IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN MEDICAL ASSOCIATION, et al., Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	)	Case No.: 1:21-cv-3231-RJL

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO PLAINTIFFS' MOTION FOR STAY OR SUMMARY JUDGMENT

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CORPORATE DISCLOSURE STATEMENT

Under Local Rule 7(o)(5), *amicus curiae* America's Health Insurance Plans, Inc. ("AHIP") submits the following corporate disclosure statement:

AHIP has no parent corporation and no publicly-traded company holds 10% or more of AHIP's stock.

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INTEREST OF *AMICUS CURIAE*[1]

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

AHIP's members strive to reach agreements with health care providers to offer consumers affordable networks that provide them with choices in the delivery of quality medical care. When unable to secure network agreements before treatment is rendered, health insurance providers have long worked to negotiate out-of-network payments to prevent surprise medical bills and reduce costs for patients. This approach was no solution to the growing problem of providers remaining out-of-network when, due to the nature of the provider's medical specialty, patients are unable to choose a provider in advance. Invariably, the result was that such out-of-network providers were paid well above typical market rates, even for their specialty peers, and consumers faced excessive costs—including to the point of bankruptcy—when providers demanded to be paid the balance of unreasonable billed charges.

AHIP strongly supports Congress's decision in the No Surprises Act to fix the market dysfunction that saddled patients with exorbitant medical bills for services they had no opportunity

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

to turn down. AHIP also agrees with Defendants' legal arguments that the Act's fix hinges on anchoring disputed out-of-network rates to the "qualifying payment amount" (QPA), absent credible information otherwise. The QPA reflects competitive, fair market rates, and Plaintiffs' unbounded alternatives would create the very problems the Act aims to remedy.

For context, AHIP briefly touches on how the No Surprises Act works, background on the surprise billing problem, and how predictable out-of-network costs benefit patients and consumers while providing fair reimbursement—topics that are also covered by other *amici*. AHIP writes separately, however, to focus on two distinct issues within its expertise. The first is operational and related to the Departments' rulemaking procedures: To protect all patients as intended, dispute resolution rules had to be finalized before completion of formal comments, given the numerous operational measures that health insurance providers needed to undertake well before the Act's January 1, 2022 effective date—measures that depended on final rules. Second, AHIP shares the experience of health insurance providers with different state out-of-network dispute resolution systems, explaining how that experience confirms the Departments' substantive interpretation of the Act to promote structured decision-making that reduces unwarranted administrative costs and protects Americans from higher premiums driven by a high volume of open-ended dispute resolution proceedings.[2]

[2] AHIP's interest in the implementation of the No Surprises Act extends to the Act's application to all health care providers subject to its provisions. AHIP has filed an amicus brief in *Association of Air Medical Services v. U.S. Department of Health and Human Services*, No. 1:21-cv-3031 (D.D.C.), covering the unique constellation of issues faced in the air ambulance sector, and in *Texas Medical Association v. U.S. Department of Health and Human Services*, No. 6:21cv425 (E.D. Tex.). Although there are common issues presented in each of these cases, each case also presents unique issues. This brief explores some topics not covered in the air ambulance brief, including operational issues relevant to the decision to proceed by interim final rule and incentives for health insurance providers to offer broad networks of medical providers.

INTRODUCTION AND SUMMARY OF ARGUMENT

Congress gave the governing Departments, health care providers, and health insurance providers only a single year to implement the No Surprises Act, given the urgency of protecting Americans from surprise medical bills and addressing spiraling out-of-network costs. Accordingly, the Departments issued rules in phases. In the first phase, the Departments issued a rule implementing the methodology for calculating the QPA—generally based on median contracted rates in the local geographic region—per Congress's July 1, 2021 statutory deadline. Rightly recognizing that the Act is not turn-key, and that clarity in Independent Dispute Resolution (IDR) rules was a precondition for timely implementation, the Departments then moved to provide guidance on the IDR process (phase two), where the QPA (defined in phase one) plays a central role.

To allow for an operational IDR process by January 1, 2022, health plans needed clear guidance. Requiring the IDR process to begin with the QPA—rather than an open-ended multi-factor weighing with no structure—provided much-needed certainty. Finalizing the rules allowed health insurance providers to:

- finalize benefit designs;
- obtain regulatory approvals;
- set up staffing, systems, and vendor contracts to handle claims and disputes;
- and, when acting as third-party administrators on behalf of employers that pay for their employees' health care services, set up systems to accurately predict those employers' anticipated costs, administer their claims, and handle any disputes.

