UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

AMERICAN SOCIETY OF ANESTHESIOLOGISTS, *et al.*, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:21-cv-06823 Honorable Marvin E. Aspen

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Pursuant to Rule 56(a) of the Federal Rules of Civil Procedure and Rule 56.1 of this Court, Plaintiffs, the American Society of Anesthesiologists, *et al.* ("Plaintiffs"), hereby move for summary judgement on the grounds that there are no disputed issues of material facts, and the Plaintiffs are entitled to judgement as a matter of law. In support of their motion, Plaintiffs rely upon the accompanying statement of material facts not in dispute, the supporting memorandum of law, and the Declarations of Jennifer Raley, MD; Christopher E. Young, MD; and Lauren Golding, MD.

Defendants, the United States Department of Health and Human Services, *et al.* ("Defendants" or "Departments"), unlawfully promulgated provisions of an interim final rule, Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021) ("IFR"), that are contrary to the No Surprises Act ("Act") and are procedurally invalid. No Surprises Act, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 2757-890 (2020). The Act generally prohibits group health plans and group and individual health insurance coverage (collectively, "insurers")

from charging patients more for receiving certain services outside the insurer's contracted network than for services received within the insurer's network. 42 U.S.C. § 300gg-111(a)(1)(C)(ii), (b)(1)(A); 29 U.S.C. § 1185e(a)(1)(C)(ii), (b)(1)(A); 26 U.S.C. § 9816(a)(1)(C)(ii), (b)(1)(A). The Act also contains consumer protections against balance billing—in which an out-of-network providers bills patients for amounts not paid by the insurer—under certain circumstances. 42 U.S.C. §§ 300gg-131(a)(1)-(2), 300gg-132(a)-(d).

To ensure fair reimbursement for non-emergency items or services provided by an out-of-network provider at an in-network health care facility and emergency services provided by an out-of-network provider or an out-of-network emergency facility, the Act also mandates an independent dispute resolution ("IDR") process to resolve payment disputes between insurers and out-of-network providers/emergency facilities if there is no applicable All-Payer Model Agreement under section 1115A of the Social Security Act or specified state law. 42 U.S.C. § 300gg-111(c)(1)(B); 29 U.S.C. § 1185e(c)(1)(B); 26 U.S.C. § 9816(c)(1)(B). The Act identifies eight factors that the IDR entity "shall consider" when determining the payment amount. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). One of these factors is the "qualifying payment amount" ("QPA"), which is the median of the contracted rates recognized by the insurer for the same or similar item or service provided within the same or similar specialty and geographic area, increased by inflation. 42 U.S.C. § 300gg-111(a)(3)(E)(i), (c)(5)(C)(i)(I); 29 U.S.C. § 1185e(a)(3)(E)(i), (c)(5)(C)(i)(I); 26 U.S.C. § 9816(a)(3)(E)(i), (c)(5)(C)(i)(I).

Defendants' IFR improperly requires the IDR entity to select the payment "offer closest to the qualifying payment amount unless the certified IDR entity determines that credible information submitted by either party … clearly demonstrates that the qualifying payment

amount is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the qualifying payment amount but in opposing directions." Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. at 56,104, 56,116, 56,128. As explained in the attached memorandum of law, these provisions of the Departments' IFR must be vacated because they are contrary to the Act, they were promulgated in excess of statutory authority, and they are substantively and procedurally invalid under the Administrative Procedure Act, 5 U.S.C. §§ 553(b)-(d), 706(2)(A), (C)-(D).

Respectfully submitted,

/s/ Ronald S. Connelly
Ronald S. Connelly (D.C. Bar No. 488298)*
Leela Baggett (D.C. Bar No. 1030000)*
POWERS PYLES SUTTER & VERVILLE, PC
1501 M Street, N.W.
Seventh Floor
Washington, DC 20005
tel. (202) 872-6762
fax (202) 785-1756
Ron.Connelly@PowersLaw.com
Leela.Baggett@PowersLaw.com

/s/ Jeremy Lewin
Jeremy Lewin (Ill. Bar No. 6269242)
POWERS PYLES SUTTER & VERVILLE, PC
1061 American Lane
Schaumburg, IL 60173
tel. (202) 349-4284
fax (202) 785-1756
Jeremy.Lewin@PowersLaw.com

Attorneys for Plaintiffs

* *admitted pro hac vice*

Dated: February 9, 2022

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

AMERICAN SOCIETY OF ANESTHESIOLOGISTS, *et al.*, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:21-cv-06823 Honorable Marvin E. Aspen

MEMORANDUM OF LAW IN SUPPORT OF
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Federal Registers

Other Authorities

INTRODUCTION

Plaintiffs, American Society of Anesthesiologists, *et al.* ("Plaintiffs") challenge specific provisions of an interim final rule ("IFR") jointly published by the United States Department of Health and Human Services, *et al.* ("Defendants" or "Departments"), which unlawfully tie the hands of a statutorily mandated independent arbitrator—referred to as an independent dispute resolution ("IDR") entity—in determining the appropriate reimbursement for certain health care items and services furnished by a provider or emergency facility that is not within the network of the insurer. Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980, 56,104, 56,116, 56,128 (Oct. 7, 2021) [hereinafter "IFR"]. Congress required the IDR entity to consider eight factors when determining the payment amount, but the Departments instead set one factor—the insurer's in-network rate—as presumptive. The IFR's presumption in favor of insurers' in-network rates will empower private health insurers to drive down reimbursement, imperiling providers, emergency facilities, and their patients. These provisions of the IFR violate the plain language of the No Surprises Act, exceed the Departments' authority granted by Congress, thwart the purpose of the statute, are inconsistent with the legislative history of the No Surprises Act, and were promulgated in violation of the Administrative Procedure Act ("APA").

The No Surprises Act establishes a process to determine fair payment for certain out-of-network health care items and services provided to participants, beneficiaries, and enrollees (collectively, "patients") in group health plans and group and individual health insurance coverage (collectively, "insurers"). No Surprises Act, Pub. L. No. 116-260, 134 Stat. 1182 (2020).[1] Congress took a balanced approach to setting the amount of payment for such out-of-

[1] The No Surprises Act amends provisions of the Public Health Service Act, the Employee Retirement Income Security Act, the Internal Revenue Code, and the Federal Employees Health Benefits Act. Plaintiffs' Local Rule 56.1(a)(2) Statement of Material Facts Not in Dispute ¶ 12

network items or services, ensuring that payment determinations would not inherently favor insurers over health care providers/facilities. 42 U.S.C. § 300gg-111(c)(5); 29 U.S.C. § 1185e(c)(5); 26 U.S.C. § 9816(c)(5). To this end, Congress enumerated specific factors—known as Subparagraph C Factors—that the IDR entity "shall consider" when identifying the appropriate reimbursement amount for items or services furnished out-of-network: 1) the insurer's in-network rate, known as the qualifying payment amount ("QPA"); 2) the provider's or facility's training, experience, and quality and outcomes measurements; 3) the market share held by the provider or facility and insurer; 4) the acuity and complexity of the care; 5) the provider's or facility's teaching status, case mix, and scope of services; 6) the good-faith efforts of the provider or facility and insurer to contract in-network rates; 7) information requested by the IDR entity relating to the party's offer; and 8) any additional information submitted by a party relating to such offer of either party. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). Congress purposely avoided giving presumptive weight to any one factor—particularly the QPA, which would tip the scales during the IDR process in favor of insurers because the QPA is tied to the insurer's median in-network rates.

Plaintiffs, the American Society of Anesthesiologists, the American College of Emergency Physicians, and the American College of Radiology, strongly support Congress's reforms in the No Surprises Act. The Departments, however, have turned Congress's reforms upside down and transformed an act intended to protect patients and their doctors into a giveaway to private insurers that will harm patients and providers/facilities. Despite Congress's clear mandate that the IDR entity "shall consider" and balance all Subparagraph C Factors, the

---

[hereinafter "Material Facts"]. The Federal Employees Health Benefits Act, as amended by the No Surprises Act, cross references the requirements described in 42 U.S.C. § 300gg-111, 29 U.S.C. § 1185e, and 26 U.S.C. § 9816 (as applicable). 5 U.S.C. § 8902(p); Material Facts ¶ 12.

Departments established a standard for determining payment that *forbids* the IDR entity from considering the non-QPA Subparagraph C Factors "unless credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, or unless the offers are equally distant from the QPA but in opposing directions." IFR, 86 Fed. Reg. at 55,999; Material Facts ¶ 15. The IFR's rebuttable presumption in favor of the QPA is thus contrary to the plain language of the No Surprises Act. The Departments exceeded the authority granted to them pursuant to the No Surprises Act in promulgating this flawed policy. This presumption in favor of the QPA and the "evidentiary standard" needed to rebut the Departments' presumption contravene the statutory text and unlawfully abrogate the discretion afforded to the IDR entity, heavily tilting IDR decisions in favor of insurers.

The IFR's rebuttable presumption undermines the purpose of the No Surprises Act, making the *independent* dispute resolution entity anything but independent. In fact, the Departments' interpretation of the No Surprises Act has already empowered insurers to reduce in-network contracted rates and threaten existing contractual arrangements with providers. *See* Declaration of Dr. Raley, Exhibit 1; Declaration of Dr. Golding, Exhibit 2.

The Departments' stated reasons for the rebuttable presumption fail to excuse their violation of the unambiguous language of the No Surprises Act. Thus, the Departments' rebuttable presumption must be invalidated under *Chevron* step one as contrary to the unambiguous statute. Furthermore, even if the statute were ambiguous, the Departments' interpretation is unreasonable and owed no deference under *Chevron* step two because the Departments' construction of the statute is unreasonable, and the IFR's rebuttable presumption is contrary to congressional intent. This Court should also not accord *Chevron* deference because

the Departments circumvented notice-and-comment rulemaking in promulgating the rebuttable presumption and failed to demonstrate "good cause" for doing so.

Therefore, the Plaintiffs ask the Court to "hold unlawful and set aside" the Departments' rebuttable presumption in favor of the QPA because it is agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;" "without observance of procedure required by law;" and "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. §§ 702, 706(2), (A), (C)-(D).

BACKGROUND

I. Reimbursement for Out-of-Network Services

Many insurers create networks of health care providers in which the insurer negotiates rates with providers for particular services as a condition of including the providers in the insurer's network. *See* Ryan J. Rosso et al., Cong. Rsch. Serv., R46856, Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services 2 (2021) [hereinafter "CRS Report"]; Material Facts ¶ 9.[2] In general, insurers reimburse "in-network" providers a contracted, in-network rate for the provision of a covered item or service. CRS Report at 2; Material Facts ¶ 9. When patients receive care from an in-network provider, the patient will be responsible for a cost-sharing amount. CRS Report at 2; Material Facts ¶ 9. The patient's out-of-pocket obligation, however, will typically be less for in-network services than if the patient received care from a provider outside the insurer's network. CRS Report at 2; Material Facts ¶ 9. An in-network provider generally does not charge the patient the difference between the provider's charges and the negotiated, in-network rate. CRS Report at 2; Material Facts ¶ 9.

[2] https://crsreports.congress.gov/product/pdf/R/R46856.

If the patient receives care from a provider who does not have a network agreement with the insurer, the patient's insurer will reimburse the provider at the insurer's out-of-network rate, which is not negotiated in advance by the provider and the insurer. CRS Report at 3-4; Material Facts ¶ 10. Prior to the enactment of the No Surprises Act, the difference between the provider's charge and the insurer's out-of-network payment could be billed by the provider to the patient unless prohibited under state law.[3] CRS Report at 4-5; Material Facts ¶ 10. This practice is commonly referred to as "balance billing." CRS Report at 4-5; Material Facts ¶ 10. Similarly, "surprise billing" occurs when the patient unknowingly receives items or services from an out-of-network provider at an in-network healthcare facility or receives emergency care provided out-of-network, and the patient is billed for cost-sharing amounts that are not paid by the insurer and are higher than if the patient received care at an in-network provider. CRS Report at 1; Material Facts ¶ 11. Over the years, "surprise billing" has become more common due to insurers offering inadequate in-network rates to emergency and other ancillary service providers, including anesthesiologists and radiologists, forcing these providers to stay out-of-network.

II. The No Surprises Act

On December 27, 2020, the President signed into law the No Surprises Act as part of the Consolidated Appropriations Act, 2021. Material Facts ¶ 12. The No Surprises Act addresses the interrelated problems of surprise billing and inadequate reimbursement by insurers for out-of-network services. The No Surprises Act establishes a comprehensive framework to protect patients from surprise medical bills and to determine fair payment for non-emergency items or services provided by an out-of-network provider at an in-network health care facility and

[3] Generally, in states that prohibit balance billing, the provider accepts the insurer's payment for out-of-network services as payment in full, even if the payment falls well below the provider's charge.

emergency services provided by an out-of-network provider or an out-of-network emergency facility. No Surprises Act, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 2757-890 (2020) (codified at 42 U.S.C. §§ 300gg-111, 300gg-131 to 132; 29 U.S.C. § 1185e; 26 U.S.C. § 9816). An out-of-network emergency facility is statutorily defined as "an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship" with the insurer for providing such item or service under the plan or coverage. 42 U.S.C. § 300gg-111(a)(3)(F)(i); 29 U.S.C. § 1185e(a)(3)(F)(i); 26 U.S.C. § 9816(a)(3)(F)(i). The No Surprises Act defines a "health care facility" as (1) a hospital, (2) a hospital outpatient department, (3) a critical access hospital, (4) an ambulatory surgical center, and (5) any other facility specified by the Departments. 42 U.S.C. § 300gg-111(b)(2)(A)(ii); 29 U.S.C. § 1185e(b)(2)(A)(ii); 26 U.S.C. § 9816(b)(2)(A)(ii).

A. Reforms to Patient Cost-Sharing

The No Surprises Act prohibits insurers from imposing a cost-sharing requirement for such items or services that is greater than the amount that would apply if these items or services were provided in-network.[4] 42 U.S.C. § 300gg-111(a)(1)(C)(ii), (b)(1)(A); 29 U.S.C. § 1185e(a)(1)(C)(ii), (b)(1)(A); 26 U.S.C. § 9816(a)(1)(C)(ii), (b)(1)(A). The No Surprises Act mandates that insurers use the "recognized amount" when calculating the cost-sharing requirement. 42 U.S.C. § 300gg-111(a)(1)(C)(iii), (b)(1)(B); 29 U.S.C. § 1185e(a)(1)(C)(iii), (b)(1)(B); 26 U.S.C. § 9816(a)(1)(C)(iii), (b)(1)(B). "Recognized amount" is defined in the No Surprises Act as (1) the amount that the state approves under the applicable All-Payer Model Agreement under section 1115A of the Social Security Act, (2) the amount determined in

[4] The No Surprises Act provides an exception to this prohibition for non-emergency items and services if certain notice and consent criteria are satisfied. 42 U.S.C. § 300gg-111(b)(1)(A); 42 U.S.C. § 300gg-132(d); 29 U.S.C. § 1185e(b)(1)(A); 26 U.S.C. § 9816(b)(1)(A).

accordance with the "specified state law" (as defined in 42 U.S.C. § 300gg-111(a)(3)(I), 29 U.S.C. § 1185e(a)(3)(I), and 26 U.S.C. § 9816(a)(3)(I)) if there is no applicable All-Payer Model Agreement under section 1115A of the Social Security Act, or (3) the amount that is the QPA for the item or service if there is no "specified state law" or applicable All-Payer Model Agreement under section 1115A of the Social Security Act.[5] 42 U.S.C. § 300gg-111(a)(3)(H); 29 U.S.C. § 1185e(a)(3)(H); 26 U.S.C. § 9816(a)(3)(H). The QPA is generally defined in statute as the "median of the contracted rates recognized by the [insurer] … for the same or a similar item or service that is provided by a provider in the same or similar specialty and … geographic region … increased by the percentage increase in the consumer price index for all urban consumers." 42 U.S.C. § 300gg-111(a)(3)(E)(i); 29 U.S.C. § 1185e(a)(3)(E)(i); 26 U.S.C. § 9816(a)(3)(E)(i).

