills

NSA § 104 added new 42 U.S.C. §§ 300gg-131 and 300gg-132, which set forth that non-participating providers, facilities, hospitals, and independent freestanding emergency departments may not bill and may not hold insureds liable for payment amounts that are more than the in-network cost-sharing requirement for out-of-network emergency services and for non-emergency services performed by non-participating providers at participating facilities, unless an insured waives the hold harmless protections (as described in sections F

and G above). Financial Services Law § 606 provides that once an insured signs an assignment of benefits form for emergency services or a surprise bill, the non-participating physician or hospital may only bill the insured for any applicable in-network copayment, coinsurance, or deductible. Given the provisions in federal law, even if a New York insured does not sign an assignment of benefits form, providers, facilities, hospitals, and independent freestanding emergency departments may not bill and may not hold insureds liable for payment amounts that are more than the in-network cost-sharing requirement for out-of-network emergency services and for non-emergency services performed by non-participating providers at participating facilities if the requirements in 42 U.S.C. §§ 300gg-131 and 300gg-132 are met. Additionally, given the provisions in 42 U.S.C. § 300gg-111(a)(1) and (b)(1), even if a New York insured does not sign an assignment of benefits form, upon receipt of a claim from a provider for a surprise bill or for emergency services, an issuer must send the initial payment or notice of denial of the payment directly to the provider. Issuers are also reminded that they must comply with the timeframes and requirements set forth in Insurance Law § 3224-a regarding payment of claims.

IV. Requirements for Air Ambulance Bills

NSA § 105 adds 42 U.S.C. §§ 300gg-112 and 300gg-135 to protect insureds from air ambulance bills and to establish a federal IDR process to determine payment for out-of-network air ambulance bills. Pursuant to 42 U.S.C. § 300gg-112(a), issuers must hold an insured harmless for any amounts that exceed the insured's in-network cost-sharing for out-of-network air ambulance services if the insured has coverage for in-network air ambulance services. Additionally, issuers must apply any cost-sharing amounts paid by an insured for out-of-network air ambulances services toward the insured's in-network deductible and out-of-pocket maximum amount. Pursuant to 42 U.S.C. § 300gg-135, out-of-network air ambulance providers must not bill, and must not hold an insured liable for payment amounts that exceed the insured's in-network cost-sharing requirement for air ambulance services if the insured has coverage for in-network air ambulance services. Air ambulance bills in New York will be subject to the federal IDR process for plan years beginning on or after January 1, 2022, and issuers and providers are expected to comply with these requirements.

V. Requirements for Disclosure of Patient Protections from Balance Billing

A. Provider Requirements

NSA § 104 adds a new 42 U.S.C. § 300gg-133 that requires providers to make certain disclosures to patients regarding balance billing protections. Beginning January 1, 2022, each health care provider and facility must make publicly available, post on their public

websites, and provide to insureds, a one-page notice in clear and understandable language containing information on: the requirements and prohibitions of such provider or facility under 42 U.S.C. §§ 300gg-131 and 300gg-132 (relating to prohibitions on balance billing for emergency services and surprise bills); any other applicable state law requirements on such provider or facility prohibiting out-of-network balancing billing (including any state laws that provide consumer protections that go beyond the NSA); and information on contacting appropriate state and federal agencies in case an individual believes that such provider or facility has violated any state or federal prohibitions on balance billing for emergency services and surprise bills.

45 C.F.R. § 149.430(c) provides clarification regarding the methods for this disclosure. When posting on the provider's or facility's website, the information or link to the information must appear on a searchable homepage of the provider's or facility's website. If a provider or facility does not have a website, this requirement does not apply. Additionally, for the information to be publicly available, the provider or facility must include the information on a sign posted prominently at the provider's or facility's location. A sign is posted prominently if the sign is posted in a central location, such as where insureds schedule care, check in for appointments, or pay bills. If the provider does not have a publicly accessible location, this requirement does not apply. Lastly, the notice provided to the insured must be a one-page (double-sided) notice, using print no smaller than 12-point font. The provider or facility must provide the notice in person or through postal mail, or if the insured consents, through electronic mail.

45 C.F.R. § 149.430 also provides clarification regarding the timing for this disclosure. A provider or facility must provide this notice to insureds no later than the date and time on which the provider or facility requests payment from the insured, or for an insured from whom the provider or facility does not request payment, no later than the date on which the provider or facility submits the claim to the insured's coverage.

Certain providers are exempt from these notice requirements. Pursuant to 45 C.F.R. § 149.430(e), providers that do not furnish items or services at a facility, or in connection with a visit to a facility, are not required to make this disclosure. Additionally, providers must make the disclosure to insureds to whom they furnish items or services, but only if such items or services are furnished at a facility, or in connection with a visit to a facility. Additionally, providers are reminded that this disclosure is only required for insureds covered by comprehensive health insurance coverage issued by an issuer.

Providers are further reminded that such disclosure requirements apply beginning on January 1, 2022. To facilitate compliance with such requirements, HHS issued a model disclosure notice regarding patient protections against surprise bills that providers and facilities may use to satisfy the disclosure requirements under 42 U.S.C. § 300gg-133. Additionally, HHS indicated that a state may develop a model notice consistent with 42 U.S.C. § 300gg-133. DFS developed a model notice for providers and facilities to use that incorporates the requirements of 42 U.S.C. § 300gg-133 and state law. Providers and facilities are encouraged to use the state-developed model notice to ensure that they adhere to the requirements of 42 U.S.C. § 300gg-133 and state law.

B. Issuer Requirements

NSA § 116 adds a new 42 U.S.C. § 300gg-115(c) that requires issuers to make certain disclosures to patients regarding balance billing protections. Beginning on January 1, 2022, each issuer must make publicly available, post on its public website, and include on each explanation of benefits for claims for emergency services or surprise bills, in clear and understandable language, information on: the requirements and prohibitions under 42 U.S.C. §§ 300gg-131 and 300gg-132 (relating to prohibitions on providers for balance billing for emergency services and surprise bills); the requirements on issuers under 42 U.S.C. § 300gg-111 (relating to protections from bills for emergency services and surprise bills); any other applicable state law on out-of-network balance billing (including any state laws that provide consumer protections that go beyond the NSA); and information on contacting appropriate state and federal agencies in case an individual believes that a provider or facility has violated any state or federal requirements prohibiting balance billing for emergency services and surprise bills.

DFS regulation 23 NYCRR Part 400 also requires issuers to provide information regarding protections from bills for emergency services and surprise bills. Pursuant to 23 NYCRR § 400.5(a)(3), for bills for emergency services, if the issuer pays less than the non-participating physician's or hospital's charges, the issuer must provide the insured with notice, included on or in conjunction with an explanation of benefits, that: (1) explains that the insured will incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or participating hospital; and (2) directs the insured to contact the issuer in the event that the non-participating physician or non-participating hospital bills the insured for the out-of-network services other than the insured's in-network cost-sharing.