Moving forward with an interim final rule facilitated health plans' readiness to implement these protections for patients on day one—including protections against out-of-control health care

costs. The Departments rightly interpreted the Act to require certified IDR entities to select the reimbursement amount closest to the QPA, absent credible information demonstrating a material difference otherwise. And they correctly found that approaching IDR by focusing on an objective, predictable, and regulated measure such as the QPA makes out-of-network costs more predictable, and health coverage more affordable for everyone, due to lower administrative costs and more reasonable payments for out-of-network services. This directly translates to lower premiums for consumers and employers, as well as lower federal health care expenditures (in the form of reduced premium tax credits that help Americans buy coverage).

Predictability lowers administrative costs in two ways. First, it reduces the number of IDR requests and proceedings, as providers and health plans are more likely to settle disputes when they can predict an IDR proceeding's likely result. This outcome is readily demonstrated by the results seen across states with different dispute resolution regimes. Second, predictability lowers costs of the IDR proceedings that do occur, by limiting the possibility of extended open-ended inquiries about immaterial factors, as most cases can be resolved by reference to the QPA alone. The lower administrative costs that follow from this increased predictability directly benefit consumers and advance a key policy goal of limiting the share of premium dollars spent on administrative costs.

A QPA anchor also works directly to reduce out-of-network costs, while recognizing that IDR entities may select higher payment amounts when warranted by credible information that makes a material difference. This results in more affordable health coverage and fair reimbursement, all while ensuring patients' access to quality networks. Nor will network coverage diminish. Contrary to the dire predictions of Plaintiffs' *amici*, health insurance providers have every reason to broaden their networks under the rule, not narrow them, given regulatory

requirements and business imperatives.

ARGUMENT

I. Timely Implementation Of The Act And Its New Dispute Resolution Process Would Have Been Impossible Without Finalization Of The IDR Rule Months Before January 1.

The No Surprises Act fixed an urgent problem facing Americans: serious financial hardship from surprise medical bills for services they were unable to turn down or for which they were unable to select their provider (as for emergency care or certain hospital-based specialties like anesthesiology or pathology). 86 Fed. Reg. 36,872, 36,874 (July 13, 2021). In such situations, providers are often "out-of-network" for patients, meaning the provider had not negotiated in advance with the patient's health plan regarding an agreed market rate for the service. Before the Act, patients and their health plans faced demands to pay whatever rate such out-of-network providers decided to charge. The Act fixed this problem by limiting what patients could be charged—typically to a percentage of the QPA, which is generally the median of competitively negotiated fair market rates—and by establishing an IDR process centered on the QPA to resolve disputes about the remainder of the payment.

The Departments, faced with getting this new system up and running in just a year, engaged in a phased rulemaking process as expressly contemplated by Congress—issuing the QPA rule first, then issuing the IDR rule after comments were received on the QPA rule. This phased approach was necessary, given the centrality of the QPA in the overall statutory scheme, including the IDR process. *See* 86 Fed. Reg. 55,980, 55,982 (Oct. 7, 2021) (describing phased approach and explaining how second "interim final rules build upon the protections in the July 2021 interim final rules"). The Departments reasonably determined that it was impracticable and contrary to public interest to delay finalizing the IDR rule pending the completion of a formal public comment period for the IDR rule. 86 Fed. Reg. at 56,044. The IDR procedures needed to be finalized sufficiently

early to allow regulated entities, including health insurance providers, time to implement necessary changes to their operations so that consumers would have the full protections contemplated by the Act on its January 1, 2022 effective date.