B. Reforms to Out-of-Network Reimbursement

The No Surprises Act mandates that insurers reimburse out-of-network providers/facilities an "out-of-network rate," minus the cost-sharing requirement of the patient. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(II), (b)(1)(D); 29 U.S.C. § 1185e(a)(1)(C)(iv)(II), (b)(1)(D); 26 U.S.C. § 9816(a)(1)(C)(iv)(II), (b)(1)(D). The "out-of-network rate" is determined by the applicable All-Payer Model Agreement under section 1115A of the Social Security Act, or if no such agreement exists, the "specified state law." 42 U.S.C. § 300gg-111(a)(3)(K)(i), (iii); 29 U.S.C. § 1185e(a)(3)(K)(i), (iii); 26 U.S.C. § 9816(a)(3)(K)(i), (iii). If there is no "specified state law" or applicable All-Payer Model Agreement under section 1115A of the Social Security Act, Congress permits insurers to determine the initial out-of-network reimbursement amount

[5] Section 1115A of the Social Security Act authorizes the Department of Health and Human Services, via its Centers for Medicare and Medicaid Services, to allow "States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals [i.e., individuals eligible for both Medicare and Medicaid]." 42 U.S.C. § 1315a(b)(2)(B)(xi).

and to send the provider/facility the initial payment, or a notice of denial of payment, not later than 30 calendar days after the insurer receives the bill of the provider or facility. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I), (b)(1)(C), (a)(3)(K)(ii); 29 U.S.C. § 1185e(a)(1)(C)(iv)(I), (b)(1)(C), (a)(3)(K)(ii); 26 U.S.C. § 9816(a)(1)(C)(iv)(I), (b)(1)(C), (a)(3)(K)(ii).

If the provider/facility disagrees with the insurer's initial payment determination, the provider/facility can initiate a 30-day open negotiation with the insurer to determine the amount of payment for the out-of-network item or service. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I), (a)(3)(K)(ii), (c)(1)(A); 29 U.S.C. § 1185e(a)(1)(C)(iv)(I), (a)(3)(K)(ii), (c)(1)(A); 26 U.S.C. § 9816(a)(1)(C)(iv)(I), (a)(3)(K)(ii), (c)(1)(A). If parties cannot agree on the amount for the out-of-network item or service, either party may initiate the IDR process within four days after the open negotiation period. 42 U.S.C. § 300gg-111(c)(1)(B); 29 U.S.C. § 1185e(c)(1)(B); 26 U.S.C. § 9816(c)(1)(B).

The parties then have three business days to jointly select an IDR entity. 42 U.S.C. § 300gg-111(c)(4)(F)(i); 29 U.S.C. § 1185e(c)(4)(F)(i); 26 U.S.C. § 9816(c)(4)(F)(i). If the parties cannot agree on an IDR entity, the Departments will select an IDR entity for them. 42 U.S.C. § 300gg-111(c)(4)(F)(ii); 29 U.S.C. § 1185e(c)(4)(F)(ii); 26 U.S.C. § 9816(c)(4)(F)(ii). Within ten days of the IDR entity's selection, the provider/facility and insurer must each submit to the IDR entity an offer for a payment amount and information requested by the IDR entity relating to the offer. 42 U.S.C. § 300gg-111(c)(5)(B)(i); 29 U.S.C. § 1185e(c)(5)(B)(i); 26 U.S.C. § 9816(c)(5)(B)(i). The provider/facility and insurer also may submit to the IDR entity any additional information relating to the initial offers submitted by either party. 42 U.S.C. § 300gg-111(c)(5)(B)(ii); 29 U.S.C. § 1185e(c)(5)(B)(ii); 26 U.S.C. § 9816(c)(5)(B)(ii).

Within thirty days of its selection, the IDR entity "shall … tak[e] into account the considerations specified in subparagraph (C)" (the Subparagraph C Factors) and "select one of the offers submitted" by the parties as the amount of payment for the item or service provided out-of-network. 42 U.S.C. § 300gg-111(c)(5)(A)(i); 29 U.S.C. § 1185e(c)(5)(A)(i); 26 U.S.C. § 9816(c)(5)(A)(i). Subparagraph C lists the factors that the IDR entity "shall consider" in its determination:

> (I) the qualifying payment amounts … for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and
>
> (II) … information on any circumstance described in clause (ii), such information as requested [by the IDR entity relating to the party's offer], and any additional information [submitted by a party relating to such offer of either party].

42 U.S.C. § 300gg-111(c)(5)(C)(i)(I)-(II), (c)(5)(B)(i)(II), (c)(5)(B)(ii); 29 U.S.C. § 1185e(c)(5)(C)(i)(I)-(II), (c)(5)(B)(i)(II), (c)(5)(B)(ii); 26 U.S.C. § 9816(c)(5)(C)(i)(I)-(II), (c)(5)(B)(i)(II), (c)(5)(B)(ii). In "clause (ii)," referenced in subclause (II) above, Congress enumerates five additional factors that the IDR entity "shall consider":

> (I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service ….
>
> (II) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.
>
> (III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.
>
> (IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.
>
> (V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the

> provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

42 U.S.C. § 300gg-111(c)(5)(C)(ii); 29 U.S.C. § 1185e(c)(5)(C)(ii); 26 U.S.C. § 9816(c)(5)(C)(ii).

In subparagraph D, Congress also delineates specific factors that the IDR entity "shall not consider" (the "Subparagraph D Factors"). These factors include usual and customary charges; the reimbursement rate for such items and services payable by a public payer (*e.g.,* Medicare, Medicaid, the Children's Health Insurance Program, TRICARE, United States Department of Veterans Affairs); or the amount that the out-of-network provider/facility would have billed for the item or service had the No Surprises Act not applied. 42 U.S.C. § 300gg-111(c)(5)(D); 29 U.S.C. § 1185e(c)(5)(D); 26 U.S.C. § 9816(c)(5)(D).

If the parties agree on a payment amount before the IDR entity makes its final payment determination, the agreed upon amount will constitute the out-of-network rate. 42 U.S.C. § 300gg-111(a)(3)(K)(ii), (c)(2)(B); 29 U.S.C. § 1185e(a)(3)(K)(ii), (c)(2)(B); 26 U.S.C. § 9816(a)(3)(K)(ii), (c)(2)(B). Otherwise, the decision of the IDR entity will be "binding … in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim." 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I); 29 U.S.C. § 1185e(c)(5)(E)(i)(I); 26 U.S.C. § 9816(c)(5)(E)(i)(I).

Further, Congress directed the Departments to establish a process to certify (and recertify) IDR entities to ensure that the IDR entity acts as an independent arbiter. 42 U.S.C. § 300gg-111(c)(4)(A); 29 U.S.C. § 1185e(c)(4)(A); 26 U.S.C. § 9816(c)(4)(A). Specifically, the Departments' certification process must ensure, among other things, that the IDR entity is not an insurer, a provider/facility, or an affiliate or subsidiary of a professional or trade association of such insurers, providers, or facilities; and does not carry out a payment determination if it (1) has

a "material familial, financial, or professional relationship" with a party to such determination; (2) is a party themselves or an employee or agent of a party with respect to the determination; or (3) otherwise has a conflict of interest with such a party. 42 U.S.C. § 300gg-111(c)(4)(A)(ii), (vi), (c)(4)(F)(i)(I)-(III); 29 U.S.C. § 1185e(c)(4)(A)(ii), (vi), (c)(4)(F)(i)(I)-(III); 26 U.S.C. § 9816(c)(4)(A)(ii), (vi), (c)(4)(F)(i)(I)-(III). The IDR entity must also have "sufficient medical, legal, and other expertise and sufficient staffing to make [payment] determinations." 42 U.S.C. § 300gg-111(c)(4)(A)(i); 29 U.S.C. § 1185e(c)(4)(A)(i); 26 U.S.C. § 9816(c)(4)(A)(i).

Congress directed the Departments to implement the IDR process through rulemaking "in accordance with the succeeding provisions of this subsection" (*i.e.,* the statutory provisions governing how the IDR entity determines the appropriate payment amount). 42 U.S.C. § 300gg-111(c)(2)(A); 29 U.S.C. § 1185e(c)(2)(A); 26 U.S.C. § 9816(c)(2)(A). Congress granted the Departments one full year after the enactment of the No Surprises Act, by December 27, 2021, to engage in notice-and-comment rulemaking and promulgate implementing regulations on the IDR process. 42 U.S.C. § 300gg-111(c)(2)(A); 29 U.S.C. § 1185e(c)(2)(A); 26 U.S.C. § 9816(c)(2)(A).

III. Interim Final Rule Published on October 7, 2021

A. Promulgation Without Notice-and-Comment Rulemaking

On October 7, 2021, nine months after enactment of the No Surprises Act, the Departments published the IFR in the Federal Register, implementing the No Surprises Act's provisions governing the IDR process. IFR, 86 Fed. Reg. 55,980 (Oct. 7, 2021); Material Facts ¶ 15.[6] Prior to this publication, the Departments did not provide general notice of proposed

[6] Prior to the IFR, on July 13, 2021, the Departments published in the Federal Register an interim final rule implementing other provisions of the No Surprises Act that are not at issue in this

rulemaking and did not afford interested parties an opportunity to participate in the rulemaking through the submission of written comments. Instead, the IFR went into effect on the same day of publication—October 7, 2021. Material Facts ¶ 22.

The Departments admitted that the timeframe from the No Surprises Act's enactment on December 27, 2020, and the effective date for the application of the IDR provisions for plan years beginning January 1, 2022, "may have allowed for … the full notice and comment rulemaking process." IFR, 86 Fed. Reg. at 56,043-44; Material Facts ¶ 22. However, they concluded that it was "impracticable and contrary to the public interest to delay putting the … interim final rules in place until a full public notice and comment process has been completed," and they found that there was "good cause to waive the delay in effective date for certain provisions of these interim final rules." *Id.* at 56,043; Material Facts ¶ 22. The Departments surmised that engaging in notice-and-comment rulemaking "would not provide sufficient time for the regulated entities to implement the requirements." IFR, 86 Fed. Reg. at 56,044; Material Facts ¶ 22. The Departments further asserted:

> Issuing these rules as interim final rules, rather than as a notice of proposed rulemaking, will allow plans and issuers to account for the regulations as they finalize rates and plan offerings and will allow IDR entities to seek certification and be available to take part in the Federal IDR process when these interim final rules go into effect. Health plans and issuers, and providers, facilities and providers of air ambulance services, require these rules to be in place to determine the out-of-network rates for emergency services, services by out-of-network providers at in-network facilities in certain circumstances, and air ambulance services. Without these final rules, providers, facilities and providers of air ambulance services will not be able to resort to the Federal IDR process (and are no longer able to balance bill patients), leaving the possibility that they will be undercompensated for their services. Such undercompensation could threaten the viability of these providers, facilities and providers of air ambulance services. This in turn, could lead to participants, beneficiaries and enrollees not receiving needed medical care, undermining the goals of the No Surprises Act.

---

action. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872 (July 13, 2021); Material Facts ¶ 13.

> Additionally, and for the same reasons, the failure to promulgate this rule in a timely fashion could lead to additional industry consolidation, potentially driving health costs higher.

IFR, 86 Fed. Reg. at 56,044; Material Facts ¶ 22.

B. Provisions Governing the Selection of an Offer Under the IDR Process

Despite Congress's enumeration of multiple factors that the IDR entity "shall consider" in selecting an offer, the Departments published the IFR establishing a "rebuttable presumption" that the appropriate out-of-network rate is the offer closest to the QPA. IFR, 86 Fed. Reg. at 56,104, 56,116, 56,128; Material Facts ¶ 15. Specifically, under the IFR, the IDR entity is obligated to select the offer closest to the QPA unless it "determines that *credible information* submitted by either party … *clearly demonstrates* that the [QPA] is *materially different* from the appropriate out-of-network rate, or if the offers are equally distant from the QPA but in opposing directions." *Id*. at 56,104, 56,116, 56,128 (emphasis added); Material Facts ¶ 15. In determining whether information is "credible," the IFR directs the IDR entity to conduct a "critical analysis" of whether information is worthy of belief and is trustworthy. IFR, 86 Fed. Reg. at 55,995, 56,100, 56,113, 56,125; Material Facts ¶ 16. The IFR further specifies that a "material difference" exists where "there is substantial likelihood that a reasonable person with the training and qualifications" of an IDR entity "would consider the information important in determining the out of network rate and view the information as showing that the QPA is not the appropriate out-of-network rate under such additional circumstances." IFR, 86 Fed. Reg. at 55,995; Material Facts ¶ 17.

In contrast to this critical analysis of the non-QPA Subparagraph C Factors, the IFR makes clear that "it is not the role of the certified IDR entity to determine whether the QPA has been calculated by the [issuer] correctly." IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 18. Moreover, if the IDR entity does not select the offer closest to the QPA, it must provide a written

decision including "a detailed explanation of the additional considerations relied upon, whether the information about those considerations submitted by the parties was credible, and the basis upon which the certified IDR entity determined that the credible information demonstrated that the QPA is materially different from the appropriate out-of-network rate." IFR, 86 Fed. Reg. at 56,000; Material Facts ¶ 19.

In other words, the Departments gave presumptive weight to only one factor—the QPA—and imposed a heighted evidentiary standard for considering all other statutory factors in the likely event that the offers are not equally distant from the QPA and in opposing directions. In rationalizing this interpretation, the Departments did not identify explicit statutory text mandating the rebuttable presumption. Instead, the Departments argue that the IFR's provisions governing the IDR entity's selection of an offer is the "best interpretation" of the statute because they assert that the QPA "represents a reasonable market-based payment for relevant items and services." IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 20. In an attempt to justify their rebuttable presumption in favor of the offer closest to the QPA, the Departments note that (1) the "statutory text lists the QPA as the first factor;" (2) the non-QPA factors appears "in a separate paragraph" and are subject to subparagraph (D), which describes certain factors that the IDR entity cannot consider in determining payment; (3) the statute "sets out detailed rules for calculating the QPA;" and (4) the No Surprises Act mentions the QPA in other provisions of the statute that do not govern the determination of payment to out-of-network providers/facilities. IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 20.