Additionally, issuers must disclose certain information to insureds regarding surprise bills. Pursuant to 23 NYCRR § 400.5(b)(3), when a claim for a surprise bill is submitted with an assignment of benefits form or the issuer otherwise determines that the claim is for a

surprise bill, the issuer must provide the insured with notice, included on or in conjunction with, an explanation of benefits, that: (1) explains that the insured will incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician or provider; and (2) directs the insured to contact the issuer in the event that the non-participating physician or non-participating referred provider bills the insured for the out-of-network service other than the insured's in-network cost-sharing.

Issuers are reminded that such disclosure requirements under the NSA are applicable for plan years beginning on or after January 1, 2022. To facilitate compliance with the disclosure requirements under the NSA, HHS issued a model disclosure notice regarding patient protections against surprise bills that issuers may use to satisfy the disclosure requirements under 42 U.S.C. § 300gg-115(c). DFS will develop a model notice for issuers, similar to the one developed for providers and facilities, to incorporate the requirements of the NSA and 23 NYCRR § 400.5. Issuers are encouraged to use the state-developed model notice to ensure that they adhere to the requirements of 42 U.S.C. § 300gg-115(c) and 23 NYCRR § 400.5.

VI. Conclusion

Issuers and providers are advised that, beginning on January 1, 2022, New York's IDR process is expanded to apply to non-participating providers in participating hospitals and ambulatory surgical centers with respect to surprise bills, non-participating providers of emergency services in hospital facilities, safety net hospitals with respect to emergency services, and all CPT codes with respect to emergency services in hospital facilities.

Issuers and providers are advised that an insured's cost-sharing under the New York IDR process should be calculated based on the issuer's original payment amount and should not increase in the event an IDR entity determines that the issuer must pay additional amounts for the services rendered. In addition, there may be situations when the insured's cost-sharing will decrease. Issuers and providers are also reminded that they must hold insureds harmless for bills for emergency services and surprise bills pursuant to requirements in state and federal law.

Issuers and providers are advised that they must hold an insured harmless for any amounts that exceed the insured's in-network cost-sharing for out-of-network air ambulance services if the insured has coverage for air ambulance services and further that the federal IDR process will apply to such bills for plan years beginning on or after January 1, 2022.

Finally, issuers and providers are advised that they must comply with the disclosure requirements set forth in the NSA and 23 NYCRR § 400.5, as applicable. Issuers and providers

are encouraged to use the state-developed model notices to ensure that they adhere to the disclosure requirements of the NSA and 23 NYCRR § 400.5. DFS will be amending the IDR regulation, 23 NYCRR 400, for consistency with the NSA requirements described in this circular letter.

Please direct any questions regarding this circular letter by email to health@dfs.ny.gov.

Very truly yours,

Lisette Johnson
Chief, Health Bureau

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[1] NSA § 102 amended 42 U.S.C. § 300gg-19a(b)(2) to define "emergency services" to mean, with respect to an emergency medical condition, a medical screening examination (as required under Social Security Act § 1867) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under Social Security Act § 1867 to stabilize the patient.

[2] Financial Services Law § 603(b) defines "emergency services" to mean, "with respect to an emergency condition: (1) a medical screening examination as required under section 1867 of the social security act, 42 U.S.C. § 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency condition; and (2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the social security act, 42 U.S.C. § 1395dd, to stabilize the patient."

[3] Financial Services Law § 603(h) defines a "surprise bill," in relevant part, as "a bill for health care services, other than emergency services, received by: (1) an insured for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center, where

a participating physician is unavailable or a non-participating physician renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered; provided, however that a surprise bill shall not mean a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a non-participating physician; or (2) an insured for services rendered by a non-participating provider, where the services were referred by a participating physician to a non-participating provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health care plan."

[4] The requirements of the NSA do not apply to governmental programs, such as Medicaid managed care, Child Health Plus, and the Essential Plan. However, changes made to the New York IDR process to incorporate the NSA protections will apply to all disputes subject to the New York IDR process under Financial Services Law § 603(a), including those disputes involving Medicaid managed care, Child Health Plus, and the Essential Plan.

[5] 42 U.S.C. § 300gg-111(a)(3)(G)(i) defines a "nonparticipating provider" to mean, "with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively."

[6] The NSA sets forth limited circumstances when the insured may agree to waive the insured's protections, as described in sections F and G below. However, the Insurance Law does not provide for a waiver of the protections for emergency services and surprise bills.

[7] Financial Services Law § 603(h)(2) also contemplates that an insured may provide explicit written consent to acknowledge that a participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the issuer. However, this provision in the Financial Services Law is not the focus of this paragraph in the circular letter.

Department of Financial Services

About Us

Mission and Leadership

Advisory Boards

Institutions That We Supervise

State Laws & Regulations

State Codes, Rules & Regulations (NYCRR)

State Laws (LBDC)

State Bills & Laws (Senate)

Website

Accessibility & Reasonable Accommodations

Disclaimer

Privacy Policy

Site Map

Language Assistance

Language Access Policies and Plans

CONNECT WITH US

TWITTER

LINKEDIN

FACEBOOK

Translation Services

This page is available in other languages

English

Español

中文

Русский

יידיש

বাঙালি

한국어

Kreyòl Ayisyen

Italiano

العربية

Polski

Français

اردو

Translate

Exhibit D

Department of Financial Services

Surprise Medical Bills and Emergency Services

Consumers in New York are protected from surprise bills when treated by an out-of-network provider at a participating hospital or ambulatory surgical center in their health plan's network. Additionally, consumers with health insurance coverage provided by an insurer or HMO are protected from surprise bills when a participating doctor refers them to a non-participating provider. Consumers in New York are also protected from bills for emergency services in hospitals, including inpatient care following emergency room treatment.

The following information explains what you need to know about these important protections if:

- you have coverage with an HMO or insurer subject to New York law
- you are uninsured or your employer or union provides self-insured coverage that is not subject to New York law
- you are a health care provider.

Information Your Doctor and Other Health Care Professionals Must Give You

Information Your Hospital Must Give You

How to Protect Yourself from a Surprise Medical Bill If You Have Health Insurance Coverage Subject To NY Law – (your health insurance ID card says "fully insured")

Surprise bills happen when an out-of-network provider treats you at an in-network hospital or ambulatory surgical center OR you are referred by an in-network doctor to an out-of-network provider. (In-network means in your health plan's network.) You only have to pay your in-network cost-sharing for a surprise bill.

It's A Surprise Bill At An In-Network Hospital or Ambulatory Surgical Center if an Out-of-Network Provider Treats You and:

- An in-network provider was not available; OR

services without your knowledge; OR

rovided when you received health care services.

It is NOT a surprise bill if you chose to receive services from an out-of-network provider instead of from an available in-network provider before you got to the hospital or ambulatory surgical center.

Beginning January 1, 2022, the following services will usually be a surprise bill when provided by an out-of-network provider in a hospital or ambulatory surgical center: emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.

If your health care services were **before January 1, 2022**, you are only protected from a surprise bill if you were treated by an out-of-network physician (and not other health care providers) at an in-network hospital or ambulatory surgical center.