A. The Act Centers Out-of-Network Payments on the QPA.

Congress charged the Departments with establishing a process to protect consumers when they receive certain out-of-network medical services. That process is centered on an amount defined by statute, known as the QPA, which is generally the health plan's local median contract rate for the same service. When a patient receives care covered by the Act, the medical provider can typically bill the patient for a percentage of the QPA, but no more than that.[3]

The patient's health plan then makes a payment for the remainder of the service within 30 days. If there is a dispute, the provider and the health plan can engage in open negotiations. If agreement is not reached within 30 days, either party may initiate IDR and submit an offer (though they may continue to negotiate while IDR is ongoing). Congress tasked the Departments with reporting IDR results in terms of how they compare with the QPA. This brief focuses on the central role that Congress gave the QPA in this IDR process, and why it was essential for clear, final guidance on that aspect of IDR to be issued no later than October 2021, when the IDR rule was issued as an interim final rule.[4]

B. Health Insurance Providers Could Not Feasibly Implement the QPA-Centric IDR Process Without the Interim Final Rule Promulgated in October 2021.

Given the QPA's cornerstone role and the congressional command to first implement the

[3] The amount the provider can bill is limited to the in-network cost-sharing for the patient's health plan, *id.* § 300gg-111(a)(1)(C)(iii), (b)(1)(B), which commonly means a percentage of the QPA, but the amount may be based on state law if one applies, *id.* § 300gg-111(a)(3)(H)(i).

[4] For the definition of the QPA, see 42 U.S.C. § 300gg-111(a)(3)(E). For the limitations on what patients can be billed, see *id.* §§ 300gg-111(a)(1)(C)(iii), (a)(3)(H), (b)(1)(B), *id.* § 300gg-131, and *id.* § 300gg-132. For the health plan's initial payment, see *id.* § 300gg-111(a)(1)(C)(iv)(I), (b)(1)(C). For provisions governing open negotiations and IDR, see *id.* § 300gg-111(c).

QPA, by July 1, 2021, 42 U.S.C. § 300gg-111(a)(2)(B), the Departments reasonably proceeded in phases, completing a comment period on the QPA rule before moving in October 2021 to the rules governing IDR that depend upon the QPA. At that point—three months from the January 1 date that the process for resolving out-of-network payments needed to be in place to protect consumers—final rules were critical to health insurance providers' ability to meet the Act's implementation deadline. Among the tasks facing health insurance providers during this time were needing to finalize benefit design and premiums, obtain any necessary regulatory approvals, and address key operational imperatives. There were a mere 370 days between the President signing the Act and the first day out-of-network claims would be subject to it. The myriad tasks that health insurance providers needed to complete prior to the Act's effective date simply would not have been possible to complete during that time with a full 60-day comment period following non-final proposed rules for each phase of the regulatory implementation. Interim final rules are specifically authorized for changes to rules implementing the relevant statutes (e.g., the Public Health Service Act and Employee Retirement Income Security Act) precisely because Congress recognized that such rulemaking procedures would often be necessary in this context—all the more so when the Departments must implement a new law that reshapes significant segments of the U.S. economy within a condensed rulemaking timeline.

The IDR rule amply demonstrates the good cause for issuing an interim final rule with comment period. As the Departments explained, health insurance providers had "to account for the[] changes [made in the IDR rule] in establishing premium or contribution rates and in making other changes to benefit designs," and needed to do so *before* January 1. 86 Fed. Reg. at 56,044. For larger employers with health plan years that begin on January 1, as many do, premiums and networks must be finalized no later than November so that employees can choose among options

during open enrollment periods. *See* Stephen Miller, *Open Enrollment Guide & Resources*, Soc'y Hum. Res. Mgmt., https://tinyurl.com/2p9xd7ym. Plan contracts are typically negotiated and entered into by April of the preceding year. The remaining months before employees enroll are used to produce and distribute required plan documents, including a Summary Plan Description, which must include detailed information on how out-of-network bills will be resolved. The months before a plan's effective date are also the period when a plan or issuer will negotiate or renegotiate contracts with providers and facilities. The more certainty around surprise billing rules both parties had, the greater chance that plans and providers would enter into network participation contracts, furthering a key public policy goal of the Act that directly benefits consumers.

Predicting likely out-of-network payments is a key aspect of benefit design. A health plan's initial payment for an out-of-network service or treatment could be as early as the end of January for a prompt claim. The payment often will be based on a reasonable rate metric specified by the plan's benefit design. Knowing the IDR rules enabled plans to finalize their out-of-network benefit design to avoid too-low initial payment amounts that would prompt a high volume of IDR requests. It would have been infeasible to finalize benefit designs without the lead time provided by the interim final rule. And related plan amendments to out-of-network processes sometimes required regulatory approval, which also "need[ed] time." 86 Fed. Reg. at 56,044.