Additionally, the Departments reference various "policy considerations" in support for their interpretation, including that the rebuttable presumption "will increase the predictability of IDR outcomes, which may encourage parties to reach an agreement outside of the Federal IDR

process to avoid the administrative costs, and will aid in reducing prices that may have been inflated due to the practice of surprise billing prior to the No Surprises Act." IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 21. They also claim that their policy "will help limit the indirect impact on [patients] that would occur from higher out-of-network rates if plans and issuers were to pass higher costs on to individuals in the form of increases in premiums." IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 21. Lastly, the Departments assert, without any evidence, that the QPA "should reflect standard market rates … established through arms-length negotiations." IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 21.

IV. APA Rulemaking

Under the APA, an agency may adopt a substantive rule of general applicability only after providing general notice of proposed rulemaking to the public, considering comments received from the public, and publishing the final rule not less than 30 days before the rule's effective date. 5 U.S.C. § 553(b)-(d). The notice-and-comment rulemaking "procedures are not a mere formality." *Cap. Area Immigrants' Rts. Coal. v. Trump*, 471 F. Supp. 3d 25, 44 (D.D.C. 2020). The procedural requirement is "designed (1) to ensure that agency regulations are tested via exposure to diverse public comment, (2) to ensure fairness to affected parties, and (3) to give affected parties an opportunity to develop evidence in the record to support their objections to the rule and thereby enhance the quality of judicial review." *Id*. (quoting *Int'l Union, United Mine Workers v. Mine Safety & Health Admin*., 407 F.3d 1250, 1259 (D.C. Cir. 2005)) (internal quotations omitted); *see also Hoctor v. U.S. Dep't of Agric*., 82 F.3d 165, 167 (7th Cir. 1996) ("Notice and comment rulemaking … facilitates the marshaling of opposition to a proposed rule, and may result in the creation of a very long record that may in turn provide a basis for a judicial challenge to the rule if the agency decides to promulgate it.").

The APA creates a limited exception to the notice-and-comment rulemaking requirement

if the agency finds "good cause" that these procedures are "impracticable, unnecessary, or contrary to the public interest." 5 U.S.C. § 553(b)(B), (d)(3). The "good cause" exception under 5 U.S.C. § 553 is "narrowly construed and only reluctantly countenanced." *New Jersey, Dep't Env't Prot. v. EPA*, 626 F.2d 1038, 1045 (D.C. Cir. 1980). It is not to be construed as an "'escape clause[]' that may be arbitrarily utilized at [an] agency's whim." *Am. Fed'n of Gov't Emps., AFL-CIO v. Block*, 655 F.2d 1153, 1156 (D.C. Cir. 1981) (quoting S. Rep. No. 752, 79th Cong., 1st Sess. (1945), *reprinted in* Administrative Procedure Act, Legislative History, 79th Cong. 1944-46 at 200, 201).

V. Standard of Review

The APA authorizes judicial review of final agency actions, requiring a reviewing court to "hold unlawful and set aside" the agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;" "without observance of procedure required by law;" and "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. §§ 702, 706(2), (A), (C)-(D); *see also Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co*., 463 U.S. 29, 41 (1983); *Cook Cnty. v. Wolf*, 962 F.3d 208, 221 (7th Cir. 2020), *cert. dismissed sub nom. Mayorkas v. Cook Cnty.*, 141 S. Ct. 1292 (2021). "Cases arising under the APA are typically resolved by summary judgment on the basis of the administrative record compiled by the agency." *Citizens for Appropriate Rural Rds., Inc. v. Foxx*, 14 F. Supp. 3d 1217, 1228 (S.D. Ind. 2014) (citing *Fla. Power & Light Co. v. Lorion*, 470 U.S. 729, 744–45 (1985)). When evaluating agency action under the APA, "the district court 'sits as an appellate tribunal,' and 'the question of whether [the agency] acted in an arbitrary and capricious manner is a legal one which the district court can resolve on the agency record.'" *Great Am. Ins. Co. v. United States*, 55 F. Supp. 3d 1053, 1057-58 (N.D. Ill. 2014) (quoting

Univ. Med. Ctr. of S. Nev. v. Shalala, 173 F.3d 438, 440 n.3 (D.C. Cir. 1999)).

When reviewing the substantive validity of an agency's rule, a court must give effect to an unambiguous statute. *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984). "First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.*; *see also Cook Cnty.*, 962 F.3d at 221. A court "owe[s] an agency's interpretation of the law no deference unless, after 'employing traditional tools of statutory construction,'" it is "unable to discern Congress's meaning." *SAS Inst., Inc. v. Iancu*, 138 S. Ct. 1348, 1358 (2018) (quoting *Chevron*, 467 U.S. at 843 n.9). In ascertaining whether the statute is clear or ambiguous, courts "consider the language itself, the specific context in which that language is used, and the broader context of the statute as a whole, and reference to dictionary definitions is appropriate." *Emergency Servs. Billing Corp. v. Allstate Ins. Co*., 668 F.3d 459, 465 (7th Cir. 2012) (internal quotations marks and citations omitted).

If the statute is silent or ambiguous, however, then the court must then determine, under the "step two" standard articulated in *Chevron*, if the interpretation provided by an agency is "based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843; *see also Jeffers v. Comm'r of Internal Revenue*, 992 F.3d 649, 654 (7th Cir. 2021). In conducting this analysis, a court must "view the agency's interpretation in light of the legislative history, the purpose of the statute, and comparative statutes in order to determine whether the agency's interpretation is reasonable." *Emergency Servs. Billing Corp.,* 668 F.3d at 466; *see MBH Commodity Advisors, Inc. v. Commodity Futures Trading Comm'n*, 250 F.3d 1052, 1061 (7th Cir. 2001). "A court may strike down an agency's interpretation of a law if, for example, the agency's reading

disregards the statutory context; its rule is based on an unreasonable interpretation of legislative history; or its new position 'would bring about an enormous and transformative expansion in [the agency's] regulatory authority without clear congressional authorization.'" *Cook Cnty.*, 962 F.3d at 226-27 (internal citations omitted). The *Chevron* step two analysis often merges with arbitrary and capricious review under the APA. *Judulang v. Holder*, 565 U.S. 42, 53 n.7 (2011) (quoting *Mayo Found. for Med. Educ. & Rsch. v. United States*, 562 U.S. 44, 53 (2011)); *Reverse Mortg. Sols., Inc. v. U.S. Dep't of Hous. & Urb. Dev.*, 365 F. Supp. 3d 931, 947 (N.D. Ill. 2019).

Lastly, "where a proper challenge is raised to the agency procedures, and those procedures are defective, a court should not accord *Chevron* deference to the agency interpretation." *Cook Cnty.*, 962 F.3d at 222 (quoting *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016)).

ARGUMENT

The Departments' rebuttable presumption in favor of the QPA is contrary to the unambiguous text of the No Surprises Act, and the Departments' unpersuasive reasons for the rebuttable presumption do not excuse their violation of the statute. Congress unequivocally mandated that the IDR entity "shall consider" all Subparagraph C Factors in determining the appropriate out-of-network rate for items and services. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). The No Surprises Act contains not a whisper of a "presumption" in favor of the QPA or the evidentiary standard established by the Departments. Had Congress wanted to establish a rebuttable presumption in favor of the QPA, it would have said so. Other provisions of the Consolidated Appropriations Act, 2021, which contains the No Surprises Act, expressly established rebuttable presumptions—in contrast, Congress did not explicitly (or implicitly) create a rebuttable presumption for the IDR entity's consideration of factors for determining payment. Instead, Congress used precise terminology

requiring the IDR entity to review all statutory factors without elevating any single factor above the others. Accordingly, "Congress has directly spoken to the precise question at issue," *Chevron*, 467 U.S. at 842, and those portions of the IFR creating the rebuttable presumption must be vacated.

The Departments flouted Congress's intent by barring the IDR entity from considering the non-QPA Subparagraph C Factors unless a party satisfies a heighted evidentiary standard that is absent from the plain language of the No Surprises Act. IFR, 86 Fed. Reg. at 56,104, 56,116, 56,128. In establishing the rebuttable presumption, the Departments exceeded their statutory authority. Because the Departments' interpretation contravenes the unambiguous text of the statute, it is invalid under *Chevron* step one.

Thus, a *Chevron* step two analysis should be unnecessary. However, the Departments' rebuttable presumption would nonetheless fail under *Chevron* step two because it embodies an impermissible interpretation of the statute. Their interpretation, which impermissibly ties the hands of the independent arbiter and skews the IDR decision in favor of insurers, frustrates the No Surprises Act's purpose. The rebuttable presumption is also inconsistent with the legislative history and the broader context of the No Surprises Act. Moreover, in creating a heighted evidentiary standard needed to overcome the presumption that the "QPA is [the] appropriate payment amount," IFR, 86 Fed. Reg. at 55,995, the Departments "relied on factors which Congress has not intended it to consider." *Motor Vehicle Mfrs. Ass'n of U.S., Inc.*, 463 U.S. at 43; *Zero Zone, Inc. v. U.S. Dep't of Energy*, 832 F.3d 654, 668 (7th Cir. 2016). Therefore, the Departments' interpretation is not "based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843. For the same reasons that it is an impermissible interpretation under *Chevron* step two, the Departments' policy is also substantively invalid under the APA.

Lastly, the rebuttable presumption in favor of the QPA is procedurally invalid under the APA. 5 U.S.C. § 553(b)(B), (d)(3). The Departments failed to demonstrate "good cause" for circumventing APA notice-and-comment rulemaking in promulgating the rebuttable presumption. Because the IFR was promulgated in violation of the APA, the Departments' rebuttable presumption is not entitled to *Chevron* deference. *Encino Motorcars*, 579 U.S. at 220-21.

For all these reasons, the Departments' policy must be set aside as agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;" "in excess of statutory … authority;" and "without observance of procedure required by law." 5 U.S.C. § 706(2)(A), (C)-(D).

I. The Departments' Rebuttable Presumption Is Invalid Under *Chevron* Step One Because It Is Contrary to the Language of the Statute

The Departments' rebuttable presumption contravenes the plain language of the No Surprises Act and is, therefore, invalid. Congress was clear that the IDR entity "shall consider" all Subsection C Factors. Elsewhere in the Consolidated Appropriations Act, 2021, Congress expressly created presumptions but did not do so for the IDR entity. The Departments have impermissibly rewritten the statute by creating a presumption in favor of the QPA and heightened standards for considering the other Subsection C Factors. Accordingly, the IFR fails under *Chevron* step one.

When interpreting a statute, a reviewing court must begin with its text. *Middleton v. City of Chicago*, 578 F.3d 655, 658 (7th Cir. 2009); *City of Evanston v. Barr*, 412 F. Supp. 3d 873, 883 (N.D. Ill. 2019) ("Statutory interpretation begins with the plain language of the statute."); *Barnhart v. Sigmon Coal Co*., 534 U.S. 438, 450 (2002) ("As in all statutory construction cases, we begin with the language of the statute."). It is well-established that "words in statutes should

be given their common meanings" "[u]nless there is a persuasive reason to the contrary." *Int'l Adm'rs, Inc. v. Life Ins. Co. of N. Am.*, 753 F.2d 1373, 1379 (7th Cir. 1985) (citing *In re Clark*, 738 F.2d 869, 872 (7th Cir. 1984)); *Niz-Chavez v. Garland*, 141 S. Ct. 1474, 1480 (2021) ("When called on to resolve a dispute over a statute's meaning, this Court normally seeks to afford the law's terms their ordinary meaning at the time Congress adopted them."). "[W]hen the statute's language is plain, the sole function of the courts … is to enforce it according to its terms." *Lamie v. United States*, 540 U.S. 526, 534 (2004) (internal quotations omitted).

A. The Departments' Rebuttable Presumption in Favor of the Offer Closest to the QPA Is Contrary to the Text of the No Surprises Act

Congress unambiguously enumerated specific factors—Subparagraph C Factors—that the IDR entity "shall consider" when identifying the appropriate reimbursement amount for items or services furnished out-of-network.[7] 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). This clear mandate appears twice in the No Surprises Act. First, in describing payment determinations in general, Congress provided that the IDR entity "*shall … taking into account the considerations specified in subparagraph (C),* select one of the offers submitted" by the parties to be the payment amount. 42 U.S.C. § 300gg-111(c)(5)(A)(i); 29 U.S.C. § 1185e(c)(5)(A)(i); 26 U.S.C. § 9816(c)(5)(A)(i) (emphasis added). Second, in subparagraph C, Congress unequivocally restated that in deciding which offer to apply, the IDR entity "*shall consider* … the qualifying payment amounts… *and*… information on any circumstance described in clause (ii), such information as requested [by the IDR entity

[7] The No Surprises Act also provides that the IDR entity "shall not consider" usual and customary charges; the reimbursement rate for such items and services payable by a public payer (e.g., Medicare, Medicaid, the Children's Health Insurance Program, TRICARE, United States Department of Veterans Affairs); or the amount that the out-of-network provider/facility would have billed for the item or service had the No Surprises Act not applied. 42 U.S.C. § 300gg-111(c)(5)(D); 29 U.S.C. § 1185e(c)(5)(D); 26 U.S.C. § 9816(c)(5)(D).

relating to the party's offer], *and* any additional information [submitted by a party relating to such offer of either party]." 42 U.S.C. § 300gg-111(c)(5)(C)(i); 29 U.S.C. § 1185e(c)(5)(C)(i); 26 U.S.C. § 9816(c)(5)(C)(i) (emphasis added). "Clause (ii)," referenced above, delineates five additional factors that the IDR entity "shall" consider.[8] 42 U.S.C. § 300gg-111(c)(5)(C)(ii); 29 U.S.C. § 1185e(c)(5)(C)(ii); 26 U.S.C. § 9816(c)(5)(C)(ii).

The text of the statute is straightforward: the IDR entity *must consider all* Subparagraph C Factors when selecting the best payment offer. Congress's use of the term "shall" creates an obligation upon the IDR entity that the Departments may not abrogate through the rulemaking process. It is a basic principle of statutory interpretation that "shall" is mandatory. *FDIC v. Chicago Title Ins. Co*., 12 F.4th 676, 683 (7th Cir. 2021); *Jefferson v. United States*, 546 F.3d 477, 484 (7th Cir. 2008); *Lexecon Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998). Congress also enumerated factors that the IDR entity "shall not consider." 42 U.S.C. § 300gg-111(c)(5)(D); 29 U.S.C. § 1185e(c)(5)(D); 26 U.S.C. § 9816(c)(5)(D). Congress was extraordinarily prescriptive, specifying precisely which factors the IDR entity "shall consider" and "shall not consider." The IFR impermissibly rewrites the statute by forbidding the IDR entity from considering most of the Subsection C Factors unless the Departments' heightened standards are met.

