Nos. 24-20051 & 24-20204

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

Guardian Flight, L.L.C.,
Plaintiff–Appellee,
v.
Medical Evaluators of Texas ASO, LLC,
Defendant–Appellant.

Guardian Flight, L.L.C.; REACH Air Medical Services, L.L.C.; CALSTAR Air Medical Services, L.L.C.,
Plaintiffs–Appellants,
v.
Aetna Health, Inc.; Kaiser Foundation Health Plan, Inc.,
Defendants–Appellees.

On Appeal from the United States District Court for the Southern District of Texas
District Court Nos. 4:22-CV-03805 & 4:22-CV-03979

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF APPELLEES IN NO. 24-20204

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CERTIFICATE OF INTERESTED PARTIES

Guardian Flight, L.L.C. v. Med. Evaluators of Texas ASO, L.L.C., No. 24-20051
Guardian Flight, L.L.C., et al., v. Aetna Health, Inc., *et al.*, No. 24-20204

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

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Under Federal Rules of Appellate Procedure 26.1 and 29(a)(4)(A), America's Health Insurance Plans, Inc. states that it has no parent corporation and that no publicly held corporation owns 10% or more of its stock.

s/Hyland Hunt
Hyland Hunt

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STATEMENT OF INTEREST OF *AMICUS CURIAE*[1]

America's Health Insurance Plans, Inc. (AHIP) is the national trade association representing the health insurance community. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. AHIP's members have extensive experience working with nearly all health care stakeholders to ensure that patients have affordable access to needed medical services and treatments. That experience gives AHIP broad first-hand knowledge and a deep understanding of how the nation's health care and health insurance systems work.

AHIP's members strive to reach agreements with health care providers to offer consumers affordable networks that provide choices in the delivery of quality medical care. When unable to secure network agreements before treatment is rendered, health plans seek to negotiate reasonable out-of-network payments to prevent surprise medical bills and reduce costs for patients. But before the No Surprises Act, some providers—particularly air ambulance providers such as Appellants here—often leveraged their refusal to participate in networks to send

[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than *amicus*, its members, or its counsel made a monetary contribution intended to fund the brief's preparation or submission. All parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a)(2), (4).

patients excessive surprise bills and extract payments well above typical market rates.

Congress, after significant debate, ultimately arrived at a bipartisan solution in the No Surprises Act to protect consumers from out-of-network payment disputes and surprise bills. The Act does this by barring providers from billing patients for the balance of their out-of-network charges and encouraging health plans and providers to resolve out-of-network payments through negotiation. If disputes persist, Congress established Independent Dispute Resolution (IDR) as a streamlined baseball-style or final offer arbitration process. Congress intended IDR to promptly and conclusively resolve payment disputes in what were supposed to be rare instances where the parties do not agree on fair payment rates.

AHIP agrees with Appellee health plans' legal arguments that the district court properly dismissed Appellant air ambulance providers' complaints seeking judicial review of final IDR arbitral awards. Air ambulance providers' generic allegations fall far short of what is necessary to plausibly allege a basis for vacating an IDR determination under the exceedingly narrow grounds permitted by the No Surprises Act and its incorporation of Federal Arbitration Act standards. AHIP writes separately to explain how accepting the air ambulance providers' limitless conception of judicial review under the Act would undercut the efficiency and finality that the Act's procedures are designed to achieve. This would ultimately

harm consumers by driving up administrative and health care costs that Congress intended to constrain.

INTRODUCTION AND SUMMARY OF ARGUMENT

The No Surprises Act addressed the urgent need to protect Americans from surprise medical bills and spiraling out-of-network costs, particularly for medical specialties where patients lack the opportunity to choose their provider (and therefore could not select a provider who had agreed to rates in advance). The need to protect patients from surprise billing was particularly acute for air ambulance services. Sky-high and ever-escalating air ambulance charges resulted from a broadly written federal statute that preempted state efforts to address unconstrained pricing, a business model based on refusing to join networks, and an influx of private equity investment. Before the Act, when air ambulances could send surprise bills to patients, health plans routinely faced pressure to pay exorbitant air ambulance charges—completely divorced from the cost to provide the service or reasonable market rates negotiated *ex ante*—and did so to protect patients from what would otherwise be astronomical surprise bills. Although paying the charges protected individual patients from medical bills running to tens of thousands of dollars, all Americans paid for unconstrained air ambulance charges in the form of higher premiums.