Beyond finalizing benefit designs and plan documents, health insurance providers had to stand up dispute resolution systems by January 1, 2022. Finalizing the rule only at the last-minute deadline of December 27, 2021, 42 U.S.C. § 300gg-111(c)(2)(A)—just four days before the Act's effective date—would have been far too late. The dispute resolution system required by the Act encompasses many steps that depend on how IDR factors will be weighed, yet occur well before an IDR proceeding ever takes place. The open negotiation period, for example, could occur as

soon as February 2022. It would be impossible to craft reasonable offers in negotiation, and to make decisions regarding whether to settle, without rules in place specifying how IDR decisions would be made. Not having the rules of the IDR process in place before negotiation begins is akin to asking litigants to settle their cases without knowing the governing law—a futile exercise.

Many core aspects of developing and operationalizing health plans' dispute processing systems—central to providing affordable coverage—also could not be finalized without the IDR rules already in hand. Set rules for IDR decision-making were essential for plans to estimate the number of IDR proceedings and therefore appropriately size their dispute-processing operations. Health insurance providers needed to hire teams or shift work responsibilities at the end of 2021 to be ready to implement an entirely new, complex system where a vast number of providers could invoke IDR to seek higher out-of-network payments. It takes time to recruit, hire, and train staff, especially in today's labor market.

Data management systems, essential to health plans' capability to process a potentially immense number of open negotiation and IDR requests in a very short timeframe, also needed to be designed and built. Developing these systems could include building automated processes to facilitate gathering, compiling, and submitting information. Any automation requires knowing in advance the necessary inputs to be considered and relied upon in an IDR proceeding (e.g., the contours of information to be gathered and submitted). Such system requirements became clear only after the IDR rule was finalized. *See* 45 C.F.R. § 149.510(c)(4)(iv) (qualifying credible information).

Finally, health insurance providers sometimes need to contract with vendors to handle parts of their dispute resolution process. Those contracts could not be negotiated until the IDR rule was final because their terms depend on, among other things, what information the vendor would need

to submit in the IDR proceedings, as well as the projected volume and complexity of IDR proceedings. An open-ended IDR process could require a vastly different set of contract terms than a more structured process.

Beyond these operational issues presented for health insurance providers offering full insurance coverage, health insurance providers offering administrative services for self-funded employer-sponsored health plans faced an additional set of tasks. In this role, health insurance providers are often referred to as third-party administrators (TPA). TPAs needed clarity on the IDR rule to finalize arrangements with employers *before* January 1, which for many plans is the beginning of a new plan year. TPAs needed to understand the IDR rules to better model employers' projected benefit costs for employers to use in designing benefits and financial planning. In addition, because employers often rely on TPAs to resolve out-of-network payment disputes, TPAs and employers needed to adjust their contracts to reflect the new IDR process, including delineating the TPA's authority to resolve disputes that go to IDR. Until IDR rules were finalized, there was scant information available to craft agreements that would accurately reflect anticipated roles. Yet those agreements, too, in many cases needed to be in place by January 1, 2022.

In sum, IDR regulations needed to be final *at least* a few months before January 1, 2022, to give health insurance providers (including those acting as TPAs) time to undertake the multitude of steps necessary to comply with the federal regulatory requirement to implement a new dispute resolution process that would ensure Americans would be protected on day one of the Act as Congress contemplated. Timely implementation of the Act would have been impossible if the rules had not been finalized until after the 60-day comment period.

II. Predictable Rules For Independent Dispute Resolution Benefit Consumers.

A. The No Surprises Act Seeks to Remedy Dysfunction in Health Care Markets Where Patients Cannot Choose Providers.

For most medical services, payments are set in advance by negotiation of rates between health insurance providers and health care providers. Health plans work with providers to offer networks that provide Americans access to affordable, high-quality care. *See* AHIP, Center for Policy and Research, *Charges Billed by Out-of-Network Providers: Implications for Affordability*, at 3 (Sept. 2015), https://tinyurl.com/ba2v83er. Such networks benefit patients, health plan sponsors like employers, and the entire health care system by reducing costs, promoting access to and utilization of care, and providing high-quality choices for enrollees. *See* AHIP, *What's the Role of Networks in Providing High-Quality Affordable Care?*, https://tinyurl.com/2p94p4xz. Networks reduce costs because health insurance providers verify the credentials of the providers, negotiate payment rates up front, and avoid the inefficiencies of negotiating every bill. The resulting contracts typically limit the provider to the agreed payment from the plan and prohibit surprise bills to patients. *See* 86 Fed. Reg. at 36,874. Out-of-network providers, in contrast, often charge higher rates, and before the Act, sometimes sent patients surprise bills for any part of their billed charges that was not paid by insurance. *Id*.