It's a Surprise Bill When Your In-Network Doctor Refers You to an Out-of-Network Provider if:

- You did not sign a written consent that you knew the services were out-of-network and would not be covered by your health plan; AND
- During a visit with your participating doctor, a non-participating provider treats you; OR
- Your in-network doctor takes a specimen from you in the office (for example, blood) and sends it to an out-of-network laboratory or pathologist; OR
- For any other health care services when referrals are required under your plan.

If You Get a Surprise Bill Because An Out-of-Network Provider Treats You At An In-Network Hospital Or Ambulatory Surgical Center OR Your Doctor Refers You To An Out-of-Network Provider:

- You only have to pay your in-network cost-sharing.
- If an out-of-network provider bills you for any amount over your in-network cost-sharing (copayment, coinsurance, or deductible) this is called balance-billing.
- If your doctor referred you to an out-of-network provider, you MUST send a Surprise Bill Certification Form to your health plan and your provider to make sure that they know you received a Surprise Bill and that you must be protected from balance billing.
- If an out-of-network provider treats you at an in-network hospital or ambulatory surgical facility, you MUST send a Surprise Bill Certification Form to your health plan and your provider if you received the health care services before January 1, 2022 to make sure that they know you received a Surprise Bill and that you must be protected from balance billing. The form is not required for services provided after January 1, 2022 at an in-network hospital or ambulatory surgical facility, but it is recommended.
- You may also file a complaint with DFS.

How To Protect Yourself From A Surprise Medical Bill If You Have Employer/Union Self-Funded Coverage (your health insurance ID card says "self-funded" or does not say "fully insured")

The Federal No Surprises Act protections from surprise medical bills from an out-of-network provider in an in-network hospital or ambulatory surgical center apply if your employer or union self-funds your coverage for plans issued or renewed on and after January 1, 2022.

You are only responsible for paying your in-network cost-sharing (copayment, coinsurance, or deductible) for a surprise bill.

For more information about the Federal consumer protections, visit the CMS No Surprises Act website.

For plans issued or renewed before January 1, 2022, you may qualify for an independent dispute resolution (IDR) through New York State by submitting an IDR application to dispute the bill. To be eligible, services must be provided by a doctor at a hospital or ambulatory surgical center and you aren't given all the required information about your care. See Information Your Doctor and Other Health Care Professionals Must Give You and Information Your Hospital Must Give You for a list of the information that must be provided to you.

Application. Complete an IDR Patient Application and send it to NYS Department of Financial Services, Consumer Assistance Unit/IDR Process, One Commerce Plaza, Albany, NY 12257.

'self From A Surprise Medical Bill If You Are Uninsured

Good Faith Estimate for Uninsured or Self-Pay Patients

If you are uninsured, or you are insured but you don't plan to file a claim with your health plan, health care providers must give you a good faith estimate of what their expected charges will be before you get health care services.

Providers must give you the good faith estimate:

- For services scheduled at least 3 business days ahead of time, within 1 business day of scheduling the service;
- For services scheduled at least 10 business days ahead of time, within 3 business days of scheduling the service; or
- When you ask for the good faith estimate, within 3 business days of you asking for the estimate.

The good faith estimate will include:

- A description of the service you will be getting;
- A list of other services that are reasonably expected to be provided with the service you are getting;
- The diagnosis and expected service codes; and
- The expected charges for the services.

For more information about good faith estimates, visit the CMS No Surprises Act website.

Patient-Provider Dispute Resolution Process For Good Faith Estimates

If you are billed for an amount that is at least $400 more than the amount on the good faith estimate you got from your health care provider, you (or your authorized representative) may dispute the charges in the Federal patient-provider dispute resolution process. You have to ask for the review within 120 days of getting the bill. An independent reviewer will look at the good faith estimate, the bill, and information from the provider to decide the amount, if any, that you have to pay for each service.

You can use the Federal patient-provider dispute resolution process starting in 2022 for billing disputes with the provider that scheduled the service for you. Later, the process will allow you to dispute bills from other providers that gave you related services.

For more information about the patient-provider dispute resolution process, visit the CMS No Surprises Act website.

NYS Patient-Provider Dispute Resolution Process If You Don't Get A Good Faith Estimate

If your provider doesn't give you a good faith estimate and you feel the charge is unreasonable, you may qualify for an independent dispute resolution (IDR) through New York State by submitting an IDR application to dispute the bill. To be eligible, services must be provided by a doctor at a hospital or ambulatory surgical center and you aren't given all the required information about your care. See Information Your Doctor and Other Health Care Professionals Must Give You and Information Your Hospital Must Give You for a list of the information that must be provided to you.

Application. Complete an IDR Patient Application and send it to NYS Department of Financial Services, Consumer Assistance Unit/IDR Process, One Commerce Plaza, Albany, NY 12257.

Information Your Doctor And Other Health Care Professionals Must Give You

Your doctor and other health care professionals, including a group practice of providers, a diagnostic and treatment center, and a health center must give patients and prospective patients the following information:

- **Health Plan Networks**. The names of health plans in which your provider is in-network. This must be given to you in writing or through a website before you receive non-emergency services and verbally when you schedule an appointment.
- **Hospital Affiliations.** The hospitals that your provider is affiliated with or that could admit you. This must be given to you in writing or through a website before you receive non-emergency services and verbally when you schedule an appointment.

ıot in-network with your health plan, your provider must tell you the estimated amount your provider

- **Providers Scheduled by Your Doctor**. If your doctor schedules anesthesiology, laboratory, pathology, radiology or assistant surgeon services to be provided in your doctor's office or refers you for these services, your doctor must tell you:
  - The provider's name, if your doctor schedules a certain provider in a practice.
  - The name of the provider's practice.
  - The provider's address.
  - The provider's telephone number.
- **When Your Doctor Schedules Your Hospital Services**. If your doctor schedules any other doctors to treat you in a hospital your doctor must tell you:
  - The doctor's name.
  - The doctor's practice.
  - The doctor's address.
  - The doctor's telephone number.
  - How to determine whether the doctor is in-network with your health plan.

Information Your Hospital Must Give You

Hospitals must post on their websites:

- **Charges**. A list of their charges (or how you can get this information if the list of charges is not posted).
- **Health Plan Networks**. The health plans in which they are in-network.
- **Information About Charges Of Doctors In The Hospital**:
  - Services provided to you by doctors in the hospital are not included in the hospital's charges.
  - Doctors who provide services in the hospital may or may not be in the same health plan networks as the hospital.
  - You should ask the doctor arranging your hospital services if the doctor is in your health plan's network.
- **Doctors That Could Provide Services to You**. The name, address, and telephone number of the doctor groups that the hospital has contracted with to provide services (such as anesthesiology, pathology or radiology) and instructions how to contact these groups to determine if they are in your health plan's network.
- **Doctors Employed By The Hospital**. The name, address, and telephone number of doctors employed by the hospital to treat patients and the health care plans where they are in-network.

Hospitals must, in registration or admission materials that they give you before non-emergency hospital services:

- **Tell You To Contact Your Doctor**. Tell you to check with the doctor arranging your hospital services to determine:
  - The name, practice name, address, and telephone number of any other doctor who will be arranged by your doctor to treat you.
  - Whether doctors who are employed or contracted by the hospital for services, such as anesthesiology, pathology and radiology, are expected to treat you.
- **How to Tell If Your Doctor is In-Network With Your Health Plan**. Tell you how to find out whether doctors who are employees of the hospital (such as for anesthesiology, pathology and radiology) are in-network with your health plan.