Congress shielded Americans from this market dysfunction by prohibiting

surprise bills and establishing IDR as a streamlined process for resolving out-of-network payments when a reasonable payment was declined or negotiations were unproductive. Central to Congress's solution is the Qualifying Payment Amount (QPA), which reflects a health insurer's median negotiated rate for a given service in the local area. The QPA is central to various aspects of the Act. Not only must IDR entities consider the QPA when choosing one of two offers to conclusively resolve the out-of-network payment amount, but the QPA also often determines the amount of a patient's cost-sharing. Congress contemplated an agency-led complaint process to address QPA issues, together with agency audits of QPA calculations for accuracy and compliance.

Congress nowhere authorized individual IDR entities to recalculate—case-by-case—the QPAs that Congress required them to consider as inputs. IDR entities must consider the QPA as a given, and may not re-examine it, because re-examination would duplicate the agencies' audit function and risk uncertainty and confusion caused by multiple disparate QPA (re-)calculations in scores of separate decisions. Instead, IDR entities are meant to take the accuracy of the QPA as a fixed point, which facilitates a simple, speedy, and final process for choosing between two offers.

Interpreting the Act to permit judicial review and vacatur of ostensibly final IDR determinations based on conclusory allegations that the QPA was erroneous,

misrepresented, or insufficiently transparent cannot be squared with the Act's text, structure, or purpose. As Appellee health plans explain, air ambulance providers' interpretation of the Act would wrongly convert exceptionally circumscribed judicial review criteria into truck-sized loopholes. *See* Aetna Answer Br. 35; Kaiser Answer Br. 28-33. The statute that Congress wrote allows only limited federal baseball-style arbitration in IDR, with extremely circumscribed judicial review; it is not an open invitation to federal court.

Besides being legally untenable, the air ambulance providers' anything-goes pitch for judicial review is disastrous from a practical standpoint. In the Act's first years, concentrated exploitation of IDR by a few firms that profited most from surprise billing before the Act—including air ambulance providers—has resulted in unexpectedly high IDR volume. Although the Act is largely working as Congress intended to protect patients from surprise medical bills and encourage voluntary dispute resolution for large swathes of medical care, a small number of private-equity-funded firms have generated outsized IDR volume, and have been successful at using the IDR process to obtain payments that often exceed even historical out-of-network payments. Based on preliminary analysis, this dynamic appears likely to drive up health care costs for all Americans.

Interpreting the Act to condone judicial re-opening of IDR determinations by accepting conclusory allegations of QPA challenges—*i.e.*, failure to disclose some

QPA detail or assertions that the QPA is too low compared to the market—dressed up as "misrepresentation," "undue means," or "fraud" claims would make the situation even worse. It would contravene congressional design, and substitute laborious, costly, and frequent litigation for the speedy, low-cost, and rare arbitral decision-making that Congress intended. Americans would pay the price in unnecessary administrative costs—the exact opposite of Congress's central goal of protecting patients from unpredictable, inflated medical costs.

ARGUMENT

I. The No Surprises Act Aims To Remedy Market Dysfunction Where Patients Cannot Choose Providers—A Particular Concern For Air Ambulances.

For most medical services, rates are set in advance through negotiation between health plans and health care providers. Health plans typically work together with providers to offer networks that provide Americans access to affordable, high-quality care. *See* AHIP, *Charges Billed by Out-of-Network Providers: Implications for Affordability*, 3 (Sept. 2015), https://tinyurl.com/3k8mfr98. Networks benefit patients, providers, health plan sponsors like employers, and the overall health care system by reducing costs, promoting access to and utilization of care, and providing high-quality choices for enrollees. *See* AHIP, *Provider Networks*, https://tinyurl.com/2p94p4xz. The goal is to achieve the highest value for patients, considering factors such as quality of care, breadth of choice, and legal requirements

for network adequacy, along with cost. *See* Gary Claxton et al., *Employer strategies to reduce health costs and improve quality through network configuration*, Peterson-KFF Health Sys. Tracker (Sept. 25, 2019), https://tinyurl.com/ydzxn6ux; Nat'l Conf. of State Legislatures, *Health Insurance Network Adequacy Requirements* (Apr. 27, 2023), https://tinyurl.com/sy4cz9hw. The resulting contracts limit the provider to the payment amount the provider has agreed to accept from the plan and prohibit surprise bills to patients. *See* 86 Fed. Reg. 36,872, 36,874 (July 13, 2021).

Out-of-network providers, in contrast, often charge higher rates, and before the Act, sometimes sent patients surprise bills for any part of their unilaterally set billed charge that was not paid by the patient's health plan. *Id*. By leveraging the threat to "balance bill" patients, such providers were often able to obtain significantly higher payments than other medical specialties. *See id.*; Zack Cooper et al., *Out-Of-Network Billing and Negotiated Payments for Hospital-Based Physicians*, 39 Health Affairs 24, 26, 29 (Jan. 2020), https://tinyurl.com/bddeyrfj (finding average rates for specialties that could balance bill were over three times Medicare rates, compared to one and a half times Medicare rates for specialties unable to balance bill).