Moreover, Congress's use of the conjunctive term "and" in describing the Subparagraph

[8] These include (1) the "level of training, experience, and quality and outcomes measurements of the provider or facility;" (2) the "market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided;" (3) the "acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual;" (4) the "teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service;" and (5) "[d]emonstrations of good faith efforts (or lack of good faith efforts)" made by the provider/facility or issuer to enter into network agreements and the contracted rates between the provider/facility and the issuer during the previous 4 plan years. 42 U.S.C. § 300gg-111(c)(5)(C)(ii); 29 U.S.C. § 1185e(c)(5)(C)(ii); 26 U.S.C. § 9816(c)(5)(C)(ii).

C payment considerations indicates its clear intent that all Subparagraph C Factors must be taken into consideration by the IDR entity before selecting a payment offer. *See, e.g.*, *In re DeMert & Dougherty, Inc*., 271 B.R. 821, 842 (Bankr. N.D. Ill. 2001); *Illinois v. I.C.C.*, 687 F.2d 1047, 1054 (7th Cir. 1982).

Despite Congress's clear mandate, the Departments established a standard for determining payment that *forbids* the IDR entity from considering the non-QPA Subparagraph C Factors unless a party satisfies additional requirements that are not found in the No Surprises Act. Specifically, under the Departments' regulatory framework, except in the rare circumstance that the offers are equally distant from the QPA but in opposing directions, the IDR entity is prohibited from considering any Subparagraph C Factors other than the QPA unless "*credible information* submitted by the parties *clearly demonstrates* that the QPA is *materially different* from the appropriate out-of-network rate." IFR, 86 Fed. Reg. at 55,995, 55,999, and 56,061 (emphasis added); Material Facts ¶ 15. In determining whether information is "credible," the IFR directs the IDR entity to conduct a "critical analysis" of whether information is worthy of belief and is trustworthy. IFR, 86 Fed. Reg. at 55,995, 56,100, 56,113, 56,125 (emphasis added); Material Facts ¶ 16. This evidentiary standard, which is absent from the No Surprises Act's text, upends the statutory scheme by turning a multifactor analysis into one that virtually guarantees that the insurer's own in-network rate will be imposed upon out-of-network providers.

Accordingly, the Departments have not interpreted the statute—they unlawfully and fundamentally altered it. *See Whitman v. Am. Trucking Ass'ns, Inc*., 531 U.S. 457, 468 (2001). By giving one factor—the QPA—controlling weight, the Departments ignored Congress's mandate that the Subparagraph C Factors must be considered together. Congress did not assign presumptive weight to any one statutory factor and did not prescribe how the IDR entity should

balance such factors. Instead, Congress requires the IDR entity to consider and balance all of the Subparagraph C Factors. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). The Departments have effectively tied the hands of the IDR entity, revoking its ability to consider and balance all of the Subparagraph C Factors when determining the appropriate out-of-network rate.

B. Congress Created Presumptions Elsewhere in the Same Act, Demonstrating That the Departments' Presumption in Favor of the Offer Closest to the QPA Is Impermissible

A wholistic reading of the statute further demonstrates that the IFR's presumption in favor of the QPA is contrary to the text of the No Surprises Act. *See FDIC v. Chicago Title Ins. Co.*, 12 F.4th 676, 683 (7th Cir. 2021) ("It is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme."); *City of Evanston v. Barr*, 412 F. Supp. 3d 873, 883 (N.D. Ill. 2019) ("The language and design of the statute as a whole may also provide guidance in determining the plain meaning of its provisions.").

Had Congress wanted to establish a presumption in favor of the QPA in the event of a payment dispute between providers/facilities and insurers, it would have done so. *See Krawczyk v. Centurion Cap. Corp.*, No. 06-C-6273, 2009 WL 395458, at *12 (N.D. Ill. Feb. 18, 2009); *Allison v. Liberty Sav.*, 695 F.2d 1086, 1089 (7th Cir. 1982). In the Consolidated Appropriations Act, 2021, which contains the No Surprises Act, Congress expressly created five different presumptions, none of which apply to the IDR entity. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182, 2185, 2208, 2300-01. For instance, in a section governing trademarks, entitled "Rebuttable Presumption of Irreparable Harm," Congress provided that a "plaintiff seeking any such injunction shall be entitled to a *rebuttable presumption* of irreparable harm upon a finding of a violation identified in this subsection …." 134 Stat. at 2208 (codified

at 15 U.S.C. § 1116(a)) (emphasis added). Congress also ordered a governmental entity (the Central Montana Regional Water Authority) to create "presumptions." 134 Stat. at 3271.

In contrast, Congress chose not to establish a rebuttable presumption in favor of the QPA in the No Surprises Act. Instead, Congress specifically listed the considerations that the IDR entity must consider when selecting an offer for payment. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). Congress's express creation of presumptions in other portions of the Consolidated Appropriations Act, 2021, while stating no such rebuttable presumption for the Subparagraph C Factors, means that Congress did not intend to establish a rebuttable presumption in favor of the QPA. *See Salinas v. U.S. R.R. Ret. Bd.*, 141 S. Ct. 691, 698 (2021) ("Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.") (quoting *Russello v. United States*, 464 U.S. 16, 23 (1983)).

C. The Departments' Presumption in Favor of the Offer Closest to the QPA Exceeds the Authority Granted by Congress to Implement the Act

The text of the No Surprises Act simply does not authorize a rebuttable presumption in favor of the offer closest to the QPA. "The jurisdiction and authority of [administrative agencies] is confined solely to that which Congress bestows." *Marquette Cement Mfg. Co. v. FTC*, 147 F.2d 589, 592-93 (7th Cir. 1945); *Atlantic City Elec. Co. v. FERC*, 295 F.3d 1, 8 (D.C. Cir. 2002) ("In the absence of statutory authorization for its act, an agency's 'action is plainly contrary to law and cannot stand.'"). The No Surprises Act only directs the Departments to establish by regulation an IDR process under which an IDR entity will determine the appropriate amount of payment "in accordance with the succeeding provisions of this subsection." 42 U.S.C. § 300gg-111(c)(2)(A); 29 U.S.C. § 1185e(c)(2)(A); 26 U.S.C. § 9816(c)(2)(A).

The "succeeding provisions" unambiguously specify that all Subparagraph C Factors must be considered when selecting an offer. The "succeeding provisions" do not authorize, and cannot be interpreted to authorize, the IFR's provisions requiring IDR entities to "presume that the QPA is an appropriate payment amount" unless a party provides "credible information" concerning the Subparagraph C Factors "clearly demonstrating" that the QPA is "materially different from the appropriate out-of-network rate" or unless the payment offers submitted by the provider/facility and the insurer are equally distant from the QPA but in opposing directions. IFR, 86 Fed. Reg. at 55,996; *see* Material Facts ¶ 15. Accordingly, the Departments exceeded their authority granted by Congress by establishing a rebuttable presumption in favor of the QPA. The Departments' interpretation is contrary to the unambiguously expressed intent of Congress and is invalid under *Chevron* step one. It is well-established that "no deference is due to agency interpretations at odds with the plain language of the statute itself." *Smith v. City of Jackson*, 544 U.S. 228, 266 (2005) (O'Connor, J., concurring) (internal quotation marks and citation omitted). The plain language of the No Surprises Act clearly mandates that the IDR entity "shall consider" all Subparagraph C Factors in determining the appropriate out-of-network rate for items and services. Courts "must presume that a legislature says in a statute what it means and means in a statute what it says." *United States v. Rosenbohm*, 564 F.3d 820, 823 (7th Cir. 2009) (internal quotation marks and citation omitted).

The statute forecloses the presumption in favor of the QPA and the heightened evidentiary standard needed to rebut the presumption. Accordingly, the No Surprises Act is neither silent nor ambiguous regarding the question at issue. "Congress has directly spoken to the precise question at issue," and the Departments are required to "give effect to the unambiguously expressed intent of Congress." *Chevron*, 467 U.S. at 842-43. Because the

Departments' interpretation flouts the unambiguous text of the statute, it is invalid under *Chevron* step one and owed no deference. Therefore, the Departments' interpretation must be vacated because it violates the plain language of the No Surprises Act and exceeds the agencies' authority under the statute.

II. The IFR's Rebuttable Presumption in Favor of the QPA Is Not Entitled to Deference Under *Chevron* Step Two Because the Departments' Statutory Analysis Is Unreasonable, the Presumption Is Contrary to Congressional Intent, and the IFR Is Procedurally Defective

Even if the statute were silent or ambiguous, however, the Departments' rebuttable presumption in the IFR would fail under *Chevron* step two. The Departments' interpretation is not "based on a permissible construction of the statute," *Chevron*, 467 U.S. at 843, because the IFR's rebuttable presumption is based on an unreasonable textual analysis of the statute, frustrates the statutory purpose, and is inconsistent with congressional intent. *See Util. Air Regul. Grp.*, 573 U.S. at 324 (2014) (A court may set aside an agency's interpretation if it "would bring about an enormous and transformative expansion in [the agency's] regulatory authority without clear congressional authorization."); *Brumfield v. City of Chicago*, 735 F.3d 619, 625-26 (7th Cir. 2013) (noting that an agency's interpretation is granted *Chevron* deference only if "Congress has authorized the agency to interpret the statute through rules carrying the force of law and the agency's interpretation is both reasonable and promulgated through the exercise of the authority given by Congress."); *Congregation of the Passion v. Johnson*, 79 F. Supp. 3d 855, 860 (N.D. Ill. 2015); *Reverse Mortg. Sols.*, 365 F. Supp. 3d at 947; *MBH Commodity Advisors, Inc. v. Commodity Futures Trading Comm'n*, 250 F.3d 1052, 1061 (7th Cir. 2001); *Coyomani-Cielo v. Holder*, 758 F.3d 908, 914 (7th Cir. 2014).

A. The Departments' Interpretation of the Statute Is an Unreasonable Textual Analysis Divorced From Canons of Construction

The Departments' stated "justifications" for establishing the rebuttable presumption in

favor of the QPA are unsupported by the unambiguous text of the No Surprises Act, which lists the Subparagraph C Factors that the IDR "shall" consider. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). In promulgating the IFR, the Departments failed to identify statutory text that explicitly directed the creation of the rebuttable presumption. Nonetheless, the Departments concluded that their atextual policy governing the IDR entity's selection of an offer was the "best interpretation" of the No Surprises Act. IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 20. The Departments came to this conclusion by manufacturing heretofore unknown canons of statutory construction that should be rejected by this Court.

The Departments arrived at their rebuttable presumption by improperly emphasizing the following aspects of the statute: (1) the "statutory text lists the QPA as the first factor;" (2) the non-QPA factors appear "in a separate paragraph" and are subject to subparagraph (D), which describes certain factors that the IDR entity cannot consider in determining payment; (3) the statute "sets out detailed rules for calculating the QPA;" and (4) the No Surprises Act mentions the QPA in other statutory provisions that do not directly govern the determination of payment for out-of-network items or services. IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 20.

The Departments' convoluted statutory analysis is divorced from established canons of construction, and the Departments cited no canon in support of their interpretation. "[L]ist[ing] the QPA as the first factor" does not imply Congress's intent to establish a rebuttable presumption in favor of the QPA. If that were the case, then every time Congress catalogues any list, the first listed item would have more weight than the others, and if Congress did not intend to create a presumption, it would have to explicitly clarify that the first factor should *not* be accorded presumptive weight.

Congress simply does not legislate in this manner, and Courts do not interpret statutes as

the Departments suggest. For example, in *American Corn Growers Ass'n v. Environmental Protection Agency*, the United States Court of Appeals for the District of Columbia Circuit held that the Environmental Protection Agency ("EPA") distorted Congress's intent by promulgating a regulation that treated one of five statutory factors dramatically different than the other factors. *Am. Corn Growers Ass'n v. EPA*, 291 F.3d 1, 6 (D.C. Cir. 2002). The Clean Air Act enumerates certain factors that states must take into consideration when determining the best available retrofit technology for controlling emissions:

> [I]n determining best available retrofit technology the State … shall take into consideration the costs of compliance, the energy and nonair quality environmental impacts of compliance, any existing pollution control technology in use at the source, the remaining useful life of the source, and the degree of improvement in visibility which may reasonably be anticipated to result from the use of such technology.

42 U.S.C. § 7491(g)(2); *see Am. Corn Growers Ass'n*, 291 F.3d at 5. The EPA's regulation, however, directed the states to consider the first four statutory factors on a source-specific basis and the fifth statutory factor on a group or "area wide" basis. *Am. Corn Growers Ass'n*, 291 F.3d at 6. In partially vacating the regulation, the court determined that "splitting … the statutory factors [was] consistent with neither the text nor the structure of the statute." *Id.* The court emphasized that "[a]lthough no weights were assigned, the factors were meant to be considered together by the states." *Id.* Similarly, Congress intended that all Subparagraph C Factors would be considered together without giving presumptive weight to only one factor. By treating the QPA "in such a dramatically different fashion" than the other Subparagraph C Factors, the Departments unlawfully "distort[ed] the judgment Congress." *See id.*

Second, even if the Departments' structural argument had merit, it would not negate Congress's unequivocal requirement that IDR entities "shall consider" all Subparagraph C Factors in determining payment. Within subparagraph C, the clause describing the QPA and the

clause generally describing the other Subparagraph C Factors co-exist in the same sentence, joined by the conjunctive term "and": the IDR entity "shall consider . . . (I) the qualifying payment amount . . . and (II) … information on any circumstance described in clause (ii)." 42 U.S.C. § 300gg-111(c)(5)(C)(i)(I)-(II); 29 U.S.C. § 1185e(c)(5)(C)(i)(I)-(II); 26 U.S.C. § 9816(c)(5)(C)(i)(I)-(II). Accordingly, such provisions should be construed together. *See, e.g.*, *Illinois v. I.C.C.*, 687 F.2d 1047, 1054 (7th Cir. 1982); *see also United States v. Kelly*, 500 F.2d 72, 74 (7th Cir. 1974) ("[I]t is immaterial whether Congress chose to state a rule and its exception in one clause or in separate clauses.").

Third, the prohibition against the consideration of certain factors set forth in subparagraph (D) does not suggest that Congress intended a rebuttable presumption in favor of the QPA. The Subparagraph D Factors are immaterial to the QPA. Congress had no need, therefore, to clarify the prohibition's application with regard to the QPA. 42 U.S.C. § 300gg-111(c)(5)(C)(i)(I); 29 U.S.C. § 1185e(c)(5)(C)(i)(I); 26 U.S.C. § 9816(c)(5)(C)(i)(I).

Fourth, the statute's rules for calculating the QPA have no bearing on the weight that it should receive. *See* 42 U.S.C. § 300gg-111(a)(3)(E); 29 U.S.C. § 1185e(a)(3)(E); 26 U.S.C. § 9816(a)(3)(E). In fact, the Departments made clear that "it is not the role of the certified IDR entity to determine whether the QPA has been calculated by the [issuer] correctly." IFR, 85 Fed. Reg. at 55,996; Material Facts ¶ 18. Moreover, the Departments promulgated policies governing the QPA calculation in a completely different interim final rule published approximately three months before the IFR was released, further suggesting that the Departments do not truly view the methodology for calculating the QPA as giving it presumptive weight. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872, 36,888-98 (July 13, 2021); *see* Material Facts ¶ 13. Therefore, this "justification" is unpersuasive.