Emergency Services - How To Protect Yourself If You Have Health Insurance Coverage Subject To NY Law (your health insurance ID card says “fully insured”)

You only have to pay your in-network cost-sharing (copayment, coinsurance, and deductible) for bills for out-of-network emergency services in a hospital.

ıospital*, and beginning in January 2022, any other providers who treat you.

ı are admitted to the hospital after your emergency room visit.

- Your provider may only bill you for your in-network cost-sharing (copayment, coinsurance, or deductible) for emergency services, including inpatient services which follow an emergency room visit.
- Let your health plan know if you receive a bill from an out-of-network provider for emergency services.
- You may also file a complaint with DFS.

Emergency Services - How To Protect Yourself If You Have Employer/Union Self-Funded Coverage (your health insurance ID card says “self-funded” or does not say “fully insured”)

The Federal No Surprises Act protections for bills for out-of-network emergency services apply if your employer or union self-funds your coverage for plans issued or renewed on and after January 1, 2022. This includes inpatient care following emergency room treatment (post-stabilization services).

You are only responsible for paying your in-network cost-sharing (copayment, coinsurance, or deductible) for emergency services.

For more information about the Federal consumer protections, visit the CMS No Surprises Act website.

For plans issued before January 1, 2022, you may qualify for an independent dispute resolution (IDR) through New York State by submitting an IDR application to dispute the bill. You will have to pay the fee for the IDR (up to $395) if your provider’s bill is upheld unless your household income is below 250% of the Federal Poverty Level. Complete an IDR Patient Application and send it to NYS Department of Financial Services, Consumer Assistance Unit/IDR Process, One Commerce Plaza, Albany, NY 12257.

Emergency Services - How To Protect Yourself If You Are Uninsured

If you are uninsured, you may file a dispute through the New York State independent dispute resolution (IDR) process if you receive a bill for emergency services in New York that you believe is excessive. You will have to pay the fee for the IDR (up to $395) if your provider’s bill is upheld unless your household income is below 250% of the Federal Poverty Level.

Complete an IDR Patient Application and send it to NYS Department of Financial Services, Consumer Assistance Unit/IDR Process, One Commerce Plaza, Albany, NY 12257.

Surprise Medical Bills - What Health Care Providers Need To Know If A Patient Has Insurance Coverage Subject To NY Law (coverage that is not self-funded)

You may only bill your patient for their in-network cost-sharing (copayment, coinsurance, or deductible) for a **Surprise Bill in a Hospital or Ambulatory Surgical Center** or for a **Surprise Bill When Your Patient Received A Referral**. Health plans must pay out-of-network providers directly for a surprise bill.

A Bill For Services In a Hospital or Ambulatory Surgical Center is a Surprise Bill If:

- Your patient receives services from an out-of-network provider* at an in-network hospital or ambulatory surgical center and: (1) an in-network provider was not available; or (2) an out-of-network provider provided services without your patient's knowledge; or (3) unforeseen medical circumstances arose at the time the health care services were provided.
- It is NOT a surprise bill when an in-network provider was available and the patient elected to obtain services from an out-of-network provider.
    - Providers must give patients all notices required under the No Surprises Act and Public Health Law regarding scheduled services.

opportunity to choose an in-network provider in advance of the services (at least 72 hours in advance ne day of the services does not give the patient a meaningful opportunity to choose an in-network provider.

- It will not be surprise bill when the patient signs the standard written notice and consent form. However, surprise bill protections will typically apply to emergency medicine, anesthesiology, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivist services (even if the patient receives written notice that you are an out-of-network provider and gives written consent.)
- It will not be a surprise bill if the out-of-network service was preauthorized in advance and the patient received notice that the service was out-of-network and other disclosures required by the Insurance Law, like the amount the health plan would pay for the service.

(*If health care services were **before** January 1, 2022, the surprise bill protections only apply to the services of out-of-network physicians (and not other health care providers) at an in-network hospital or ambulatory surgical center.)

A Bill For Services Referred By An In-Network Doctor To An Out-of-Network Provider Is A Surprise Bill If:

- Your patient did not sign a written consent acknowledging that the services would be out-of-network and would result in costs not covered by the patient's health plan AND (1) During a visit with an in-network doctor, an out-of-network provider treats the patient; or (2) The patient's in-network doctor takes a specimen from the patient in the office (for example, blood) and sends it to an out-of-network laboratory or pathologist; or (3) For any other health care services when referrals are required under the patient's plan.

Surprise Bill Certification Form. An out-of-network provider may ask their patient to sign a Surprise Bill Certification Form at the time that services are provided. An out-of-network provider must send a copy to the patient's health plan. For services at an in-network hospital or ambulatory surgical center, an out-of-network provider can sign the Surprise Bill Certification Form and send it to the health plan with the claim for dates of service on and after January 1, 2022.

Disclosure of Balance Billing Protections. Providers must make publicly available (post in the provider's public location), post on their public websites, and provide to patients, a one-page notice in clear and understandable language containing information on:

- The Federal requirements and prohibitions relating to prohibitions on balance billing for emergency services and surprise bills;
- New York requirements prohibiting balancing billing for emergency services and surprise bills; and
- Information on how to contact New York and Federal agencies in case an individual believes that a provider has violated any state or federal prohibitions on balance billing for emergency services and surprise bills.

Model Disclosure Form. NYS Department of Financial Services has a model disclosure form that providers can use that will satisfy these disclosure requirements.

Submit an Independent Dispute Resolution (IDR).

- Log onto the DFS portal to obtain a tracking number;

DFS Portal

- Complete the IDR Provider and Insurer Application; AND
- Send the application to the assigned Independent Dispute Resolution entity.

Surprise Medical Bills - What Health Care Providers Need To Know If A Patient Is Uninsured

If your patient is uninsured, a bill will be a surprise bill if: Services are provided by a doctor at a hospital or ambulatory surgical center and the patient is not given all the required information about their care. See Information Your Doctor and Other Health Care Professionals Must Give You and Information Your Hospital Must Give You for a list of the information that must be provided to patients. In such cases, your patient may dispute the amount of the bill through the New York State independent dispute resolution process.

Health Insurance

ls - What Health Care Providers Need To Know If A Patient Has Employer/Union Self-Funded Coverage

The Federal No Surprises Act protections from surprise medical bills from an out-of-network provider in an in-network hospital or ambulatory surgical center apply if your patient has employer or union self-funded coverage for plans issued or renewed on and after January 1, 2022. Your patient is only responsible for paying their in-network cost-sharing (copayment, coinsurance, or deductible) for a surprise bill.

For more information about the Federal IDR process for surprise bills visit the CMS No Surprises Act website.

For plans issued or renewed before January 1, 2022, your patient may qualify for an independent dispute resolution (IDR) through New York State by submitting an IDR application to dispute the bill. A bill will be a surprise bill if services are provided by a doctor at a hospital or ambulatory surgical center and the patient is not given all the required information about their care. See Information Your Doctor and Other Health Care Professionals Must Give You and Information Your Hospital Must Give You for a list of the information that must be provided to patients.