Before the Act, air ambulance services were an extreme—but significant—example of this skewed market dynamic, resulting in exorbitant surprise bills for patients and higher health care costs for all Americans with health insurance.

"[A]voidance of insurance network participation combined with aggressive collection" was "a business strategy of some providers of air ambulance services" before the Act. 86 Fed. Reg. at 36,923. Under that business model, air ambulance providers extracted payments from commercially insured patients well above costs. *Cf.* U.S. Gov't Accountability Office, GAO-17-637, *Air Ambulance: Data Collection & Transparency Needed to Enhance DOT Oversight*, at 14 (2017), https://tinyurl.com/h5mybwz (majority of air ambulance revenue from commercially insured patients who comprise a minority of transports).

In addition, private equity firms invested heavily in air ambulance providers, drawn by the ability to aggressively raise prices in part because of a pre-Act regulatory vacuum.[2] Loren Adler et al., *High air ambulance charges concentrated in private equity-owned carriers*, Brookings Inst. (Oct. 13, 2020), https://tinyurl.com/3dbyn523. Charges soared, nearly tripling over ten years. Erin C. Fuse Brown et al., *The Unfinished Business of Air Ambulance Bills*, Health Affairs Forefront (Mar. 26, 2021), https://tinyurl.com/yxbzfpb7.

Because air ambulance charges were so exorbitant, health plans "place[d] a high value on preventing enrollee surprise bills." *Id*. To help protect their beneficiaries from surprise bills and debt collection suits, health plans often agreed

[2] Air ambulance billing practices are protected from state regulation by the Airline Deregulation Act. *See, e.g., Air Evac Ems v. Sullivan*, 8 F.4th 346, 349 (5th Cir. 2021).

to pay air ambulance providers' full billed charges. *See* 86 Fed. Reg. at 36,923. As the expert agencies implementing the No Surprises Act recognized, such pre-Act payments to air ambulance providers do not "reflect[] market rates under typical contract negotiations," *id.* at 36,889, but instead result from threats to balance bill a patient for an often excessive amount. The upshot of those inflated payments was higher premiums for everyone who purchased health coverage, not just air ambulance patients.

The Act remedied this acute market dysfunction by taking several steps to protect patients from unpredictable and out-of-control out-of-network costs, including for air ambulance services. First, unless state law provides otherwise—or cost-sharing is a flat co-pay amount—the Act sets patients' cost-sharing based on the QPA, which is generally the health plan's median in-network contract rate for the same service in the same area.[3] Providers are prohibited from balance billing patients for the rest of their charges.[4] Second, the Act establishes IDR as a streamlined arbitration process to conclusively resolve the amount to be paid for out-of-network services and provides that IDR entities "shall consider" the QPA when making payment decisions.[5] Permitting bare allegations of misrepresented QPAs or nondisclosure of QPA mechanics to open the door to judicial review of IDR

[3] 42 U.S.C. § 300gg-111(a)(1)(C)(iii), (a)(3)(E), (b)(1)(B).
[4] *Id*. §§ 300gg-131, 300gg-132, 300gg-135.
[5] *Id.* § 300gg-112(b)(5)(C)(i).

determinations would undermine both aspects of the Act.

II. Permitting Judicial Review Based On Conclusory Allegations Of Misrepresentation Or Partiality Would Contravene Congressional Design And Harm Consumers.

A. Congress Designed IDR to Be a Rarely Used, Efficient Process to Conclusively Resolve Payment Disputes.

To stop the practice of providers hounding patients to collect on surprise bills (and the resulting crushing medical debt), the Act created a new streamlined arbitration process for medical providers and health plans to resolve the amounts to be paid for covered out-of-network services, protecting patients from any payment disputes. In setting up the IDR process, Congress "devised an expert and inexpensive method for dealing with a class of questions … particularly suited" to arbitral resolution. *Stern v. Marshall*, 564 U.S. 462, 494 (2011) (citation omitted).

While this new IDR arbitration system creates administrative costs that do not exist in some state systems that resolve out-of-network payments without resort to arbitration, Congress took great care to minimize those costs by designing the process around three key features: settlement focus, efficiency, and finality. *See* Jack Hoadley & Kevin Lucia, *Are Surprise Billing Payments Likely to Lead to Inflation in Health Spending?*, Commonwealth Fund (Apr. 26, 2021), https://tinyurl.com/w8mu5mve (describing how four states' surprise billing laws rely solely on payment standards, without arbitration).