Fifth, it is unreasonable for the Departments to infer that Congress intended a rebuttable presumption based on the mention of the QPA in other provisions of the statute that do not directly govern the determination of payment. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. at 36,888-98. Had Congress wanted to create a rebuttable presumption in favor of the QPA, it would not have hidden the directive in other, unrelated statutory provisions. *See Whitman v. Am. Trucking Ass'ns, Inc*., 531 U.S. 457, 468 (2001). ("Congress, we have held, does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes."). Notably, unlike the No Surprises Act's provisions governing cost-sharing requirements, Congress did not establish the QPA as the "out-of-network rate" when there is no "specified state law" or applicable All-Payer Model Agreement under section 1115A of the Social Security Act. *Compare* 42 U.S.C. § 300gg-111(a)(3)(K); 29 U.S.C. § 1185e(a)(3)(K); 26 U.S.C. § 9816(a)(3)(K) *with* 42 U.S.C. § 300gg-111(a)(3)(H); 29 U.S.C. § 1185e(a)(3)(H); 26 U.S.C. § 9816(a)(3)(H). Thus, the Departments' attempt to cobble together isolated provisions of the statute cannot overcome Congress's unambiguous directive for IDR entities to consider all Subparagraph C Factors.

Additionally, in support for their decision to "[anchor] the determination of the out-of-network rate to the QPA," the Departments point to several "policy considerations." IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 21. The Departments have no authority to rewrite unambiguous statutory terms to further their own policy goals. *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 325-28 (2014) ("[A] core administrative-law principle that an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate."); *Ciox Health, LLC v. Azar*, 435 F. Supp. 3d 30, 65 (D.D.C. 2020) ("Disagreeing with Congress's expressly codified policy choices isn't a luxury administrative agencies enjoy.") (quoting *Cent. United Life Ins. Co.*

v. Burwell, 827 F.3d 70, 73 (D.C. Cir. 2016)). In creating a heighted evidentiary standard needed to overcome the presumption that the "QPA is [the] appropriate payment amount," IFR, 86 Fed. Reg. at 55,995, the Departments "relied on factors which Congress has not intended it to consider." *Motor Vehicle Mfrs. Ass'n of U.S.,* 463 U.S. at 43; *Zero Zone, Inc.*, 832 F.3d at 668. Accordingly, the Departments' rebuttable presumption is an unreasonable interpretation of the statute. *Chevron*, 467 U.S. at 843.

B. The Departments' Rebuttable Presumption in Favor of the Offer Closest to the QPA Thwarts Congress's Intent

The rebuttable presumption in favor of the QPA undercuts the statute's purpose and is inconsistent with congressional intent to create an unbiased IDR entity that would consider all Subsection C Factors when determining out-of-network rates. At *Chevron* step two, courts in the Seventh Circuit examine legislative history to determine whether an agency's interpretation is reasonable under *Chevron* step two.[9] *See Coyomani-Cielo v. Holder*, 758 F.3d 908 (7th Cir. 2015); *see also*, *Allison v. Liberty Sav.,* 695 F.2d 1086, 1089 (7th Cir. 1982); *Pfeiffer v. Essex Wire Corp*., 682 F.2d 684, 686 (7th Cir. 1982) (a statute's legislative history and purpose can illuminate congressional intent).

Congressional intent for the No Surprises Act demonstrates that Congress did not intend for the Departments to mandate a rebuttable presumption in favor of the QPA in the determination of payment for certain health care items and services furnished by a provider or

[9] The Supreme Court, however, has considered legislative history at *Chevron* step one. *See FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120 (2000). Most federal circuits also analyze legislative history at *Chevron* step one to determine whether Congress's intent is clear. *See Santana v. Holder*, 731 F.3d 50 (1st Cir. 2013); *WPIX, Inc. v. IVI, Inc.*, 691 F.3d 275 (2d Cir. 2012); *Schafer v. Astrue*, 641 F.3d 49 (4th Cir. 2011); *BNSF Ry. Co. v. United States*, 775 F.3d 743 (5th Cir. 2015); *Sierra Club v. EPA*, 781 F.3d 299 (6th Cir. 2015); *N. Dakota ex re. Olson v. CMS*, 403 F.3d 537 (8th Cir. 2005); *Ron Peterson Firearms, LLC v. Jones*, 760 F.3d 1147 (10th Cir. 2014); *Catawba Cnty. v. EPA*, 571 F.3d 20 (D.C. Cir. 2009); *Kingdomware Techs., Inc. v. United States*, 754 F.3d 923 (Fed. Cir. 2014).

facility that is not within the network of the insurer. To resolve payment disputes between providers/facilities and insurers, Congress crafted an "*independent* dispute resolution process," carefully enumerating statutory factors that a neutral arbiter must consider in rendering payment determinations. U.S. House Committees on Ways and Means, Energy and Commerce, and Education and Labor, *Protecting Patients from Surprise Medical Bills* (Dec. 21, 2020),[10] (indicating that the "arbitrator must equally consider [the Subparagraph C] factors"); U.S. Senate Committee on Health, Education, Labor & Pensions, *Congressional Committee Leaders Announce Surprise Billing Agreement* (Dec. 11, 2020);[11] Letter from Members of Congress to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep't Sec'ys, 1 (Nov. 5, 2021) [hereinafter "November 5th Letter"].[12] Congress took a balanced approach to setting the amount of payment for the out-of-network items or services, ensuring that payment determinations would not inherently favor one party over the other. 42 U.S.C. § 300gg-111(c)(5); 29 U.S.C. § 1185e(c)(5); 26 U.S.C. § 9816(c)(5).

To this end, Congress intentionally avoided giving presumptive weight to the QPA, which would tip the scales during the IDR process in favor of the insurers because the QPA is tied to the insurer's median in-network rates. *See* Letter from Richard E. Neal, Chairman, Comm. on Ways & Means, and Kevin Brady, Ranking Member of Comm. on Ways & Means, to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep't Sec'ys, 2 (Oct. 4, 2021) ("[T]he legislation reported out of the Committee on Ways and Means, which was adopted in the No Surprises Act, authorizes IDR but does not preference in-network rates to determine the payment

[10] https://gop-waysandmeans.house.gov/protecting-patients-from-surprise-medical-bills/.
[11] https://www.help.senate.gov/ranking/newsroom/press/congressional-committee-leaders-announce-surprise-billing-agreement.
[12] https://www.acep.org/globalassets/new-pdfs/advocacy/2021.11.05-no-surprises-act-letter.pdf.

amount.") [hereinafter "October 4th Letter"];[13] U.S. House Committees on Ways and Means, Energy and Commerce, and Education and Labor, *Protecting Patients from Surprise Medical Bills* (Dec. 21, 2020).[14] In fact, during the legislative process, Congress rejected the idea of "rel[ying] on the median in-network rate as the benchmark for payment." October 4th Letter at 2; November 5th Letter at 1; *see, e.g.*, Lower Health Care Costs Act, S. 1895, 116th Cong. § 103(a) (2019) (proposing that insurers pay providers "the median in-network rate" for certain services); *cf*. U.S. House Committees on Ways and Means, Energy and Commerce, and Education and Labor, *Protecting Patients from Surprise Medical Bills* (Dec. 21, 2020) (The No Surprises Act "includes NO benchmarking or rate-setting.").[15]

The Departments subverted Congress's intent by establishing a rebuttable presumption in favor of the QPA, abrogating the discretion afforded to the IDR entity and heavily tilting IDR decisions in favor of insurers. *See* October 4th Letter; November 5th Letter. By letter dated October 4, 2021, the Chairman and Ranking Member of the House Ways and Means Committee expressed their significant concerns to the Departments that the IFR's rebuttable presumption "biases the IDR entity" and "do[es] not reflect the law that Congress passed." October 4th Letter at 1-2; *see* Material Facts ¶ 24. The letter underscores that the No Surprises Act's directive "to consider all of the factors without giving preference or priority to any one factor" is the "express result of substantial negotiation and deliberation among those Committees of jurisdiction, and reflects Congress's intent to design an IDR process that does not become a de facto benchmark." October 4th Letter at 2.

In addition, on November 5, 2021, 152 Members of the U.S. House of Representatives

---

[13] https://www.aans.org/-/media/Files/AANS/Advocacy/PDFS/surprise-billing-regs-Neal-Brady-letter.ashx.
[14] https://gop-waysandmeans.house.gov/protecting-patients-from-surprise-medical-bills/.
[15] https://gop-waysandmeans.house.gov/protecting-patients-from-surprise-medical-bills/.

sent a letter to the Department emphasizing that the IFR's rebuttable presumption "establishes a de-facto benchmark rate" and is "contrary to the statute." November 5th Letter at 1-2 (finding that the IFR's provisions on the IDR process "do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes"); *see* Material Facts ¶ 25. The members of the U.S. House of Representatives stressed that the IFR's rebuttable presumption "could incentivize insurance companies to set artificially low payment rates, which would narrow provider networks and jeopardize patient access to care – the exact opposite of the goal of the law." November 5th Letter at 2.

The concerns expressed by Members of Congress, unfortunately, have already materialized. The Departments' interpretation of the No Surprises Act has empowered insurers to reduce in-network contracted rates and threaten existing contractual arrangements with providers. *See* Declaration of Dr. Raley; Declaration of Dr. Golding; *FDIC v. Chicago Title Ins. Co*., 12 F.4th 676, 684 (7th Cir. 2021) (courts "may also consider the 'effects and consequence' of the interpretation of the statute"). For instance, Blue Cross Blue Shield of North Carolina sent letters to providers demanding a reduction in contracted rates as a direct result of the Departments' IFR. Declaration of Dr. Golding (stating that Blue Cross Blue Shield of North Carolina's "letter cites the IFR as justification to 'warrant a significant reduction in (our) contracted rates with Blue Cross NC' and warns of additional rate reductions once the qualifying payment amount is established"); Declaration of Dr. Raley (noting that Blue Cross Blue Shield of North Carolina's letter states that the "IFR provides 'enough clarity to warrant a significant reduction in [Wake Emergency Physicians, P.A.'s] contracted rate with Blue Cross NC'"); Material Facts ¶ 23. The letters from Blue Cross Blue Shield of North Carolina further state that if providers do not accept the rate reduction in light of the Departments' IFR, their contracts will

be "quickly terminated." *See* Declaration of Dr. Golding; Declaration of Dr. Raley; Material Facts ¶ 23.

Congress clearly did not intend this result. By establishing a rebuttable presumption that skews IDR decisions in favor of the QPA, which benefits insurers at the expense of providers and facilities, the Departments disrupted Congress' balanced approach to provider payment and adversely impacted providers/facilities' negotiating position with insurers. This, in turn, jeopardizes provider networks and patient access to care. Therefore, the rebuttable presumption in favor of the QPA thwarts the purpose of the No Surprises Act and is inconsistent with congressional intent.

C. The Departments' Interpretation of the Statute Is Not Entitled to *Chevron* Deference Because the IFR Is Procedurally Defective

Additionally, courts may not accord *Chevron* deference when a "regulation is 'procedurally defective'—that is[,] where the agency errs by failing to follow the correct procedures in issuing the regulation." *Encino Motorcars,* 579 U.S. at 220 (quoting *United States v. Mead Corp*., 533 U.S. 218, 227 (2001)); *see also Abbas v. Selling Source, LLC*, No. 09 CV 3413, 2009 WL 4884471, at *5 (N.D. Ill. Dec. 14, 2009). As addressed below in section III, the Departments flouted the APA's rulemaking requirements by ignoring the statute's notice-and-comment procedures prior to publishing the IFR and failing to demonstrate "good cause" for doing so. Because the IFR was promulgated in violation of the APA, the Departments' rebuttable presumption is not entitled to *Chevron* deference. *Encino Motorcars*, 579 U.S. at 220-21.

III. The IFR's Presumption in Favor of the Offer Closest to the QPA Was Promulgated in Violation of the Rulemaking Requirements of the APA

The Departments' flawed rebuttable presumption in favor of the QPA is procedurally invalid under the APA because the Departments failed to demonstrate "good cause" for

circumventing the APA's notice-and-comment requirements. Congress intended the "good cause" exception to apply "when the regular course of rulemaking procedure would interfere with the agency's ability to perform its functions within the time constraints imposed by Congress." *U.S. Steel Corp. v. EPA*, 605 F.2d 283, 287 (7th Cir. 1979). Here, Congress gave the Departments a substantial period of time within which to engage in notice-and-comment rulemaking and promulgate final regulations on the IDR process. 42 U.S.C. § 300gg-111(c)(2)(A); 29 U.S.C. § 1185e(c)(2)(A); 26 U.S.C. § 9816(c)(2)(A). Specifically, under the No Surprises Act, the Departments were required to promulgate regulations on the IDR process "[n]ot later than 1 year after December 27, 2020"—an *entire year* after the enactment of the No Surprises Act. 42 U.S.C. § 300gg-111(c)(2)(A); 29 U.S.C. § 1185e(c)(2)(A); 26 U.S.C. § 9816(c)(2)(A). This, by no means, is a tight statutory deadline. *Cf. U.S. Steel Corp.*, 605 F.2d at 285 n.1, 285-87 (60-day statutory deadline).

However, the Departments chose to wait almost nine months after the enactment of the No Surprises Act to issue regulations. IFR, 86 Fed. Reg. 55,980 (October 7, 2021); *see* Material Facts ¶ 22. They now "raise up the 'good cause' banner" to excuse their own delay in issuing rules on the IDR process. *See Nat. Res. Def. Council v. Nat'l Highway Traffic Safety Admin.*, 894 F.3d 95, 114-15 (2d Cir. 2018) (internal quotation marks and citation omitted). It would be improper for the Departments to benefit from their dilatory tactics. *See Nat'l Ass'n of Farmworkers Orgs. v. Marshall*, 628 F.2d 604, 622 (D.C. Cir. 1980) (finding that good cause did not exist where the "Department waited nearly seven months between the initial regulation promulgated through notice and comment and the first modification of it promulgated without the requisite procedures"). Simply put, "[g]ood cause cannot arise as a result of the agency's own delay." *See Nat. Res. Def. Council*, 894 F.3d at 114.

The Departments conceded Congress's timeframe from enactment of the No Surprises Act on December 27, 2020, to the effective date of the IDR provisions for plan years beginning January 1, 2022, "may have allowed for … the full notice and comment rulemaking process." IFR, 86 Fed. Reg. at 56,043-44; Material Facts ¶ 22. Nonetheless, the Departments published the IFR approximately three months before the No Surprises Act's December 27, 2021, deadline for promulgating regulations governing the IDR process. The Departments could have engaged in notice-and-comment rulemaking during this time and before the IDR process commenced in 2022.