Emergency Services Bills - What Health Care Providers Need To Know If A Patient Has Health Insurance Coverage Subject To NY Law (not self-funded)

When You Bill A Patient. If you are an out-of-network provider that provided emergency services in a hospital, including inpatient services that follow an emergency room visit, you are prohibited from billing a patient for any amount over their in-network cost-sharing (copayment, coinsurance, or deductible).

Payment for emergency services. Health plans are required to pay out-of-network providers directly for emergency services.

Independent Dispute Resolution (IDR). Health care providers (including hospitals) that are not in a health plan's network may dispute the amount they are paid by the health plan for emergency services in a hospital, including payment for inpatient services that follow an emergency room visit, through the New York State independent dispute resolution process.

Submit an Independent Dispute Resolution (IDR).

- Log onto the DFS portal to obtain a tracking number;

DFS Portal

- Complete the IDR Provider and Insurer Application; AND
- Send the application to the assigned Independent Dispute Resolution entity.

Emergency Services Bills - What Health Care Providers Need To Know If A Patient Has Employer/Union Self-Funded Coverage

The Federal No Surprises Act protections from bills for emergency services apply if your patient has employer or union self-funded coverage for plans issued on and after January 1, 2022. Your patient is only responsible for paying their in-network cost-sharing for emergency services.

For more information about the Federal IDR process for emergency services visit the CMS No Surprises Act website.

For plans issued or renewed before January 1, 2022, your patient may qualify for an independent dispute resolution (IDR) through New York State by submitting an IDR application to dispute the bill.

Health Insurance

s Bills - What Health Care Providers Need to Know if a Patient is Uninsured

Your patient may dispute the amount of the bill through the New York State independent dispute resolution process.

Health Care Providers - How To Submit A Dispute Through The New York Independent Dispute Resolution (IDR) Process

For health care providers to start the IDR process:

- Log onto the DFS portal to obtain a tracking number;

DFS Portal

- Complete the IDR Provider and Insurer Application;
- Send the application to the assigned Independent Dispute Resolution entity.

Review Of Disputes By Independent Dispute Resolution Entity (IDRE)

IDR Entity Reviews. Disputes are reviewed by independent dispute resolution entities (IDREs). Decisions will be made by a reviewer with training and experience in health care billing and reimbursement in consultation with a licensed physician in active practice in the same or similar specialty as the physician providing the service that is the subject of the dispute.

30 Day Timeframe. The IDRE will make a determination within 30 days of receipt of the dispute. Parties to the dispute must submit all necessary information with their IDR application and immediately when contacted by the IDRE, or the information will not be considered.

IDRE Determines The Fee. For disputes involving health plans, the IDRE chooses either the out-of-network provider's bill or the health plan's payment. For disputes submitted by uninsured patients, the IDRE determines the fee.

IDRE Considers These Factors When Making a Determination:

- Whether there is a gross disparity between the fee charged by the provider and (1) fees paid to the provider for the same services provided to other patients in health care plans in which the provider is out-of-network, and (2) the fees paid by the health plan to reimburse similarly qualified out-of-network providers for the same services in the same region;
- The provider's training, education, experience, and usual charge for comparable services when the provider does not participate with the patient's health plan;
- In the case of a hospital, the teaching status, scope of services, and case mix;
- The circumstances and complexity of the case;
- Patient characteristics; and
- For physician services, the usual and customary cost of the service.

IDRE may direct a good faith negotiation for settlement. In cases when settlement is likely, or if the health plan's payment and the provider's fee are unreasonably far apart, the IDRE may direct the parties to negotiate.

Review is Binding. The review is binding but admissible in court.

Payment For Independent Dispute Resolution (IDR)

Disputes Between a Provider and a Health Plan, Involving an Insured Patient.

- Provider pays the cost of the dispute resolution when the IDRE determines that the health plan's payment is reasonable.

Health Insurance

ute resolution when the IDRE determines that the provider's fee is reasonable.

ıe prorated cost when there is a settlement.

- There may be a minimal fee to the provider or health plan submitting the dispute if the dispute is found ineligible or incomplete.

Disputes involving an Uninsured Patient.

- The provider pays the cost of the dispute resolution when the IDRE determines that the provider's fee is not reasonable.
- The patient pays the cost of the dispute resolution when the IDRE determines that provider's fee is reasonable, unless it would pose a hardship to the patient. "Hardship" means a household income below 250% of the Federal Poverty Level.

Questions About IDR

If you have questions about IDR, or need help completing an application, call (800) 342-3736 or email IDRquestions@dfs.ny.gov. Where applicable, please indicate the date(s) of service in your inquiry as different laws and processes may apply depending on when you received the services.

Questions About Becoming a Certified IDRE

For further information on how to become a certified Independent Dispute Resolution Entity ("IDRE") please visit our IDRE information page or email IDRquestions@dfs.ny.gov.

Consumer Questions and Complaints

If you are unable to find the answer to your questions here, check our FAQs. If you are still having trouble, you can file a complaint or contact us for further assistance:

CHECK OUR FAQS

FILE A COMPLAINT

CALL US

SEND US AN EMAIL

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Institutions That We Supervise

The Department of Financial Services supervises many different types of institutions. Supervision by DFS may entail chartering, licensing, registration requirements, examination, and more.

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Exhibit E

Chart Regarding Applicability of the Federal Independent Dispute Resolution Process in Bifurcated States

The **No Surprises Act** establishes a Federal Independent Dispute Resolution (IDR) process that providers, emergency facilities, and providers of air ambulance services and group health plans and health insurance issuers in the group and individual market, as well as Federal Employees Health Benefits (FEHB) carriers, may use following the end of an unsuccessful open negotiation period to determine the out-of-network (OON) payment amount for certain qualified IDR items and services, which include:

- Emergency services (including post-stabilization services);[1]
- Nonemergency items and services furnished by OON providers with respect to patient visits at certain in-network health care facilities[2], and
- Air ambulance services furnished by OON providers of air ambulance services[3]

The Federal IDR process **does not apply** to items and services payable by Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE. The Federal IDR Process also **does not apply** in instances where a specified state law (SSL) or All-Payer Model Agreement (APMA) under Section 1115A of the Social Security Act provides a method for determining the total OON amount payable under a group health plan or group or individual health insurance coverage.

The Federal IDR process **does apply** to self-insured plans sponsored by private employers, private employee organizations, or both (i.e., self-insured plans governed by the Employee Retirement Income Security Act (ERISA)) in all states, except in cases in which a self-insured plan has opted to subject itself to an SSL, as permitted under some states' laws, or if an APMA applies with respect to the plan, the nonparticipating provider or nonparticipating emergency facility, and the item or service.[4] Similarly, in all states, the Federal IDR Process **does apply** to health benefits plans offered through the FEHB Program, where an Office of Personnel Management (OPM) contract with an FEHB Carrier does not provide that an SSL will apply.

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[1] See 26 CFR 54.9816-4T(c)(2), 29 CFR 2590.716-4(c)(2), and 45 CFR 149.110(c)(2).