1. Congress designed IDR to encourage voluntary settlement.

For starters, the Act encourages prompt, voluntary resolution of out-of-network payment disputes within a few months of a claim. Health plans must pay or deny claims within 30 days of receiving a sufficiently documented claim, followed by up to 30 days for either party to initiate a 30-day open negotiations period.[6] Health plans are not limited to the QPA when paying a claim; they may allow more or less on the claim, based on the plan terms and a reasonable market rate for the service.[7] If the parties still cannot agree, then one may initiate IDR, but only if it does so within 4 days.[8] Even after IDR is initiated, however, the parties may continue negotiations and settle at any time before the IDR entity makes a decision.[9] If there is no settlement, the certified IDR entity must then select one of the two offers submitted by the parties.[10]

These features, often called "baseball-style" arbitration due to the historical association with Major League Baseball salary disputes, have long been recognized as reducing costs by encouraging settlement. *See* Jeff Monhait, *Baseball Arbitration: An ADR Success*, 4 J. Sports & Ent. L. 105, 131 (2013) ("[T]he system lowers costs

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[6] 42 U.S.C. § 300gg-112(a)(3), (b)(1)(A) (governing air ambulance claims); *see also id.* § 300gg-111(c) (materially same process for medical providers).
[7] *See id.*; *see Glossary*, Healthcare.gov, https://tinyurl.com/2yr8k3vp (defining "allowed amount").
[8] 42 U.S.C. § 300gg-112(b)(1)(B).
[9] *Id.* § 300gg-112(b)(2)(B).
[10] *Id.* § 300gg-112(b)(5)(A)(i).

by encouraging the parties to negotiate reasonably, and it incentivizes settlement prior to a hearing."). "In nearly every sector that has been studied, … the presence of a [baseball-style arbitration] clause often leads to a negotiated settlement prior to the need for a hearing." Erin Gleason & Edna Sussman, *Final Offer/Baseball Arbitration: The History, The Practice, and Future Design*, 37 Alt. to High Costs Litigation, Jan. 2019, at 8, 9. Baseball-style arbitration is so effective at encouraging settlement because parties tend to "propose reasonable offers which will be closer to each other." Rodrigo Barradas & Jorge Vazquez, *Baseball Arbitration as a Suitable Alternative for Construction and Real Estate Disputes*, 40 J. Int'l Arbitration 211, 215 (2023). Unlike more open-ended arbitration, where the arbitrator might be expected to split the difference, parties in baseball-style arbitration have incentives to land on a more reasonable final offer, "discouraging any exaggeration." *Id*.

2. IDR is intended to be quick and low-cost.

If the parties do not settle, Congress crafted IDR to be an expeditious yet well-informed process to arrive at an expert payment decision, not a drawn-out enterprise. IDR entities must have "sufficient medical, legal, and other expertise and sufficient staffing to make determinations ... on a timely basis."[11] To ensure timeliness, the Act requires parties to submit offers within 10 days, and the IDR entity to choose one of

[11] 42 U.S.C. § 300gg-111(c)(4)(A)(i).

the offers within 30 days.[12] The IDR entity "shall consider"—not examine, much less recalculate—the submitted QPA (*i.e.*, the median network rate) when making its choice, and select the offer that "best represents the value of the … item or service."[13]

Cost-effectiveness and speed are key features of the IDR process, as they are with baseball-style arbitration generally. *See* Barradas & Vazquez, *supra*, at 218 (finding baseball arbitration "simplifies the process" and is a "time-cost efficient solution ... to achieve a final decision"). Congress intended that IDR be efficient and minimize costs. *E.g.,* 42 U.S.C. § 300gg-111(c)(3)(A) (requiring the Departments to permit batching to "encourag[e] … efficiency (including minimizing costs) of the IDR process"). All told, IDR should resolve payment disputes within about four months of a claim. Unfortunately, the system has yet to live up to its promise, largely due to the overwhelming volume of claims initiated by a tiny minority of providers and further stymied by repeated provider-initiated litigation. *See* pp. 17-20, *infra*.

3. IDR is meant to be conclusive.

Congress intended that payment disputes would be conclusively resolved by a well-informed, streamlined IDR process. IDR results "shall not be subject to judicial review" except in the four constrained circumstances of the Federal

[12] *Id.* § 300gg-112(b)(5)(A)-(B).
[13] *Id.* § 42 U.S.C. § 300gg-112(b)(5)(C)(i)(I); 45 C.F.R. § 149.510(c)(4)(ii)(A); *id.* § 149.520(b)(1) (generally applying § 149.510 to air ambulance determinations).