For services where patients are unable to choose an in-network provider in advance, providers lack the same incentives to join networks, resulting in lower network participation rates for certain providers, like those that provide emergency care, or are assigned by the hospital without patient direction, such as anesthesiologists and pathologists. *See* 86 Fed. Reg. at 56,046; Gary Claxton et al., *An analysis of out-of-network claims in large employer health plan*s, Peterson-KFF Health System Tracker (Aug. 13, 2018), https://tinyurl.com/3fp5psf9; *see also* 86 Fed. Reg. at 36,874. A list of medical specialties that most often invoke out-of-network dispute resolution

illustrates the breadth of the problem, and shows how patients who do everything they can to obtain care in an in-network facility can still often be saddled with out-of-network bills. For example, the top five specialties involved in out-of-network arbitrations in Texas are emergency department physicians, anesthesiologists, certified registered nurse anesthetists, radiologists, and surgical assistants. *See* Tex. Dep't of Ins., *Senate Bill 1264: 2021 midyear report*, at 6 (July 2021) ("Texas IDR Report"), https://tinyurl.com/yc34f3r5.

Patients often receive care from an out-of-network provider at an in-network hospital because the physicians who provide care within a hospital are often not hospital employees, and instead negotiate separately with health insurance providers. Zack Cooper et al., *Surprise! Out-of-Network Billing for Emergency Care in the United States*, 128 J. Pol. Econ. 3626, 3617 (2020). Approximately two-thirds of hospitals outsource the staffing of their emergency departments, in particular, to physician staffing companies. *Id.* at 3631. Two national private-equity-owned physician staffing firms account for about a third of such outsourced staffing. *Id*.

When hospitals contract with national or local physician groups, they sometimes require "facility-based emergency, ancillary, and similar clinicians to contract with all the same health plans as the facility as a condition of practicing at that facility," a practice known as "network matching." Loren Adler et al., *Network Matching: An Attractive Solution to Surprise Billing*, Health Affairs Forefront (May 23, 2019), https://tinyurl.com/2p8pwrp9. Network matching "slipped out of favor around 2000 as major physician staffing companies—which tend to make more money when they're out of network—gained market power." Tara Bannow, *Hospitals' solution to surprise out-of-network bills: Make physicians go in-network*, Modern Healthcare (Jan. 12, 2019), https://tinyurl.com/mwk7vpv9. While out-of-network providers remain relatively rare (but not entirely absent) in a majority of hospitals, in other hospitals an out-of-network business

model is the norm for their physician staffing. Cooper, 128 J. Pol. Econ. at 3645. Combined, this presented a persistent and all-too-frequent problem where patients could receive a surprise medical bill even when they deliberately went to an in-network facility, which in some cases could be for an astronomical amount that could threaten that patient and their family with financial ruin.

Before the No Surprises Act, providers who were out-of-network could often "balance bill" the patient the difference between what they charged and how much the health plan paid, allowing providers to leverage higher payments—whether in exchange for agreeing to join networks, or in out-of-network negotiations. *See* 86 Fed. Reg. at 36,874; *see also* Zack Cooper et al., *Out-Of-Network Billing and Negotiated Payments for Hospital-Based Physicians*, 39 Health Affairs 24, 26 (Jan. 2020), https://tinyurl.com/bddeyrfj (finding in-network rates of 343% and 367% of Medicare rates for pathologists and anesthesiologists compared to 164% of Medicare rates for orthopedists). One study of a national physician staffing firm found that when it "enters into a new contract to manage a hospital's [emergency department] services, it immediately exits insurer networks, ... and seeks to collect charges (which it doubles relative to the charges billed by the prior physician group in that hospital)." Cooper, 128 J. Pol. Econ. at 3629.[5]