[2] See 26 CFR 54.9816–3T, 29 CFR 2590.716–3, and 45 CFR 149.30.

[3] See 86 CFR 36872, p 36885 (July 2021) ("Given the applicability of the [Airline Deregulation Act of 1978], the Departments are not aware of any state laws that would meet the criteria to set the out-of-network rate for nonparticipating providers of air ambulance services when providing services subject to the protections in the No Surprises Act."), https://www.federalregister.gov/d/2021-14379/p-132. The Departments note the state of Alaska's assertion that the Alaska Division of Insurance applies 3 AAC 26.110(a) to all out- of-network health care claims paid by insurance companies including to air ambulance providers as summarized in their enforcement letter: https://www.cms.gov/files/document/caa-enforcement-letters-alaska.pdf.

[4] Payment disputes with non-federal governmental plans may be subject to an SSL, either because the SSL applies broadly to non-federal governmental plans in the state or because the plan has voluntarily opted to subject itself to an SSL, as permitted under the SSL.

Currently the Federal IDR process applies for determining an OON payment amount:

- **in 28 states, the District of Columbia and four US territories for all qualified IDR items and services for all plans, issuers and FEHB carriers** subject to the No Surprises Act[5] ; and
- **in all states and the District of Columbia, for self-insured plans** sponsored by private employers, private employee organizations, or both, unless the self-insured plan voluntarily opts into an SSL where permissible by the state;
    - **there are six states that allow self- insured plans to opt into** an SSL: Georgia, Maine, Nevada, New Jersey, Virginia, and Washington. Please note that because opting into a state's process is not mandatory, any given self-insured plan in the state may or may not have opted in. In determining Federal IDR process eligibility of payment disputes involving self- insured plans in these states, certified IDR entities must ascertain whether the plan has opted into the state process. Payment disputes involving **self- insured plans in these states that have not opted into the relevant state's process are subject to the Federal IDR Process.**

In order for an SSL or APMA to determine the out-of-network rate, any such SSL or APMA must apply to:

1. the plan, issuer, or coverage involved, including where a SSL applies because the state has allowed a plan that is not otherwise subject to applicable state law an opportunity to opt in, subject to section 514 of ERISA,
2. the OON provider or OON emergency facility involved (and in the case of state out-of-network rate laws, the OON provider of air ambulance services involved), and
3. the item or service involved.

In instances where an SSL or APMA does not satisfy all these criteria, the SSL or APMA does not apply to determine the OON rate.

To view a basic chart for determining the applicability of a state or Federal IDR process, please go here.

In some 'bifurcated states', some items or services provided by OON providers, facilities or providers of air ambulance services **may be subject to the Federal IDR process, while other items and services are subject to an SSL or APMA.** There are currently 21 bifurcated states,[6] where either the state law or Federal law will apply depending on what is specified in the SSL or APMA. The chart below is a

[5] Alabama, Arizona, Arkansas, District of Columbia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Minnesota Mississippi, Montana, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, West Virginia, Wisconsin, Wyoming, American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and U. S. Virgin Islands

[6] California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Maine, Maryland, Michigan, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Texas, Virginia, and Washington

tool to assist certified IDR entities in determining whether a given payment dispute is subject to the Federal IDR process in bifurcated states. Please note that this tool does not contain all available information about SSLs or APMAs that may apply to certain items and services instead of the Federal IDR process.

The information in this chart related to SSLs and APMAs is current as of January 11, 2023 and the Departments intend to update this content periodically to capture relevant changes. The information included in the chart does not constitute legal advice, and its content should not be relied upon as a substitute for legal research and analysis sufficient to ensure the integrity of a certified IDR entity's determinations regarding the applicability of the Federal IDR process to a particular payment dispute, or as a substitute for a certified IDR entity's reasonable judgment.

For more information about these bifurcated-process states, certified IDR entities should review relevant state law (including relevant administrative or case law) and APMAs. Certified IDR entities may also consult with appropriate state authorities regarding whether an SSL, APMA, or the Federal IDR process applies to a particular payment dispute.

The state letters available here, capture the Centers for Medicare and Medicaid Service's understanding of relevant portions of the Public Health Service Act, as amended by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriation Act, 2021 . These letters also communicate whether the Federal IDR process applies in each state, and in what circumstances.

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
California	No	In California, the Federal IDR process applies to: • Emergency items and services covered by Exclusive Provider Organizations (EPOs) and Preferred Provider Organizations (PPOs) under the jurisdiction of the California Department of Insurance (CDI) • Air ambulance services furnished by OON providers	California's SSL applies to the following: • Emergency items and services by OON providers or OON facilities for all HMOs, PPOs, and EPOs under the jurisdiction of the Department of Managed Health Care (DMHC) • Nonemergency items and services by OON providers at in-network facilities for all HMOs and those PPOs and EPOs under the jurisdiction of the Department of Managed Health Care (DMHC). • Nonemergency items and services by OON providers at in-network facilities for PPOs and EPOs under California Department of Insurance (CDI) jurisdiction Note: CDI's laws apply to entities that have the term "insurance" in their name. Most health care service plans under the jurisdiction of DMHC have "of California" in their name.)	CA SSL Supplemental CA SSL Info DMHC Guidance, March 21, 2022 CA Enforcement Letter
Colorado	No	In Colorado, the Federal IDR process applies to: • Air ambulance services furnished by OON providers	Colorado's SSL applies to the following: • Emergency services by OON providers or facilities and nonemergencies, including ancillary services or treatment at in-network facilities provided by an OON provider • Post stabilization emergency services	CO SSL Supplemental CO SSL Info CO Enforcement Letter Colorado HB 1284

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
Connecticut	No	In Connecticut, the Federal IDR process applies to: • Air ambulance services furnished by OON providers	In Connecticut, the SSL applies to: • Emergency services furnished to insured individuals, regardless of whether the services are performed by an OON provider, and regardless of whether the services are furnished by an in-network or OON facility. • The Connecticut SSL also provides for a payment methodology for OON nonemergency services when either of the following occurs: 1. The services were furnished to an insured individual by an OON provider at an in-network facility when an in-network provider was not available, and the individual did not knowingly elect to obtain these services and the services were authorized by the payer; or 2. The services were furnished to an insured individual by an out-of-network provider assisting an in-network provider at an in-network facility.	CT SSL Supplemental CT SSL Info CT Enforcement Letter
Delaware	No	In Delaware, the Federal IDR process applies to: • Nonemergency items and services furnished by OON providers at in-network facilities • Air ambulance services furnished by OON providers	Delaware's SSL will apply for purposes of determining the OON rate with respect to emergency services that originated in a hospital emergency facility or comparable facility by non-network providers. Note: this includes free standing emergency facilities and OON facilities DE law does not make a distinction between providers and facilities for emergency medical conditions.	§ 3349. Emergency care (DE) § 3565. Emergency care (DE) Supplemental DE SSL Info DE Enforcement Letter