Arbitration Act,[14] which are "extraordinarily narrow." *YPF S.A. v. Apache Overseas, Inc*., 924 F.3d 815, 819 (5th Cir. 2019). Moreover, IDR decisions preclude further IDR proceedings between the same parties about the same service for 90 days.[15]

Considering IDR design as a whole, "the congressional goal of promoting efficient dispute resolution" is clear. *See Commodity Futures Trading Comm'n v. Schor*, 478 U.S. 833, 837 (1986) (describing Congress's purpose in adopting administrative dispute system in lieu of litigation). As designed, IDR offers all the benefits of arbitration: "lower costs, greater efficiency and speed, and the ability to choose expert adjudicators to resolve specialized disputes." *Stolt-Nielsen S.A. v. AnimalFeeds Int'l Corp*., 559 U.S. 662, 685 (2010). Congress's choice of baseball-style arbitration—a particularly efficient process that is now used in a host of different commercial and government contexts, Gleason & Sussman, *supra*, at 10—is essential to reducing IDR administrative costs.

If implemented as designed, the Act will "minimize reliance on the … IDR process and encourage parties to submit reasonable offers." 86 Fed. Reg. 55,980, 56,053 (Oct. 7, 2021). Over time, strict adherence to IDR's statutory guardrails will benefit consumers and taxpayers by making health care more affordable for everyone.

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[14] 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II).
[15] *Id.* § 300gg-111(c)(5)(E)(ii).

B. Undermining the Finality of IDR Determinations Would Vitiate Congress's Cost-Effective Process, Especially Given High IDR Volume.

1. Judicial review based on conclusory QPA-misrepresentation allegations would defeat the timeliness and finality of IDR.

The benefits of arbitration generally depend upon finality, and IDR is no different. The "primary purpose served by the arbitration process is expeditious dispute resolution." *Univ. of Notre Dame (USA) in England v. TJAC Waterloo, LLC*, 49 F.4th 13, 21 (1st Cir. 2022). "Arbitration loses some of its luster, though, when one party refuses to abide by the outcome and the courts are called in after all." *Id.*; *see Positive Software Solutions, Inc. v. New Century Mortg. Corp*., 476 F.3d 278, 285 (5th Cir. 2007) (en banc) (declining to adopt standard for vacatur of arbitral awards that "would seriously jeopardize the finality of arbitration").

For this reason, the Federal Arbitration Act's limited grounds for vacating an arbitration award—incorporated by reference into the No Surprises Act—"substantiat[e] a national policy favoring arbitration with just the limited review needed to maintain arbitration's essential virtue of resolving disputes straightaway." *Hall St. Assocs., L.L.C. v. Mattel, Inc.*, 552 U.S. 576, 588 (2008). Any other approach would "open[] the door to the full-bore legal and evidentiary appeals that can rende[r] informal arbitration merely a prelude to a more cumbersome and time-consuming judicial review process, and bring arbitration theory to grief in postarbitration process." *Id.* (citations omitted; second alteration in original).

Appellant air ambulance providers' theory of judicial review for any bare allegation of QPA-related "misrepresentation," failure to disclose some QPA detail, or legal error would invite just such post-arbitration grief and interfere with the carefully reticulated process that Congress designed to maximize efficiency. If each IDR can be converted into a court case on nothing more than allegations that a QPA was, in the air ambulance provider's view, "improbably low as compared with market data," Air Ambulance Br. 13; a health plan "refused to explain" how the QPA was calculated, *id.*; or a QPA was misrepresented, *id.* at 14-15, IDR determinations would no longer be final or binding as Congress intended. Instead, IDR would become nothing more than a way station en route to protracted litigation.

Final payment determinations would also inevitably be delayed under air ambulance providers' approach—if the system did not break down altogether. Whenever a dissatisfied provider in search of higher payment runs to court, Congress's intended few-month process could be extended by a year or more. *See* Admin. Office of U.S. Courts, *Civil Judicial Business* (2023), Table C-5, https://tinyurl.com/4wu9nya5 (median time of 16.3 months from filing to disposition for cases filed in district court and resolved after motion to dismiss stage but before trial stage).

What's more, lawsuits against the arbitrators themselves—whom air ambulance providers have included here, as well as in their many cookie-cutter suits

proceeding across the country, *see* Kaiser Answer Br. 20—are likely to discourage an already limited pool of qualified entities from serving as certified IDR entities or from issuing IDR decisions involving frequent litigants. It is increasingly clear that any pall cast by such suits would only operate to delay IDR decisions across the board, and risks bringing the processing of IDR claims for certain types of services and providers to a screeching halt.