The Departments' assertions that good cause existed for ignoring the APA's notice-and-comment rulemaking requirements fall short of the standard needed to invoke this exception. *See Jifry v. FAA,* 370 F.3d 1174, 1179 (D.C. Cir. 2004). Their assertions generally describe "the bare need to have regulations" and "the goal of reducing uncertainty," which are insufficient to invoke the good cause exception. *Nat'l Ass'n of Farmworkers Orgs.*, 628 F.2d at 621; *United States v. Johnson*, 632 F.3d 912, 929 (5th Cir. 2011). "[D]esire to provide immediate guidance, without more, does not suffice for good cause." *Johnson*, 632 F.3d at 929 (internal quotation and citation omitted). Furthermore, the "possibility of an alteration to the interim rule after its promulgation increases rather than eliminates uncertainty." *Id.* (internal quotations and citations omitted). The Departments' justifications also fail to acknowledge that, in light of the multi-step dispute resolution process (which includes a 30-day open negotiation period prior to IDR proceedings), an IDR entity would not begin reviewing offers until well after January 1, 2022. *See* 42 U.S.C. § 300gg-111(a)(1)(C)(iv), (b)(1)(C), (c); 29 U.S.C. § 1185e(a)(1)(C)(iv), (b)(1)(C), (c); 26 U.S.C. § 9816(a)(1)(C)(iv), (b)(1)(C), (c).

Lastly, the Departments' speculation regarding under-compensation and access to care

does not supply good cause. *See Dialysis Patient Citizens v. Burwell*, No. 4:17-CV-16, 2017 WL 365271, at *4 (E.D. Tex. Jan. 25, 2017) ("Speculation that some patients will not have foresight to arrange for alternative coverage does not provide good cause to bypass notice and comment."). To the contrary, the IFR's rebuttable presumption will likely cause the potential harm described by the Departments. The QPA, for various reasons, is not reflective of the fair market value of items and services furnished by out-of-network providers/facilities in the marketplace.[16] *See* Declaration of Dr. Christopher E. Young, Exhibit 3; Declaration of Dr. Raley; Declaration of Dr. Golding. By significantly restricting the IDR entity's consideration of all statutory factors, the IFR will result in a disproportionately high number of IDR decisions that are closer to the QPA. As a result, the IFR's rebuttable presumption will undermine providers' and facilities' ability to be fairly reimbursed for their out-of-network services, which will, in

[16] The QPA does not accurately represent the prevailing market rates for out-of-network items and services due to the manner in which the median contracted rate is calculated pursuant to the Departments' interim final rule published on July 13, 2021. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. at 36,888-899; *see* Material Facts ¶ 13. For example, in calculating the median contracted rate, each contracted rate for an item or service is treated as a single data point regardless of the total number of claims paid at that rate. *Id*. at 36,889. Ignoring the volume of claims paid at the contracted rate misrepresents the true market value of the item or service. *See* Letter from Am. Coll. of Emergency Physicians & Emergency Dep't Prac. Mgmt. Ass'n to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep't Sec'ys 11 (Aug. 31, 2021), https://www.regulations.gov/comment/CMS-2021-0117-5695 [hereinafter "ACEP Comment Letter"]; Letter from Am. Soc'y of Anesthesiologists to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep't Sec'ys 3 (Sept. 7, 2021), https://www.regulations.gov/comment/CMS-2021-0117-7410 [hereinafter "ASA Comment Letter"]; Letter from Am. Coll. of Radiology to Chiquita Brooks-LaSure, Adm'r, CMS 2 (Sept. 7, 2021), https://www.regulations.gov/comment/CMS-2021-0117-7239 [hereinafter "ACR Comment Letter"]. Moreover, the Departments prohibit insurers from including risk sharing, bonus, or penalty, and other incentive-based and retrospective payments or payment adjustments in the determination of the median contracted rate. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. at 36,894. This exclusion results in QPAs that are lower than the full payment amount for the applicable out-of-network item or service. *See* ACEP Comment Letter at 14-15; ASA Comment Letter at 3; ACR Comment Letter at 2. Plaintiffs submitted letters to the Departments in response to this interim final rule describing in greater detail the various reasons why the QPA does not reflect fair market value. ACEP Comment Letter at 10-17; ASA Comment Letter at 3-4; ACR Comment Letter at 2; Material Facts ¶ 14.

turn, threaten their ability to operate in the marketplace. Additionally, the Departments have created a perverse incentive for insurers to significantly reduce their in-network rates or to refuse to enter into network agreements with providers/facilities. *See* Declaration of Dr. Golding; Declaration of Dr. Raley. If more providers/facilities are forced out-of-network due to this rebuttable presumption, patients will lose access to in-network care. Accordingly, the IFR's rebuttable presumption will hinder patients' access to care.

In sum, the Departments did not demonstrate that engaging in notice-and-comment rulemaking would be "impracticable, unnecessary, or contrary to the public interest." 5 U.S.C. § 553(b)(B), (d)(3). Because good cause did not exist for circumventing the APA's rulemaking procedures when issuing the IFR's provisions establishing the rebuttable presumption in favor of the offer closest to the QPA, the rebuttable presumption violates the APA's notice-and-comment rulemaking procedures. Such provisions of the IFR were issued "without observance of procedure required by law," and are, therefore, invalid. *Id.* § 706(2)(D).

CONCLUSION

For the foregoing reasons, the Court should vacate the following provisions of the Departments' IFR requiring the IDR entity to select the offer closest to the QPA unless it determines that credible information submitted by either party clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the QPA but in opposing directions:

a. 45 C.F.R. § 149.510(a)(2)(v); 45 C.F.R. § 149.510(a)(2)(viii); the second and third sentence of 45 C.F.R. § 149.510(c)(4)(ii)(A); the final sentence of 45 C.F.R. § 159.510(c)(4)(iii)(C); 45 C.F.R. § 510(c)(4)(iv); and 45 C.F.R. § 510(c)(4)(vi)(B).

b. 26 C.F.R. § 54.9816-8T(a)(2)(v); 26 C.F.R. § 54.9816-8T(a)(2)(viii); the second

and third sentence of 26 C.F.R. § 54.9816-8T(c)(4)(ii)(A); the final sentence of 26 C.F.R. § 54.9816-8T(c)(4)(iii)(C); 26 C.F.R. § 54.9816-8T(c)(4)(iv); and 26 C.F.R. § 54.9816-8T(c)(4)(vi)(B).

c. 29 C.F.R. § 2590.716-8(a)(2)(v); 29 C.F.R. § 2590.716-8(a)(2)(viii); the second and third sentence of 29 C.F.R. § 2590.716-8(c)(4)(ii)(A); the final sentence of 29 C.F.R. § 2590.716-8(c)(4)(iii)(C); 29 C.F.R. § 2590.716-8(c)(4)(iv); and 29 C.F.R. § 2590.716-8(c)(4)(vi)(B).

Respectfully submitted,

/s/ Ronald S. Connelly
Ronald S. Connelly (D.C. Bar No. 488298)*
Leela Baggett (D.C. Bar No. 1030000)*
POWERS PYLES SUTTER & VERVILLE, PC
1501 M Street, N.W.
Seventh Floor
Washington, DC 20005
tel. (202) 872-6762
fax (202) 785-1756
Ron.Connelly@PowersLaw.com
Leela.Baggett@PowersLaw.com
** Admitted pro hac vice*

/s/ Jeremy Lewin
Jeremy Lewin (Ill. Bar No. 6269242)
POWERS PYLES SUTTER & VERVILLE, PC
1061 American Lane
Schaumburg, IL 60173
tel. (202) 349-4284
fax (202) 785-1756
Jeremy.Lewin@PowersLaw.com

Attorneys for Plaintiffs

Dated: February 9, 2022

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

AMERICAN SOCIETY OF ANESTHESIOLOGISTS, *et al.*, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No.: 1:21-cv-06823 Honorable Marvin E. Aspen

PLAINTIFFS' LOCAL RULE 56.1(a)(2) STATEMENT OF MATERIAL FACTS NOT IN DISPUTE

Pursuant to Rule 56 of the Federal Rules of Civil Procedure and Local Rule 56.1(a)(2) of this Court, Plaintiffs American Society of Anesthesiologists ("ASA"), American College of Emergency Physicians ("ACEP"), and American College of Radiology ("ACR") (collectively, "Plaintiffs"), respectfully submit the following statement of material facts as to which Plaintiffs contend there is no genuine issue:

Parties

1. Plaintiff ASA is a voluntary professional association comprised of approximately 54,000 physician anesthesiologists and others involved in the medical specialty of anesthesiology, critical care, and pain medicine. Compl. ¶ 16. ASA is headquartered in Schaumburg, Illinois. *Id*. One of ASA's purposes is to advocate for the interests of its members and their patients, including on matters concerning adequate and fair reimbursement for anesthesia services. *Id*.

2. Plaintiff ACEP is a voluntary professional association comprised of more than 40,000 emergency physicians, residents, and medical students. *Id.* ¶ 17. ACEP is headquartered in Irving, Texas. *Id.* One of ACEP's core purposes is to advocate for the interests of emergency physicians and their patients. *Id.* Among its many purposes, ACEP seeks to ensure that insurers provide patients and their emergency physicians with adequate and fair reimbursement for emergency services. *Id.*

3. Plaintiff ACR is a voluntary professional association comprised of approximately 40,000 diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians, and medical physicists. *Id.* ¶ 18. ACR is headquartered in Reston, Virginia. *Id.* ACR's core functional areas—advocacy, economics, education, quality and safety, research, and membership value—seek to improve, promote, and protect the practice of radiology. *Id.* One of ACR's purposes is to advocate for the interests of its members and their patients. *Id.* This includes advocating for adequate and fair reimbursement for radiology services provided to patients. *Id.*

4. Members of ASA, ACEP, and ACR will be impacted by the provisions of the interim final rule, Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021) ("IFR"), governing the manner in which the independent dispute resolution ("IDR") entity determines the appropriate reimbursement amount for certain health care items and services furnished out-of-network. Compl. ¶¶ 16-20; *see* Decl. of Dr. Jennifer Raley Ex. 1; Decl. of Dr. Lauren Golding Ex. 2; Decl. of Dr. Christopher Young Ex. 3.

5. Defendant Department of Health and Human Services ("HHS") is a department of the federal executive branch and is headquartered in Washington, DC. Compl. ¶ 21. Defendant Xavier Becerra is the Secretary of HHS and is the federal officer responsible for administering

the Public Health Service Act, as amended by the No Surprises Act. *Id*. ¶ 22.

6. Defendant Department of Labor ("DOL") is a department of the federal executive branch and is headquartered in Washington, DC. *Id*. ¶ 23. Defendant Martin J. Walsh is the Secretary of DOL and is the federal officer responsible for administering the Employee Retirement Income Security Act, as amended by the No Surprises Act. *Id*. ¶ 24.

7. Defendant Department of the Treasury ("DOT") is a department of the federal executive branch and is headquartered in Washington, DC. *Id*. ¶ 25. Defendant Janet Yellen is the Secretary of DOT and is the federal officer responsible for administering the Internal Revenue Code, as amended by the No Surprises Act. *Id*. ¶ 26.

8. Defendant Office of Personnel Management ("OPM") is an independent federal agency of the United States and is headquartered in Washington, DC. *Id*. ¶ 27. Defendant Kiran Ahuja is the Director of OPM and is the federal officer responsible for administering the Federal Employees Health Benefits Act, as amended by the No Surprises Act. *Id*. ¶ 28.

Reimbursement for Certain Out-of-Network Services

9. Many insurers create networks of health care providers in which the insurer negotiates rates with providers for particular services as a condition of including the providers in the insurer's network. *Id*. ¶ 29; *see* Ryan J. Rosso et al., Cong. Rsch. Serv., R46856, Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services 2 (2021) [hereinafter "CRS Report"].[1] In general, insurers reimburse "in-network" providers a contracted, in-network rate for the provision of a covered item or service. Compl. ¶ 29; *see* CRS Report at 2. When patients received care from an in-network provider, the patient will be responsible for a cost-sharing amount. Compl. ¶ 29; *see* CRS Report

[1] https://crsreports.congress.gov/product/pdf/R/R46856.

at 2. The patient's out-of-pocket obligation, however, will typically be less for in-network services than if the patient received care from a provider outside the insurer's network. Compl. ¶ 29; *see* CRS Report at 2. An in-network provider generally does not charge the patient the difference between the provider's charges and the negotiated, in-network rate. Compl. ¶ 29; *see* CRS Report at 2.

10. If the patient receives care from a provider who does not have a network agreement with the insurer, the patient's insurer will reimburse the provider at the insurer's out-of-network rate, which is not negotiated in advance by the provider and the insurer. Compl. ¶ 30; *see* CRS Report at 3-4. Prior to the enactment of the No Surprises Act, the difference between the provider's charge and the insurer's out-of-network payment could be billed by the provider to the patient unless prohibited under state law. Compl. ¶ 30; *see* CRS Report at 4-5. This practice is commonly referred to as "balance billing." Compl. ¶ 30; *see* CRS Report at 4-5.

11. "Surprise billing" occurs when the patient unknowingly receives items or services from an out-of-network provider at an in-network healthcare facility or receives emergency care provided out-of-network, and the patient is billed for cost-sharing amounts that are not paid by the insurer and are higher than if the patient received care at an in-network provider. Compl. ¶ 31; *see* CRS Report at 1.

The Consolidated Appropriations Act, 2021

12. On December 27, 2020, the President signed into law the Consolidated Appropriations Act, 2021, which contains the No Surprises Act. No Surprises Act, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 2757-890 (2020) (codified at 42 U.S.C. § 300gg-111; 29 U.S.C. § 1185e; 26 U.S.C. § 9816); Compl. ¶ 33. The No Surprises Act amended provisions of the Public Health Service Act, the Employee Retirement Income Security Act, the Internal Revenue

Code, and the Federal Employees Health Benefits Act. 42 U.S.C. § 300gg-111; 29 U.S.C. § 1185e; 26 U.S.C. § 9816; 5 U.S.C. § 8902(p); Compl. ¶ 1 n.1. The Federal Employees Health Benefits Act, as amended by the No Surprises Act, cross references the requirements described in 42 U.S.C. § 300gg-111, 29 U.S.C. § 1185e, and 26 U.S.C. § 9816 (as applicable). 5 U.S.C. § 8902(p); Compl. ¶ 1 n.1.

Interim Final Rule Published on July 13, 2021

13. On July 13, 2021, the Departments published in the Federal Register an interim final rule implementing certain provisions of the No Surprises Act, including the methodology to calculate the qualifying payment amount ("QPA"). Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872 (July 13, 2021).