[5] Air ambulance services have been a particularly acute example of the skewed out-of-network market dynamic resulting in exorbitant surprise bills for patients and higher health care costs for all consumers with health insurance. AHIP addresses issues specific to air ambulance providers in the amicus brief it filed in *Association of Air Medical Services v. U.S. Department of Health and Human Services*, No. 1:21-cv-3031 (D.D.C.). The critical importance of predictability for reducing administrative costs and making health care more affordable, however, applies to both air ambulances and medical providers alike. Accordingly, this brief's coverage of those topics (section II.B) is substantially similar, though not identical, to the discussion in the brief filed by AHIP in *Association of Air Medical Services.*

B. Centering the QPA Is Essential for IDR Predictability, Which Reduces Administrative Costs and Makes Health Care More Affordable.

1. Rulemaking Was Required to Guide IDR Decision-Making, and the Departments Reasonably Interpreted the Act to Favor Predictability.

Congress listed the QPA first among the "[c]onsiderations" for IDR entities, followed by "additional circumstances" in a separate paragraph. 42 U.S.C. § 300gg-111(c)(5)(C). It also centered the QPA in the IDR reporting requirements. *Id.* §§ 300gg-111(c)(7)(A)(v), (B)(iii)-(iv). But it did not explicitly direct *how* IDR entities were to consider the QPA and additional factors.

The Departments reasonably determined that it was most "in accord[]" with the Act, *id.* § 300gg-111(c)(2)(A), for the QPA to be considered first, requiring selection of the offer closest to the QPA absent credible information dictating a materially different rate. *See* Defs. Cross-Mot. for Summ. J., Dkt. 52, at 14-19. By expressly frontloading a congressionally defined numerical factor that is central to the statutory scheme, and then listing a variety of other potential considerations, Congress did not issue a self-executing command to weigh each consideration equally—particularly the open-ended possibility of "such information as requested by the certified IDR entity," 42 U.S.C. § 300gg-111(c)(5)(B)(i)(II). Nor did Congress authorize weighing the various factors however a particular IDR entity might choose from day to day, with no consistency even for the same decision-maker, much less across scores of decision-makers nationwide. Such a system with no guardrails would be inconsistent with standard norms of adjudicative decision-making. *Cf. Kirtsaeng v. John Wiley & Sons, Inc.*, 136 S. Ct. 1979, 1986 (2016) ("[U]tterly freewheeling inquiries often deprive litigants of 'the basic principle of justice that like cases should be decided alike.'") (quoting *Martin v. Franklin Capital Corp.*, 546 U.S. 132, 139 (2005)). There is no indication that Congress mandated such a "freewheeling" system. Rather, Congress ensured consistency and predictability by focusing IDR on the QPA and charging the Departments with discretion to dictate how the factors would be weighed.

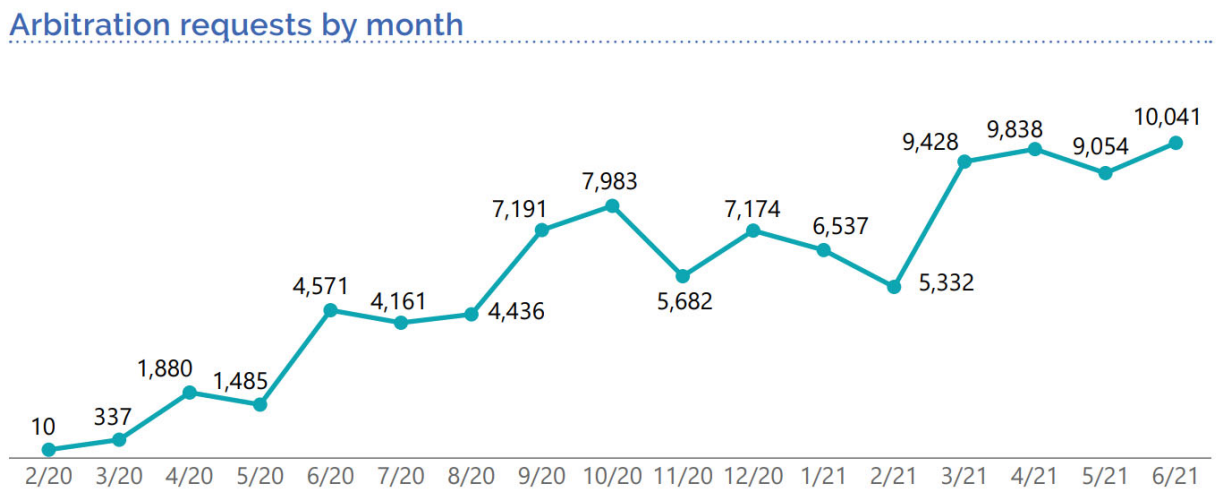
Absent clear guidance on how the different factors should be weighed to choose between the parties' offers, the IDR process would be subjective and unpredictable. In contrast, the rule as written enables predictable decisions and promotes fairness by permitting IDR awards to align with credible, material information—including when such information dictates payments higher than the QPA. By clarifying how the Act ties IDR outcomes to the QPA cornerstone in most (but not all) cases, the IDR rule makes out-of-network costs more predictable. *See* 86 Fed. Reg. at 55,996 ("Anchoring the determination of the out-of-network rate to the QPA will increase the predictability of IDR outcomes."). That predictability, in turn, generates a host of beneficial effects for health care markets and, ultimately, patients and consumers.