2. High IDR volume makes it even more crucial to preserve Congress's judicial-review boundaries.

Evidence from the Act's implementation confirms the importance of ensuring that IDR works as Congress intended—quickly, cost-effectively, and conclusively. For patients—and for most health care providers—the Act has been working to protect patients from surprise bills and to encourage voluntary settlements around a QPA that reflects reasonable market rates. Throughout 2023, the Act protected patients from receiving surprise medical bills that otherwise could have resulted from about 13.5 million claims. AHIP & Blue Cross Blue Shield Ass'n (BCBSA), *No Surprises Act Continues to Prevent More than 1 Million Surprise Bills Per Month, While Provider Networks Grow* (Jan. 2024), http://tinyurl.com/4majdzam (finding more than 10 million claims were subject to the Act's protections between January 1 and September 30, 2023).

Per AHIP/BCBSA research, for more than three-quarters of items or services covered by the Act and not subject to state dispute resolution processes, initial

payments for those services—generally centering around the QPA, but not limited to it—were accepted without any dispute. *See id.* Of the 24% that enter open negotiations, nearly three in four (73%) are resolved by settlement. *Id.* Thus, fewer than 7% of out-of-network claims subject to the Act even enter IDR, *id.*, and many of those are withdrawn or settle before the IDR entity issues a payment determination, Ctrs. for Medicare & Medicaid Servs., *Supplemental Background on the Federal IDR PUF*, *July 1 – December 31, 2023*, at 2-3 (June 13, 2024), https://tinyurl.com/36b2963j ("IDR Update").

Though about 7% of claims entering IDR may seem small, it is still far more than Congress intended, and large enough to generate substantial costs—costs which would only escalate exponentially if litigation costs were to be routinely incurred. Over 489,000 IDR proceedings were initiated between mid-April 2022 and June 2023, nearly fourteen times the disputes projected for the first year. 88 Fed. Reg. 75,744, 75,753 (Nov. 3, 2023). And the volume is accelerating. More than 390,000 disputes were initiated in the second half of 2023, 35% more than the first half of the year. IDR Update, *supra*, at 2.

Closer examination of that volume reveals concentrated exploitation of the IDR system by a handful of investment-backed provider firms. Just four "[l]arge investor-backed provider groups … have accounted for a large and disproportionate share of [non-air-ambulance] IDR cases," covering nearly three-quarters of disputed

services in the first half of 2023. Matthew Fiedler & Loren Adler, *A first look at outcomes under the No Surprises Act arbitration process*, fig. 1, Brookings Inst. (Mar. 27, 2024), https://tinyurl.com/ub6hutwb. That trend continued throughout 2023, IDR Update, *supra*, at 2 (top three initiating parties accounted for approximately 58% of disputes).

Air ambulance volume was similarly driven by a few investment-backed companies, with just three firms (out of more than 60) generating over 80% of IDR proceedings in 2023. Ctrs. for Medicare & Medicaid Servs., *Federal IDR Supplemental Tables for 2023 Q1 through Q4*, tbls. 10 (Feb. 15 and June 13, 2024), https://tinyurl.com/49x3j7p9 ("2023 Tables"); Ctrs. for Medicare & Medicaid Servs., *Partial Report on the [IDR] Process: October 1 – December 31, 2022*, at 25 (Apr. 27, 2023), https://tinyurl.com/mrx7sk66. Global Medical Response, parent corporation to all three plaintiffs here, initiated IDR most frequently, filing between 43% and 53% of disputes in each quarter of 2023. 2023 Tables, *supra*.

Contrary to the narrative that IDR does not provide an "adequate process" for medical providers, *see* Opening Br. 47-53, recent data strongly suggests that the process results in higher provider compensation. An analysis of IDR results for medical services in the first half of 2023 (which did not cover air ambulance data) indicates median IDR decisions exceed historical mean out-of-network payments for some services, are often more than double median in-network rates, and are nearly

four times (or more) the rate that Medicare would pay for the same service. Fiedler & Adler, *First look*, at fig. 1. And those payment rates have only increased since then. Matthew Fiedler & Loren Adler, *Outcomes under the No Surprises Act arbitration process: A brief update*, Brookings Inst. (July 31, 2024), https://tinyurl.com/7t4febpw.

A handful of providers thus expend extensive resources to leverage the IDR process, and this effort by a contentious few has caused the IDR system to buckle under the strain. Consider that by the end of 2023, there was a 72-day median time to resolve disputes (despite a 30-day statutory deadline) and a backlog of about 360,000 IDR cases. 2023 Tables, *supra* (analysis of "Length of Time to Make Determination" in public use files); IDR Update, *supra,* at 2-3 (stating number of disputes initiated and closed in 2023). Flinging open the courthouse doors to make it ever easier to challenge IDR determinations will only make this already unsustainable dynamic worse, harming the millions of patients and tens of thousands of medical providers for whom the Act is working to promote quick, voluntary, and reasonable resolution of payment disputes.