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
Florida	No	In Florida, the Federal IDR process applies to: Emergency items and services and non-emergency items and services furnished by OON providers at in-network facilities for disputes involving "Health plans" as defined by F.S. 408.7057(1)(b), which include Health Maintenance Organizations (HMOs) and Prepaid Health Clinics (PHCs) authorized under F.S. 409.912, Exclusive Provider Organizations (EPOs) certified under F.S. 627.6472, and major medical expense health insurance policies, as defined in F.S. 627.643(2)(e), offered by a group or individual market health insurer, including Preferred Provider Organization (PPOs) defined in F.S. 627.6471, for the following: 1. Hospital Inpatient services: Single claims with a value below $10,000, or batched claims with an aggregate value below $10,000 (this value threshold is not applicable to services provided by rural hospitals as defined by F.S. 395.602(2)(e)) 2. Hospital Outpatient services: Single or batched claims with a value below $3,000 (value threshold not applicable to services provided by rural hospitals) 3. Professional services: Single or batched claims with a value below $500 In Florida, the Federal IDR process also applies to air ambulance services by OON providers.	Florida SSL will apply to the following: Emergency items and services, and non-emergency items and services by OON providers at in-network facilities, including free-standing emergency facilities for claim disputes involving HMOs, PHCs, EPOs, PHPs, PPOs related to the following payment threshold amounts: 1. Hospital Inpatient Claims (contracted providers) $25,000 2. Hospital Inpatient Claims (non-contracted providers) $10,000 3. Hospital Outpatient Claims (contracted providers) $10,000 4. Hospital Outpatient Claims (non-contracted providers) $3,000 5. Physicians $500 6. Rural Hospitals None 7. Other Providers None Claims for less than the minimum amounts listed above for each type of service are ineligible	FL SSL Supplemental FL SSL FL Enforcement Letter

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
Georgia	Yes	In Georgia, the Federal IDR process applies to: • Air ambulance services furnished by OON providers	Georgia's SSL applies to: • Emergency items and services by OON providers and at OON emergency facilities • Nonemergency items and services furnished by OON providers at in-network facilities	GA SSL GA Multiple Employer Self-Insured Health Plans GA SSL Self-Funded Plan Opt In [Updated Enforcement Letter will be available soon]

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
Illinois	No	In Illinois, the Federal IDR process applies to: • Air ambulance services furnished by OON providers	Illinois' SSL applies to covered services received at a participating health care facility from an OON provider that are: a. Ancillary services, b. Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time the item or service is furnished, or c. Items or services received when the facility or the OON provider fails to satisfy the notice and consent criteria specified under Section 356z.3a. Illinois' SSL applies to: • Emergency items and services by OON providers and at OON emergency facilities, including independent emergency facilities • Nonemergency items and services furnished by OON providers at in-network facilities • Effective July 1, 2022, items and services furnished by an HMO plan	IL SSL Supplemental IL SSL Info IL Enforcement Letter
Maine	Yes	In Maine, the Federal IDR process applies to: • Air ambulance services furnished by OON providers	Maine's SSL applies to the following: • Emergency items and services by OON providers and non-emergency items and services by OON providers at in-network facilities.	Maine SSL.1 Additional Maine SSL Info [ME Enforcement letter will be available soon.]

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
Maryland	No	In Maryland, the Federal IDR process applies to: • Emergency and nonemergency items and services furnished by OON providers (who are not hospital based or on call if they don't accept assignments of benefits for EPO and PPO enrollees) at in-network health care facilities • Air Ambulance services furnished by OON providers	Maryland's APMA determines the OON rate for claims for emergency and nonemergency items and services involving HMO, PPO or EPO plans governed by Maryland law, or hospital-based or on-call physicians paid directly by a PPO or EPO (assignment of benefits).	MD SSL.1-HMO MD SSL.2-PPO MD Enforcement Letter

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
Michigan	No	In Michigan, the Federal IDR process applies to: • Any emergency items furnished at in-network and OON facilities by OON providers • Any eligible nonemergency items furnished by OON providers at in-network facilities • Emergency services furnished by OON providers who are dentists and nurse aids, whether they are or are not licensed, registered, or otherwise authorized in MI • Nonemergency services furnished by OON dentists and nurse aids, whether they are or are not licensed, registered, or otherwise authorized in MI at in-network facilities • Non-emergency services furnished by an OON provider with respect to a visit at an in-network health care facility, but where the provider is not physically located at the facility, in accordance with the NSA's definition of "visit" • Air Ambulance services furnished by OON providers	Michigan's SSL will apply for purposes of determining the OON rate for services involving plans, issuers, or coverage subject to state insurance regulation (insurers, including HMOs) that are as follows: • Pre-stabilization emergency services • Post-stabilization emergency services at independent freestanding emergency departments, emergency department of a hospital, and at hospitals • Furnished by OON providers licensed, registered, or otherwise authorized to engage in a health profession in MI (excluding dentists and nurse aids) • Non-emergency services furnished by an OON provider with respect to a visit at an in-network health care facility if the provider is physically located at the facility, if MI disclosure was not provided or patient does not have ability or opportunity to choose an in-network provider (excluding dentists or nurse aids) • Self-funded plans maintained by State of Michigan or local government for employees Note: Under MCL 333.24504(4), "Provider" means an individual who is licensed, registered, or otherwise authorized to engage in a health profession under article 15, but does not include a dentist licensed under part 166.	MI SSL Section 333.24507 MI SSL Section 333.24509 MI Surprise Medical Billing Information for Providers, Carriers [Updated MI Enforcement Letter will be available soon.]

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
Missouri	No	In Missouri, the Federal IDR process applies to: • Emergency services at OON facilities • Nonemergency items and services furnished by OON providers at in-network health care facilities • Air ambulance services furnished by OON providers	Missouri's SSL will apply for purposes of determining the OON rate with respect to: • Unanticipated OON emergency care furnished to individuals by OON health care professionals at an in-network facility per Section 376.690, Missouri Revised Statute (RSMo): "health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged."	MO SSL Supplemental MO SSL Info MO Enforcement Letter
Nebraska	No	In Nebraska, the Federal IDR process applies to: • Post-stabilization emergency services furnished by OON providers or facilities • Nonemergency services from out-of-network providers at in-network facilities • Air ambulance services furnished by OON providers	Nebraska's SSL will apply for determining the OON rate with respect to emergency services only up to stabilization furnished by OON health care providers at in-network emergency facilities.	NE SSL Supplemental NE SSL Info NE Enforcement Letter

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
Nevada	Yes	In Nevada, the Federal IDR process applies to: • Emergency items and services at critical access hospitals • Post emergency medical treatment after 24 hours • Nonemergency items and services by OON providers at in network health care facilities • Air ambulance services furnished by OON providers	Nevada SSL will apply to determine the OON rate for: • Emergency services provided by an OON facility or an OON provider at an in-network facility, except for critical access hospitals. • Nevada law provides predetermined payment amounts to OON providers and facilities that provide emergency services that vary depending on the length of a previously existing contract between the provider or facility with the plan/issuer and how a contract may have been terminated (a specified predetermined rate if the contract was within the 24 months immediately preceding the date on which the medically necessary emergency services were rendered and another predetermined rate there was a contract within the 12 months preceding the service.)	NV SSL Additional NV SSL Info Supplemental NV SSL Info NV Enforcement Letter
New Hampshire	No	In New Hampshire, the Federal IDR process applies to: • Emergency items and services furnished at out-of-network facilities, including claims at free-standing emergency departments, for non-managed care plans • Items and services furnished by an OON provider at an in-network facility which are not related to anesthesiology, radiology, emergency medicine, and pathology services for emergency and non-emergency items and services • Air Ambulance services furnished by OON providers	New Hampshire's SSL applies to out-of-network anesthesiologists, pathologists, radiologists, and emergency physicians and prohibits balance billing when care was provided at an in-network hospital or in-network ambulatory surgical center.	NH SSL Supplemental NH SSL Info NH Enforcement Letter