2. IDR Predictability and Efficiency Reduce Administrative Costs.

IDR administrative costs are driven by the volume and efficiency of proceedings. On both counts, enhanced predictability helps reduce costs. As to volume, enhanced predictability reduces the number of disputes to resolve. As the Departments explained, predictable outcomes "may encourage parties to reach an agreement outside of the Federal IDR process." 86 Fed. Reg. at 55,996. The Act is designed to encourage voluntary dispute resolution and minimal use of IDR: It bars a party from taking a dispute about the same item or service to IDR within 90 days of a decision in an earlier IDR invoked by that party and involving the same health plan, provider, and service. 42 U.S.C. § 300gg-111(c)(5)(E)(ii). The rule works toward that same goal whereas an unpredictable IDR process would work at cross-purposes. State experience confirms that the more predictable the dispute resolution results, the less likely that parties will need to invoke IDR.

In Texas, arbitrators are required to consider 10 disparate factors with no guidance on how to weight them. Tex. Ins. Code § 1467.083(b). New Jersey has a similar system. Benjamin Chartock et al., *Arbitration Over Out-Of-Network Medical Bills: Evidence From New Jersey Payment Disputes*, 40 Health Affairs 130, 131 (Jan. 2021). In both states, unpredictable decision-

making has led to a high volume of dispute resolution proceedings for contested out-of-network charges, with numbers increasing over time. *See* Texas IDR Report, at 4 (50,230 in first half of 2021, compared to 44,910 in 2020); *compare* N.J. Dep't of Banking & Ins., 2019 Report, https://tinyurl.com/4dfeevnf, *with* 2020 Report, https://tinyurl.com/2p9dmvp7 (arbitrations nearly doubled from 2019 to 2020). This ever-increasing volume of arbitrations—for Texas depicted below—inevitably leads to higher administrative costs and thus higher premiums.



See Texas IDR Report, at 6.

In contrast, in states with more predictable decision-making systems, arbitration is a relatively rare option for addressing unique circumstances. In California, an out-of-network provider is paid the higher of the average contracted rate or 125% of the Medicare rate; although the parties may negotiate a different amount or request arbitration, the initial payment amount is a strong anchor. *See* Cal. Health & Safety Code §§ 1371.30, 1371.31(a)(1). Data on median in- and out-of-network rates features in Washington's system. *See* Wash. Office of Ins. Comm'r, *Arbitration and using the Balance Billing Protection Act data set*, https://tinyurl.com/yeyuaemu. Compared to tens of thousands of arbitrations per year (as in Texas), California has seen only 124 proceedings since 2018, and Washington received 71 requests in the first year its system was

operational. Cal. Dep't of Managed Health Care, *AB 72 Independent Dispute Resolution Process Quarterly Report*, at 1 (Oct. 13, 2021), https://tinyurl.com/2p8437ha; Wash. Office of Ins. Comm'r, *Balance Billing Protection Act Arbitration Proceedings: Annual Repor*t, at 6 (June 29, 2021), https://tinyurl.com/5ezh8axu.