3. The excessive and unwarranted costs generated by undermining IDR finality will be borne by consumers.

Although IDR is streamlined and cost-effective, it is not cost-free. Understanding that IDR would generate some administrative costs, Congress designed the Act to minimize those costs and expected they would be offset by

savings generated by aligning payments for out-of-network services with reasonable, negotiated market rates. *See* Cong. Budget Off. (CBO), *Cost Estimate: H.R. 2328, Reauthorizing and Extending America's Community Health Act*, at 9 (Sept. 2019), https://tinyurl.com/mryj3nmb (describing how predecessor bill would "create new administrative costs for insurers" but "net effect of all th[e] changes would be lower insurance premiums").

But unconstrained IDR proceedings appear to be driving payments higher, not lower. *See* Fiedler & Adler, *Brief update, supra*; Hoadley & Lucia, *supra* ("[I]f early results persist, CBO's estimated premium trend reduction may not be achieved."). Moreover, if contrary to statutory design, providers can also effectively sue whenever they are dissatisfied, it would cause administrative costs to skyrocket, and the savings Congress intended to secure would evaporate.

At high volume, IDR proceedings are costly. Both parties must pay an administrative fee (now $115), and the losing party must pay IDR fees that can reach $840 for a single item, or up to nearly $1,200 or more for a batched claim with a substantial number of items. 88 Fed. Reg. 88,494, 88,523 (Dec. 21, 2023). There are also substantial IDR-related staffing and technology expenses.

Yet these already high administrative costs pale in comparison to the costs to litigate the validity of IDR decisions every time a medical provider claimed that QPA amounts were "improbably low" or that a health plan (allegedly) failed to make

some required QPA disclosure. *See* Opening Br. 13. Litigation costs would almost certainly be orders of magnitude higher than IDR costs alone.

The upshot would be increased health care costs for all Americans. This wasteful spending—not contemplated (much less authorized) by Congress—directly harms consumers who purchase insurance and indirectly harms taxpayers by increasing expenditures for premium tax credits. *See* 86 Fed. Reg. at 56,059. Because health plans are subject to premium rate reviews by state or federal regulators, *e.g.*, 42 U.S.C. § 300gg-94, and some plans must be designed to cover a certain percentage of costs, *e.g.*, 42 U.S.C. § 18022(d), when costs go up, some mix of premiums, deductibles, and cost-sharing must go up, too.

Given this regulatory obligation, all Americans would ultimately bear the increased costs caused by vitiating the safeguards that keep IDR comparatively inexpensive and efficient. This outcome cannot be squared with either the Act's purpose to protect consumers from high out-of-network costs, or the broader legal, commercial, and regulatory imperatives for health plans to limit the amount spent on administrative costs. *See, e.g.*, 42 U.S.C. § 300gg-18(b).

C. Judicial Review Directing QPA Recalculation Would Undermine the Act's QPA Lynchpin.

The atextual theory that judicial review can be obtained by alleging failure to make QPA-related disclosures or a misrepresented QPA—based on nothing more than disagreement about market rates or a health plan paying more than the QPA,

see Opening Br. 38-42—not only undercuts IDR finality, but damages the Act's wider structure and operation. As the agencies implementing the Act have made clear, IDR entities themselves are not permitted to recalculate the QPA. 87 Fed. Reg. 52,618, 52,627 & n.31 (Aug. 26, 2022). Instead, IDR "payment determinations … should center on a determination of a total payment amount … based on the facts and circumstances of the dispute at issue, rather than an examination of a plan's or issuer's QPA methodology." *Id.* at 52,626.

IDR entities cannot, and should not, look behind a given QPA not only because there is no statutory text authorizing them to do anything but "consider" an already-set QPA, but also because the "statute places the responsibility for monitoring the accuracy of plans' and issuers' QPA calculation methodologies with the Departments (and applicable state authorities) by requiring audits." *Id.*

Congress tasked the governing agencies with maintaining such tight oversight of the QPA because it serves as a lynchpin of the Act, providing a key input for several statutory functions, well beyond the bounds of any individual IDR decision. First, the QPA often establishes the amount owed in patient cost sharing, enhancing the predictability of out-of-pocket costs.[16] Second, the QPA "as defined" by the Act is a mandatory IDR consideration in every case.[17] Finally, the Act requires IDR

[16] 42 U.S.C. § 300gg-111(a)(1)(C)(iii), (b)(1)(B).
[17] *Id*. § 300gg-111(c)(5)(C)(i)(I).

offers and results to be reported as percentages of the QPA.[18] If instead, each IDR proceeding could recalculate the QPA, a single pull of the thread could unravel the important role Congress intended the QPA to serve throughout the Act.