14. In response to this interim final rule, Plaintiffs ASA, ACEP, and ACR submitted letters to the Departments expressing concerns regarding the methodology for calculating the QPA. Letter from Am. Coll. of Emergency Physicians & Emergency Dep't Prac. Mgmt. Ass'n to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep't Sec'ys 11 (Aug. 31, 2021);[2] Letter from Am. Soc'y of Anesthesiologists to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep't Sec'ys 3 (Sept. 7, 2021);[3] Letter from Am. Coll. of Radiology to Chiquita Brooks-LaSure, Adm'r, CMS 2 (Sept. 7, 2021).[4]

Interim Final Rule Published on October 7, 2021

15. On October 7, 2021, the Departments published the IFR in the Federal Register, implementing the No Surprises Act's provisions governing the IDR process. IFR, 86 Fed. Reg. 55,980 (Oct. 7, 2021); Compl. ¶ 50. The IFR provides that the IDR entity must:

[2] https://www.regulations.gov/comment/CMS-2021-0117-5695.
[3] https://www.regulations.gov/comment/CMS-2021-0117-7410.
[4] https://www.regulations.gov/comment/CMS-2021-0117-7239.

> Select as the out-of-network rate for the qualified IDR item or service one of the offers submitted under paragraph (c)(4)(i) of this section, taking into account the considerations specified in paragraph (c)(4)(iii) of this section (as applied to the information provided by the parties pursuant to paragraph (c)(4)(i) of this section). The certified IDR entity must select the offer closest to the qualifying payment amount unless the certified IDR entity determines that credible information submitted by either party under paragraph (c)(4)(i) clearly demonstrates that the qualifying payment amount is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the qualifying payment amount but in opposing directions. In these cases, the certified IDR entity must select the offer as the out-of-network rate that the certified IDR entity determines best represents the value of the qualified IDR item or services, which could be either offer.

IFR, 86 Fed. Reg. at 56,103-04, 56,116, 56,128; *see* Compl. ¶ 53.

16. The IFR defines "credible information" as "information that upon critical analysis is worthy of belief and is trustworthy." IFR, 86 Fed. Reg. at 56,100, 56,113, 56,125; Compl. ¶ 55.

17. The IFR defines "material difference" as:

> [A] substantial likelihood that a reasonable person with the training and qualifications of a certified IDR entity making a payment determination would consider the submitted information significant in determining the out of network rate and would view the information as showing that the qualifying payment amount is not the appropriate out-of-network rate.

IFR, 86 Fed. Reg. at 56,101, 56,113, 56,125; *see* Compl. ¶ 57.

18. The IFR states that "it is not the role of the certified IDR entity to determine whether the QPA has been calculated by the [issuer] correctly." IFR, 86 Fed. Reg. at 55,996; Compl. ¶ 56.

19. If the IDR entity does not select the offer closest to the QPA, it must provide a written decision including "a detailed explanation of the additional considerations relied upon, whether the information about those considerations submitted by the parties was credible, and the basis upon which the certified IDR entity determined that the credible information

demonstrated that the QPA is materially different from the appropriate out-of-network rate." IFR, 86 Fed. Reg. at 56,000; Compl. ¶ 58.

20. The Departments stated: "The Departments are of the view that the best interpretation of [the statute] is that when selecting an offer, a certified IDR entity must look first to the QPA, as it represents a reasonable market-based payment for relevant items and services, and then to other considerations." IFR, 86 Fed. Reg. at 55,996; Compl. ¶ 59. The Departments justify the rebuttable presumption in favor of the offer closest to the QPA with the following reasoning: (1) the "statutory text lists the QPA as the first factor;" (2) the non-QPA factors appears "in a separate paragraph" and are subject to subparagraph (D), which describes certain factors that the IDR entity cannot consider in determining payment; (3) the statute "sets out detailed rules for calculating the QPA;" and (4) the No Surprises Act mentions the QPA in other provisions of the statute that do not govern the determination of payments to out-of-network providers/facilities. IFR, 86 Fed. Reg. at. 55,996; Compl. ¶ 59.

21. The Departments reference various "policy considerations" in support for their interpretation:

> The Departments are also of the view that policy considerations support the approach taken under these interim final rules regarding which offer a certified IDR entity must select. Generally, the QPA should reflect standard market rates arrived at through typical contract negotiations and should therefore be a reasonable out-of-network rate under most circumstances. The QPA is generally based on the median of contracted rates, and these contracted rates are established through arms-length negotiations between providers and facilities and plans and issuers (or their service providers). Anchoring the determination of the out-of-network rate to the QPA will increase the predictability of IDR outcomes, which may encourage parties to reach an agreement outside of the Federal IDR process to avoid the administrative costs, and will aid in reducing prices that may have been inflated due to the practice of surprise billing prior to the No Surprises Act. Finally, anchoring the determination to the QPA will help limit the indirect impact on participants, beneficiaries, and enrollees that would occur from higher out-of-network rates if plans and issuers were to pass higher costs on to

individuals in the form of increases in premiums.

IFR, 86 Fed. Reg. at 55,996; *see* Compl. ¶ 60.

22. The IFR went into effect on the same day of publication—October 7, 2021. IFR, 86 Fed. Reg. at 55,980; Compl. ¶ 50. Prior to this publication, the Departments did not provide general notice of proposed rulemaking and did not afford interested parties an opportunity to participate in the rulemaking through the submission of written comments. Compl. ¶ 51. The Departments "determined that it would be impracticable and contrary to the public interest to delay putting the provisions in these interim final rules in place until a full public notice and comment process has been completed and find that there is good cause to waive the delay in effective date for certain provisions of these interim final rules." IFR, 86 Fed. Reg. at 56,043; *see* Compl. ¶ 52. The Departments stated:

> The IDR and internal claims appeals and external review provisions generally apply for plan years (in the individual market, policy years) beginning on or after January 1, 2022. … Although this effective date may have allowed for the regulations, if promulgated with the full notice and comment rulemaking process, to be applicable in time for the applicability date of the provisions in the No Surprises Act, this timeframe would not provide sufficient time for the regulated entities to implement the requirements.

IFR, 86 Fed. Reg. at 56,043-44. The Departments further asserted:

> Issuing these rules as interim final rules, rather than as a notice of proposed rulemaking, will allow plans and issuers to account for the regulations as they finalize rates and plan offerings and will allow IDR entities to seek certification and be available to take part in the Federal IDR process when these interim final rules go into effect.
>
> Health plans and issuers, and providers, facilities and providers of air ambulance services, require these rules to be in place to determine the out-of-network rates for emergency services, services by out-of-network providers at in-network facilities in certain circumstances, and air ambulance services. Without these final rules, providers, facilities and providers of air ambulance services will not be able to resort to the Federal IDR process (and are no longer able to balance bill patients), leaving the possibility that they will be undercompensated for their

> services. Such undercompensation could threaten the viability of these providers, facilities and providers of air ambulance services. This in turn, could lead to participants, beneficiaries and enrollees not receiving needed medical care, undermining the goals of the No Surprises Act. Additionally, and for the same reasons, the failure to promulgate this rule in a timely fashion could lead to additional industry consolidation, potentially driving health costs higher.

Id. at 56,044.

Response to the Interim Final Rule Published on October 7, 2021

23. In response to the IFR, Blue Cross Blue Shield of North Carolina sent letters to certain providers demanding a reduction in contracted rates. Decl. of Dr. Lauren Golding Ex. 2 (stating that Blue Cross Blue Shield of North Carolina's "letter cites the IFR as justification to 'warrant a significant reduction in (our) contracted rates with Blue Cross NC' and warns of additional rate reductions once the qualifying payment amount is established"); Decl. of Dr. Jennifer Raley Ex. 1 (noting that Blue Cross Blue Shield of North Carolina's letter states that the "IFR provides 'enough clarity to warrant a significant reduction in [Wake Emergency Physicians, P.A.'s] contracted rate with Blue Cross NC'"). These letters from Blue Cross Blue Shield of North Carolina further state that if the providers do not accept the rate reduction, their contracts will be "quickly terminated." *See* Decl. of Dr. Lauren Golding Ex. 2; Decl. of Dr. Jennifer Raley Ex. 1.

24. By letter dated October 4, 2021, Chairman Richard Neal and Ranking Member Kevin Brady of the House Ways and Means Committee expressed concerns to the Departments with respect to the implementation of the No Surprises Act. Letter from Richard E. Neal, Chairman, Comm. on Ways & Means, and Kevin Brady, Ranking Member of Comm. on Ways & Means, to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep't Sec'ys (Oct. 4, 2021) Ex.

4;[5] Compl. ¶ 73.

25. By letter dated November 5, 2021, 152 Members of the U.S. House of Representatives expressed concerns regarding the Departments' interpretation of the No Surprises Act. Letter from Members of Congress to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep't Sec'ys (Nov. 5, 2021) Ex. 5.[6]

Respectfully submitted,

/s/Ronald S. Connelly
Ronald S. Connelly (D.C. Bar No. 488298)*
Leela Baggett (D.C. Bar No. 1030000)*
POWERS PYLES SUTTER & VERVILLE, PC
1501 M Street, N.W., Seventh Floor
Washington, DC 20005
tel. (202) 872-6762
fax (202) 785-1756
Ron.Connelly@PowersLaw.com
Leela.Baggett@PowersLaw.com
* *admitted pro hac vice*

/s/ Jeremy Lewin
Jeremy Lewin (Ill. Bar No. 6269242)
POWERS PYLES SUTTER & VERVILLE, PC
1061 American Lane
Schaumburg, IL 60173
tel. (202) 349-4284
fax (202) 785-1756
Jeremy.Lewin@PowersLaw.com

Attorneys for Plaintiffs

Dated: February 9, 2022

[5] https://www.aans.org/-/media/Files/AANS/Advocacy/PDFS/surprise-billing-regs-Neal-Brady-letter.ashx.
[6] https://www.acep.org/globalassets/new-pdfs/advocacy/2021.11.05-no-surprises-act-letter.pdf.

EXHIBIT 1

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

AMERICAN SOCIETY OF ANESTHESIOLOGISTS, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, and AMERICAN COLLEGE OF RADIOLOGY, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. _____

DECLARATION OF JENNIFER RALEY, MD

I, Jennifer Raley, MD declare as follows:

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

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

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

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

5. Currently, I serve as an emergency physician and a full shareholder at Wake Emergency Physicians, P.A. ("WEPPA"), which is located at 210 Towne Village Drive, Cary,

NC 27513. WEPPA contracts with WakeMed in Raleigh, North Carolina as well as hospital systems in the surrounding Johnston, Nash, and Granville Counties respectively, to provide emergency medical services.

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

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

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

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

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

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

12. Despite this focus on contracting, WEPPA nonetheless treats some "out-of-network" patients each month. When WEPPA is an out-of-network provider, I am an out-of-network provider.

13. I am aware that the United States Department of Health and Human Services, the United States Department of Labor, the United States Department of the Treasury, and the United States Office of Personnel Management recently published an interim final rule ("IFR") governing an independent dispute resolution ("IDR") process to determine how much reimbursement an insurer must pay for certain out-of-network items or services. Under the IFR, the entities determining the amount of reimbursement must "presume that the [qualifying payment amount ("QPA")] is an appropriate payment amount" unless "credible information" is submitted by the provider or insurer "clearly demonstrating" that the QPA is "materially different from the appropriate out-of-network rate," unless the reimbursement offers submitted by the provider and the insurer are equally distant from the QPA but in opposing directions. Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980, 55,995 (Oct. 7, 2021).

14. It is my understanding that the QPA is not reflective of the fair market value for emergency department care. Accordingly, the IFR's "rebuttable presumption" in favor of the QPA will result in significantly lower reimbursement rates than WEPPA is currently receiving for out-of-network emergency department care.

15. Because certified IDR entities have limited capability to consider other statutory factors (codified at 42 U.S.C. § 300gg-111(c)(5); 29 U.S.C. § 1185e(c)(5); 26 U.S.C. § 9816(c)(5)), the "rebuttable presumption" in favor of the QPA will tilt IDR deliberations in favor of the insurer. If certified IDR entities were able to consider these factors, I would be better positioned to receive adequate and fair reimbursement for my out-of-network services.

16. Therefore, the IFR's "rebuttable presumption" in favor of the QPA will adversely impact the out-of-network payments that WEPPA receives for my services that are subject to the No Surprises Act. Because the compensation that I receive from WEPPA depends, in large part, upon the revenues we receive from insurers, the IFR will adversely impact my compensation.

17. Moreover, I reasonably believe that the IFR's "rebuttable presumption" has and will continue to empower insurers to reduce WEPPA's/my in-network contracted rate with insurers or refuse to contract with WEPPA as an in-network provider.

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

19. In addition, I have personally had conversations with representatives from UnitedHealthcare and Cigna in the last year where they have demanded immediate and significant rate reductions and specifically raised the No Surprises Act during the conversation.

UnitedHealthcare has given us notice that our contract will terminate on May 30, 2022.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge and belief. Executed on December 22, 2021, in Raleigh, NC.

12/22/2021

Jennifer Raley, MD — Date

EXHIBIT 2

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

AMERICAN SOCIETY OF ANESTHESIOLOGISTS, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, and AMERICAN COLLEGE OF RADIOLOGY, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.* *Defendants*.	Case No. _____

DECLARATION OF LAUREN GOLDING, MD

I, Lauren Golding, MD declare as follows:

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

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

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

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

5. Currently, I serve as Chief Executive Officer at Triad Radiologists, which is located at 3010 Trenwest Dr, Winston Salem, NC. Triad Radiology Associates contracts with hospitals, hospital outpatient departments, outpatient imaging facilities, and critical access

hospitals in the Winston-Salem area for the provision of radiology treatment and care.

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

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

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

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

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

11. I am aware that the United States Department of Health and Human Services, the United States Department of Labor, the United States Department of the Treasury, and the United States Office of Personnel Management recently published an interim final rule ("IFR") governing an independent dispute resolution ("IDR") process to determine how much reimbursement an insurer must pay for certain out-of-network items or services. Under this IFR, the entities determining the amount of reimbursement must "presume that the [qualifying

payment amount] is an appropriate payment amount" unless "credible information" is submitted by the provider or insurer "clearly demonstrating" that the qualifying payment amount is "materially different from the appropriate out-of-network rate," unless the reimbursement offers submitted by the provider and the insurer are equally distant from the qualifying payment amount but in opposing directions. Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980, 55,995 (Oct. 7, 2021).

12. It is my understanding that the "qualifying payment amount" is not reflective of the fair market value for out-of-network radiology care. Accordingly, the IFR's "rebuttable presumption" in favor of the qualifying payment amount will result in significantly lower reimbursement rates than I am currently receiving.

13. Because certified IDR entities have limited capability to consider other statutory factors (codified at 42 U.S.C. § 300gg-111(c)(5); 29 U.S.C. § 1185e(c)(5); 26 U.S.C. § 9816(c)(5)), the "rebuttable presumption" will tilt IDR deliberations in favor of the insurer. If certified IDR entities were able to consider these factors, I would be better positioned to receive adequate and fair reimbursement for my out-of-network services.

14. Therefore, the IFR's "rebuttable presumption" in favor of the qualifying payment amount will adversely impact the out-of-network payments that Triad Radiology Associates receives for my services that are subject to the No Surprises Act. Because my profit distributions that I receive from Triad Radiology Associates dependent, in large part, upon the revenues from insurers, the IFR will adversely impact my profit distributions.