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
New Jersey	Yes	In New Jersey, the Federal IDR process applies to: • Air ambulance services furnished by OON providers	New Jersey's SSL applies for purposes of determining the OON rate with respect to OON services rendered on an inadvertent and/or emergency or urgent basis to individuals covered under a health benefits plan issued in New Jersey, including emergency items and services at free standing emergency facilities.	NJ SSL Supplemental NJ SSL Info N.J.A.C. 11:4-56, Self-Funded Multiple Employer Welfare Arrangements NJ Enforcement Letter
New Mexico	No	In New Mexico, the Federal IDR process applies to: • Air ambulance services furnished by OON providers	New Mexico's SSL applies when a covered person receives an emergency health care service at an OON facility or receives non-emergent care from an OON provider at an in-network facility. This broadly applies to nonemergency care rendered by an OON provider when: 1. the covered person at an in-network facility does not have the ability or opportunity to choose an in-network provider who is available to provide the covered services; or 2. medically necessary care is unavailable within a health benefits plan's network; provided that "medical necessity" shall be determined by a covered person's provider in conjunction with the covered person's health benefits plan and health insurance carrier. Note: The limitation on charges for non-emergency care is described in Section 59A-57A-4 NMSA 1978.	NM SSL Supplemental NM SSL Info NM Enforcement Letter

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
New York	No	In New York, the Federal IDR process applies to: • Air ambulance services furnished by OON providers	New York's SSL applies to treatment by an out-of-network provider at an in-network hospital or ambulatory surgical center. Additionally, consumers with HMO coverage are protected from surprise bills when an in-network doctor refers them to an OON provider. New York's SSL also applies to emergency services in hospitals, including inpatient care following emergency room treatment, as well as emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. New York's law also applies to non-emergency services by an out-of-network provider at an in-network facility or ambulatory surgical center.	NY SSL Supplemental NY SSL Info NY Insurance Circular Letter NY Enforcement Letter

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
Ohio	No	In Ohio, the Federal IDR process applies to: • Emergency services and nonemergency items and services furnished by OON providers at in-network facilities only for claims which are less than $750. • Air ambulance services furnished by OON providers	Ohio's SSL applies to the following: • **Emergency services** provided at OON health care facilities and emergency services provided by an OON-network health care provider at in-network facilities, including free standing emergency facilities, if the emergency services are "unanticipated out-of-network care" as defined at Revised Code 3902.50(L) and subject to R.C. 3922.01., including self-funded multiple employer welfare arrangement and non-federal governmental health plans. • **Nonemergency** services by an OON network provider at an in-network facility if the nonemergency services are "unanticipated out-of-network care" as defined at Revised Code 3902.50(L). Note: "Unanticipated out-of-network care" per R.C. 3902.50(L) means health care services, including clinical laboratory services, that are covered under a health benefit plan and that are provided by an out-of-network provider when either of the following conditions applies: 1. The covered person did not have the ability to request such services from an in- network provider; or 2. The services provided were emergency services.	OH SSL Types of OH health plans OH Enforcement Letter

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
Texas	No	In Texas, the Federal IDR process applies to: • Non-federal governmental plans that are not subject to Texas' balance billing laws, which may include plans for employees of state universities, and school districts that have opted out of participation in the Teacher Retirement System health plan. • Air ambulance services furnished by OON providers	Texas law will apply for purposes of determining the OON rate for state regulated PPO, EPO, and HMO plans, as well as Employee Retirement System/Teacher Retirement System and Texas Farm Bureau plans for the following: • Emergency care and post-stabilization services provided by an OON provider at an in-network hospital emergency room or a licensed free-standing emergency room • Emergency services and post-stabilization services at OON facilities • OON diagnostic imaging or laboratory services that were performed in connection with in-network emergency care, (whether in-network or OON facility) • Nonemergency services provided by an OON facility-based provider in an in-network facility	TX SSL Texas Administrative Code TX OON Claim Dispute Resolution Supplemental TX SSL Info TX Enforcement Letter

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
Virginia	Yes	In Virginia, the Federal IDR process applies to: • Emergency items and services furnished at an independent freestanding emergency facility • Post-stabilization emergency services • Nonemergency items and services that do not involve surgical or ancillary services furnished by OON providers at in-network health care facilities • Air ambulance services furnished by OON providers	Virginia's SSL applies to items and services for a Virginia-issued fully-insured policy, a state employee health plan or other self-funded group health plan that has opted in to Virginia's balance billing protections In Virginia, protected services are: • Emergency covered services received at either an in-network or out-of-network hospital, not including post-stabilization services received at an out-of-network hospital • Nonemergency covered surgical or ancillary services received at an in-network facility Note: Surgical or ancillary services means any professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services. "Facility" means an institution providing health care related services or a health setting, including hospital or other licensed inpatient center; ambulatory surgical or treatment center; skilled nursing center; residential treatment center; diagnostic, lab, or imaging center; rehabilitation and other therapeutic health setting.	VA SSL Additional VA SSL Application of Surprise Billing Laws: Comparison Chart Federal and Virginia SSL Supplemental VA SSL Info Search Virginia's list of elective group health plans VA Enforcement Letter

State	Available Self-insured (ERISA) Opt-In?	Information on Scope of Federal IDR Process (This describes items and services to which the Federal IDR process applies for claims involving an insured group plan, Federal Employees Health Benefits (FEHB) program plan, or group or individual health insurance coverage in states with an SSL or APMA)	Information on Specified State Law (SSL) or All-Payer Model Agreement (APMA)	Resources
Washington	Yes	In Washington, the Federal IDR process applies to: • Air ambulance services furnished by OON providers	In Washington, until July 1, 2023 or a later date determined by the Commissioner, Washington's SSL applies to: • Emergency services, up to the point of stabilization, including those from behavioral health emergency services providers, regardless of the network status of a hospital or provider and without prior authorization. • Non-emergency health care services performed by OON providers at in-network facilities. Note: Emergency services encompass screening, stabilization, and post-stabilization services, including observation, or an inpatient and outpatient stay with respect to the visit during which screening and stabilization services were provided. Behavioral health emergency services providers include, in addition to a hospital emergency department, mobile crisis response teams, crisis triage and stabilization facilities, evaluation and treatment facilities, agencies certified by the state to provide outpatient crisis services and medical withdrawal management services.	WA SSL Supplemental WA SSL Info Contact WA with your self-funded group health plan opt-in questions Washington Enforcement Letter