Permitting courts to re-examine QPA calculations as a basis for vacating IDR decisions—when IDR entities cannot, should not, and are not equipped to themselves recalculate the QPA—is *a fortiori* destructive to the QPA's role as a lodestar. As Appellee health plans explain, the bare allegation of a QPA misstatement provides no warrant for reopening IDR determinations on judicial review under either a "fraud" theory or Appellants' new argument about a distinct legal cause of action for QPA misrepresentations. Kaiser Answer Br. 33-58; Aetna Answer Br. 27-35. And accepting Appellants' invitation to impermissibly rewrite the statute in this way would frustrate Congress's considered choice to assign across-the-board QPA monitoring compliance to expert agencies—not a patchwork of IDR decisions, much less court rulings.

Given the QPA's role in cost-sharing, allowing a court to reopen the calculation of the QPA—or to require an IDR entity to do so—after the consumer already paid a cost-share based on an agency-audited QPA would also (re)introduce just the type of risk and uncertainty for consumers that the No Surprises Act was intended to address. Case-by-case QPA recalculations would also yield a host of

[18] *Id.* § 300gg-111(c)(7)(A)(v), (B)(iii)-(iv).

questions for implementing the reporting provisions that depend on the QPA, like: which QPA should be used for reporting results? The statutorily defined one, calculated by health insurers, used to establish patient cost-sharing, and audited by the Departments? Or the one generated by a court (or many conflicting courts) reviewing an IDR decision? What should a health insurer do if the Departments' audit confirms a QPA is accurately stated, but a court decision says otherwise? The statute stops these questions from arising, because it provides that the agency is the exclusive authority over matters related to the accuracy of the QPA, which neither IDR entities nor courts may recalculate.

In lieu of piecemeal review of IDR decisions through unauthorized judicial re-examination, Congress assigned QPA monitoring and compliance to an express statutory complaint and audit procedure. If an air ambulance provider believes a QPA asserted in IDR was erroneous or misrepresented, it may file a complaint with the Department of Health and Human Services. *See* 42 U.S.C. § 300gg-111(a)(2)(B)(iv). The Department has set up a portal for that purpose, *see No Surprises Provider Complaint Form*, https://tinyurl.com/5n8htspa. The Department and other regulators may audit QPA calculations based on complaints, and the Act requires them to do so on a random sampling basis. *See* 42 U.S.C. § 300gg-111(a)(2), (a)(3)(E). Such audits are now underway, and the Departments have projected spending about 10% of their entire 2024 IDR-administration budget on QPA audits

initiated by provider complaints (not counting expenses for random audits). *See* 88 Fed. Reg. at 88,504-05.

There is no evidence the Department is failing to respond to any provider's QPA-related complaints. Allowing courts to perform the audit function that Congress assigned to the Departments and other regulators (including state authorities) is contrary to the plain language of the statute and risks undermining oversight efforts already underway. *See* 87 Fed. Reg. at 52,627 & n.31; Ctrs. for Medicare & Medicaid Servs., *Report to Congress: 2022 and 2023 [QPA] Audits*, at 3 (Apr. 2024), https://tinyurl.com/mrj47nuv (23 audits initiated since June 2022). It also risks interference with the Department's carefully calibrated corrective actions. *See* Opening Br. 40 n.14 (objecting to how the Department resolved a recent audit).

Interpreting the Act to permit courts to vacate IDR determinations on allegations that health plans misrepresented the QPA to IDR entities would contravene Congress's choice to delegate questions about QPA accuracy to expert administrative judgement, while only creating risk and uncertainty for consumer cost-sharing and other purposes. The No Surprises Act was meant to solve such problems, not create them. Unwanted uncertainty can be avoided by following Congress's vision of preserving the regulatory audit process as the guarantor of QPA compliance, not case-by-case reconsideration in the courts.

CONCLUSION

The judgment dismissing claims against the health plan defendants should be affirmed.

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Respectfully submitted,

s/Hyland Hunt

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CERTIFICATE OF COMPLIANCE

The foregoing brief is in 14-point Times New Roman proportional font and contains 5,907 words, and thus complies with the type-volume limitation set forth in Rules 29(a)(5) and 32(a)(7)(B) of the Federal Rules of Appellate Procedure.

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October 14, 2024

CERTIFICATE OF SERVICE

I hereby certify that on October 14, 2024, I served the foregoing brief upon all counsel of record by filing a copy of the document with the Clerk through the Court's electronic docketing system.

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