15. Moreover, I reasonably believe that the IFR's "rebuttable presumption" will empower insurers to reduce Triad Radiology Associates' in-network contracted rate with insurers or refuse to contract with me as an in-network provider. Triad Radiology Associates has

already received correspondence from Blue Cross Blue Shield of North Carolina demanding an immediate 10% reduction in our contracted rates, which were previously negotiated in good faith. This letter cites the IFR as justification to "warrant a significant reduction in (our) contracted rates with Blue Cross NC" and warns of additional rate reductions once the qualifying payment amount is established. The letter states that if Triad Radiology Associates does not accept the immediate rate reduction, our contract will be "quickly terminated".

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge and belief. Executed on December 21, 2021, in Winston Salem, North Carolina.

12/22/21

Lauren Golding, MD Date

EXHIBIT 3

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

AMERICAN SOCIETY OF ANESTHESIOLOGISTS, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, and AMERICAN COLLEGE OF RADIOLOGY, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.* *Defendants*.	Case No. _____

DECLARATION OF CHRISTOPHER E. YOUNG, MD

I, Christopher Young, MD declare as follows:

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

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

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

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

payments from private and public health insurers.

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

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

7. I also provide "out-of-network" anesthesia services to patients at EHS's hospital and ambulatory surgical center that are within the network of the patient's insurer. I expect to continue providing such services after the implementation of the No Surprises Act.

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

9. I am confident that at least some of the claims for out-of-network anesthesia services that I render at the in-network, EHS hospital and ambulatory surgical center will be adjudicated by the certified IDR entity pursuant to the No Surprises Act.

10. It is my understanding that the interim final rule entitled, "Requirements Related to Surprise Billing; Part II," 86 Fed. Reg. 55,980 (Oct. 7, 2021) (the "October IFR"), which implements the IDR process, requires the certified IDR entity to "select the offer closest to the qualifying payment amount unless the certified IDR entity determines that credible information submitted by either party … clearly demonstrates that the qualifying payment amount is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the qualifying payment amount but in opposing directions." *Id.* at 56,104, 56,116, 56,128.

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

12. Had the October IFR not established a "rebuttable presumption" in favor of the qualifying payment amount, certified IDR entities could have freely examined the statutory factors delineated in the No Surprises Act codified at 42 U.S.C. § 300gg-111(c)(5); 29 U.S.C. § 1185e(c)(5); 26 U.S.C. § 9816(c)(5). Consideration of these factors is critical to determining adequate and fair reimbursement for out-of-network anesthesia services.

13. Because the October IFR restricts the certified IDR entity's ability to consider these statutory factors by establishing a rebuttable presumption in favor of the qualifying payment amount, the October IFR will adversely impact the out-of-network payments that ACE receives for the anesthesia services that I provide to patients at EHS's hospital and ambulatory surgical center. This will, in turn, will negatively impact our income at ACE and diminish our ability to provide the level of high quality anesthesia services our patients currently receive.

14. Further, I expect that the October IFR's rebuttable presumption will adversely affect ACE's negotiating position with insurers because the October IFR's rebuttable presumption heavily favors insurers over providers. Because the October IFR's will result in significantly reduced out-of-network payments, I anticipate that insurers will leverage the rebuttable presumption to reduce ACE's in-network contracted rate with insurers.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge and belief. Executed on December 22, 2021, in Chattanooga, Tennessee.

Christopher E Young, MD 12/22/2021

Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, D.C 20515-0348
http://waysandmeans.house.gov

October 4, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Re: Implementation of the No Surprises Act

Dear Secretaries Becerra, Yellen, and Walsh:

We write regarding our concerns with respect to the implementation of the historic and bipartisan No Surprises Act by your Departments. We are concerned that the regulation published on September 30, 2021, as well as the decision to delay full implementation of the Advanced Explanation of Benefits (AEOB) and other patient protections, do not reflect the law that Congress passed. While this law represents one of the greatest consumer protection reforms in American history, its success depends on your Departments fulfilling Congressional intent and swiftly implementing all necessary provisions.

For far too long, patients received devastating surprise out-of-network medical bills and suffered from a lack of price transparency. Payers and providers put patients in the middle of their payment disputes. They kept patients in the dark about the cost of their care, then saddled them with insurmountable and unexpected charges. Congress stepped in to protect patients by ending the practice of surprise medical billing. In so doing, Congress sought to promote fairness in payment disputes between insurers and providers—carefully specifying all the various factors that should be considered during the independent dispute resolution (IDR) process. Your

Departments are also charged with ensuring that payers and providers work together to provide patients with transparent information that includes the patients' costs and the network status of their providers in the form of an AEOB.

The IDR process was subject to extensive Congressional consideration for nearly two years prior to the enactment of the No Surprises Act. The law incentivizes insurers and providers to act in good faith and resolve disputes amongst themselves while also recognizing that the parties may be unable to resolve their differences in certain instances. As a result, the law provides for an IDR process overseen by an independent and neutral arbiter who must consider a number of factors equally in deciding whether to select the provider or payer's offer. Such factors include median in-network rates, prior contracted rates during the previous four plan years, the relative market share of both parties involved, the provider's training and experience, the patient's acuity, the complexity of furnishing the item or service, and in the case of a provider that is a facility, its teaching status, case mix and scope of services, demonstrations of good faith efforts (or lack of good faith efforts) to enter into a network agreement, and other items. Congress deliberately crafted the law to avoid any one factor tipping the scales during the IDR process.

As you know, the Committees of jurisdiction worked through multiple proposals to end surprise billing throughout the 116th Congress. The compromise reflected in the No Surprises Act balanced the various approaches alongside the significant political and economic considerations at issue. Multiple proposals that ultimately did not become law relied on the median in-network rate as the benchmark for payment, with baseball-style arbitration designed as a backstop to, at most, result in a mere adjustment to the benchmark rate. In contrast, the legislation reported out of the Committee on Ways and Means, which was adopted in the No Surprises Act, authorizes IDR but does not preference in-network rates to determine the payment amount. The law Congress enacted directs the arbiter to consider all of the factors without giving preference or priority to any one factor—that is the express result of substantial negotiation and deliberation among those Committees of jurisdiction, and reflects Congress's intent to design an IDR process that does not become a de facto benchmark.

Despite the careful balance Congress designed for the IDR process, the September 30, 2021 interim final rule with comment strays from the No Surprises Act in favor of an approach that Congress *did not* enact in the final law and does so in a very concerning manner. The rule crafts a process that essentially tips the scale for the median contracted rate being the default appropriate payment amount. Under the interim final rule, the IDR entity is only allowed to deviate from the median amount where the parties present "credible information about additional circumstances [that] clearly demonstrates that the [median in-network rate] is materially different from the appropriate out-of-network rate." Such a standard affronts the provisions enacted into law, and we are concerned that this approach biases the IDR entity toward one factor (a median rate) as opposed to evaluating all factors equally as Congress intended.

In addition, we are concerned by the Administration's decision to delay the implementation of certain key transparency provisions slated to take effect on January 1, 2022. In guidance from August 2021, the Centers for Medicare and Medicaid Services delayed the compliance date for when consumers should receive a good faith estimate of the cost of services

through an AEOB despite the date specified by Congress. We are concerned that without a strict implementation deadline, payers and providers will not work toward expanding the current data transfer technology framework to ensure full compliance with the law. This provision was enacted to bring unprecedented transparency to patients about the cost of their health care, and delaying its implementation will leave patients vulnerable.

We understand that implementing the No Surprises Act to end the practice of surprise medical billing in a year is no small task, and that complexities exist as your individual Departments work together, but we must remain steadfast in ending this predatory practice. We request a written follow-up explaining how the regulation issued last week establishing the IDR process and designing a new test for how factors should be considered comports with the law Congress enacted. We are also requesting a timeline for full implementation that declares interim plans to build on current technology available to allow for implementation of these patient protections, specifically the AEOB and true and honest cost estimate, as soon as practicable. Finally, we ask that you revisit this interim final rule and consider adjustments that better align with the law Congress enacted.

Sincerely,

Richard E. Neal
Chairman
Committee on Ways and Means

Kevin Brady
Ranking Member
Committee on Ways and Means

Congress of the United States
House of Representatives
Washington, DC 20515

November 5, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Dear Secretary Becerra, Secretary Yellen, and Secretary Walsh:

We write regarding the interim final rule (IFR) released on September 30 entitled "Requirements Related to Surprise Billing; Part II". The bipartisan No Surprises Act, passed by Congress in December 2020, was one of the most important patient protection bills in American history, but its success will depend on your departments following the letter of law in its implementation. We urge you to amend the IFR in order to align the law's implementation with the legislation Congress passed.

Congress passed the No Surprises Act after extensive bipartisan and bicameral deliberations to protect patients from surprise medical bills and create a balanced process to resolve payment disputes between insurance plans and health care providers. During these deliberations, multiple proposals were considered including a benchmark rate, an independent dispute resolution (IDR) process, and a hybrid. Following a comprehensive process that included hearings, markups, and extensive negotiations, Congress rejected a benchmark rate and determined the best path forward for patients was to authorize an open negotiation period coupled with a balanced IDR process.

The No Surprises Act specified an IDR process that takes patients out of the middle of payment disputes. It allows providers and payors to bring any relevant information to support their payment offers for consideration, except for billed charges and public payor information. Per this process, the certified IDR entity shall consider:

- Median in-network rates
- Provider training and quality of outcomes
- Market share of parties
- Patient acuity or complexity of services
- In the case that a provider is a facility: teaching status, case mix, and scope of services
- Demonstrations of previous good faith efforts to negotiate in-network rates
- Prior contract history between the two parties over the previous four years

The process laid out in the law expressly directs the certified IDR entity to consider each of these listed factors should they be submitted, capturing the unique circumstance of each billing dispute without causing any single piece of information to be the default one considered.

Unfortunately, the parameters of the IDR process in the IFR released on September 30 do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes. The IFR directs IDR entities to begin with the assumption that the median in-network rate is the

appropriate payment amount prior to considering other factors. This directive establishes a de-facto benchmark rate, making the median in-network rate the default factor considered in the IDR process. This approach is contrary to statute and could incentivize insurance companies to set artificially low payment rates, which would narrow provider networks and jeopardize patient access to care – the exact opposite of the goal of the law. It could also have a broad impact on reimbursement for in-network services, which could exacerbate existing health disparities and patient access issues in rural and urban underserved communities.

We appreciate the complex nature of the patient protections that must be established and look forward to a final rule that accurately reflects Congress's multi-year bipartisan and bicameral work to pass this landmark legislation. Therefore, we urge you to revise the IFR to align with the law as written by specifying that the certified IDR entity should not default to the median in-network rate and should instead consider all of the factors outlined in the statute without disproportionately weighting one factor.

Thank you for your continued efforts on this important matter. We look forward to working with you to ensure the best outcomes for our patients and the health of our communities.

Sincerely,

Thomas R. Suozzi
Member of Congress

Brad R. Wenstrup, D.P.M.
Member of Congress

Raul Ruiz, M.D.
Member of Congress

Larry Bucshon, M.D.
Member of Congress

Additional Signatories

Alma S. Adams, Ph.D.
Colin Allred
Jodey C. Arrington
Cindy Axne
Ami Bera, M.D.
Jack Bergman
Andy Biggs
Dan Bishop
Sanford D. Bishop, Jr.
Mike Bost
Julia Brownley
Vern Buchanan
Tim Burchett
Michael C. Burgess, M.D.
Salud Carbajal
André Carson
Earl L. "Buddy" Carter, R.Ph.
Liz Cheney
Judy Chu
Steve Cohen
Tom Cole
J. Luis Correa
Jim Costa
Charlie Crist
Jason Crow
Sharice L. Davids
Danny K. Davis
Madeleine Dean
Suzan DelBene
Mark DeSaulnier
Neal P. Dunn, M.D.
Jake Ellzey
Tom Emmer
Adriano Espaillat
Ron Estes
Dwight Evans
Randy Feenstra
A. Drew Ferguson, IV
Brian Fitzpatrick
Chuck Fleischmann

John Garamendi
Andrew R. Garbarino
Louie Gohmert
Jimmy Gomez
Josh Gottheimer
Mark E. Green, M.D.
Glenn Grothman
Michael Guest
Josh Harder
Andy Harris, M.D.
Brian Higgins
J. French Hill
Ashley Hinson
Chrissy Houlahan
Richard Hudson
Ronny L. Jackson, M.D
Sheila Jackson Lee
Chris Jacobs
Dusty Johnson
Eddie Bernice Johnson
Henry C. “Hank” Johnson Jr.
John Joyce, M.D.
John Katko
Mike Kelly
Daniel T. Kildee
Derek Kilmer
Young Kim
Ron Kind
Raja Krishnamoorthi
Darin LaHood
Doug LaMalfa
Conor Lamb
Doug Lamborn
James R. Langevin
Jake LaTurner
Barbara Lee
Debbie Lesko
Julia Letlow
Mike Levin
Ted W. Lieu
Barry Loudermilk
Alan Lowenthal
Frank D. Lucas
Stephen F. Lynch
Nicole Malliotakis
Carolyn B. Maloney
Sean Patrick Maloney
Tracey Mann
Lucy McBath
James P. McGovern
David B. McKinley P.E
Peter Meijer
Grace Meng
Dan Meuser
Carol D. Miller
Mariannette J. Miller-Meeks, M.D.
Alex X. Mooney
Joseph D. Morelle
Frank J. Mrvan
Gregory F. Murphy, M.D.
Stephanie Murphy
Jerrold Nadler
Grace F. Napolitano
Dan Newhouse
Eleanor Holmes Norton
Devin Nunes
Jimmy Panetta
Bill Pascrell, Jr.
Ed Perlmutter
Dean Phillips
Bill Posey
Tom Reed
Guy Reschenthaler
Tom Rice
David Rouzer
Lucille Roybal-Allard
Bobby L. Rush
Tim Ryan
Linda T. Sánchez
Bradley S. Schneider
David Schweikert
Austin Scott
David Scott
Pete Sessions
Terri A. Sewell
Brad Sherman
Mike Simpson
Albio Sires
Christopher H. Smith
Jason Smith
Lloyd Smucker
Elise Stefanik
Eric Swalwell
Van Taylor
Mike Thompson
Rashida Tlaib
Ritchie Torres
Michael R. Turner
Jefferson Van Drew, D.M.D.
Beth Van Duyne
Nydia M. Velázquez
Jackie Walorski
Daniel Webster
Bruce Westerman
Robert J. Wittman
Steve Womack
John Yarmuth
Don Young

CC: Daniel Barry, Acting General Counsel, U.S. Department of Health and Human Services
Laurie Schaffer, Principal Deputy General Counsel, U.S. Department of the Treasury
Peter Constantine, Associate Solicitor for Legal Counsel, U.S. Department of Labor
Lynn Eisenberg, General Counsel, U.S. Office of Personnel Management