Differences in volume are extremely significant at a national scale. Analysis indicates that if federal IDR decision-making were to follow Texas's unstructured path, it would result in over 70 times more IDR proceedings than the roughly 17,000 proceedings the Departments projected in the IDR Rule. *See* 86 Fed. Reg. at 56,056. Texas's share of the national private insurance market is about 8%. *See* Employee Benefits Sec. Admin., *Health Insurance Coverage Bulletin*, at 5-6 (Mar. 2019), https://tinyurl.com/yc3u6rrr. Assuming Texas experienced a similar number of proceedings in the second half of 2021 as it did in the first, Texas IDR Report, at 4, volume on a Texas scale would lead to a massive number of federal IDR proceedings:

Projected Annual Texas IDR cases	Texas Share of Private Health Coverage Market	Estimated Federal IDR Cases
100,460	8.0%	1,259,887

When dispute resolution proceedings are not anchored to reasonable rates, not only does the number of disputes increase almost exponentially, so too does the cost of proceedings. Cost experience from Texas puts the median arbitration fee at $1,000, *higher* than the average single-claim award of $883 for an actual medical service. Texas IDR Report, at 8. The highest fee was $5,000, *id.*, and fee amounts don't include the parties' administrative costs to gather and present information to the arbitrator—which only increase with the number of factors to be considered. Such administrative costs that exceed the amount of the actual disputed out-of-network charges make no sense. In contrast to such high arbitration fees in Texas, federal certified IDR entities, after considering the IDR rule, have set fees ranging from $285 to $500 for single proceedings.

See Ctrs. for Medicare & Medicaid Servs., *List of certified independent dispute resolution entities*, https://tinyurl.com/2p9d7t72.

Texas's experience shows that unbounded arbitrations are likely to be more costly, a result that cannot be squared with legal, commercial, and regulatory imperatives for health plans to limit the share of premium dollars they spend on administrative costs. *See, e.g.*, 42 U.S.C. § 300gg-18(b). Additional administrative costs come with consequences, either in the form of higher premiums and/or increased out of pocket expenses for consumers, or even potentially fewer benefits, particularly as employer sponsors consider how to offset the increased cost of providing benefits for their employees.

3. Predictability Makes Health Care More Affordable, While Ensuring Fair Reimbursement.

Centering the QPA also makes out-of-network costs more affordable by anchoring IDR results to locally negotiated market rates (absent credible information that the appropriate rate is materially different). Unlike billed charges—which are unilaterally set by providers—negotiated rates reflect competitive, fair market prices. And even these negotiated rates "may have been inflated due to the practice of surprise billing prior to the No Surprises Act." 86 Fed. Reg. at 55,996. The data bear this out. Cooper, 39 Health Affairs at 27. But the QPA negotiated rates—around which IDR is centered—are still substantially less than the billed charges balance-billing providers demanded from patients before the Act.

Anchoring the IDR process to market rates determined through arms-length negotiation between health plans and providers, 86 Fed. Reg. at 55,996, also helps to ensure premiums reflect reasonable negotiated rates, rather than unlimited billed charges. Without such structure, arbitration can result in out-of-network rates that are both volatile and excessive, thwarting the consumer-protection goals of the Act. In New Jersey, the median award is 5.7 times higher than

the median in-network rate, and nearly a third of awards are more than 10 times higher than in-network rates. Chartock, 40 Health Affairs at 132. Predictability disappears, with awards reaching more than 25 times in-network rates, and 2-6% of awards distributed at each multiple from 3 to 13. *Id.* at 133. In Texas, awards were nearly 5 times the initial health plan payment in 2020, and although initial payments increased in 2021, awards are still 3.4 times higher. Texas IDR Report, at 5.

Even though the Act bans surprise billing, Americans would still pay the increased costs of an unpredictable dispute resolution process through higher premiums. *See* 86 Fed. Reg. at 55,996. Centering the QPA both stabilizes and reduces health care costs, as shown by the Congressional Budget Office's projection of premium savings—which hinged on the assumption that the QPA would anchor IDR. *See* Cong. Budget Office, Estimate for Divisions O Through FF, H.R. 133, at 2-3, https://tinyurl.com/3eec2a4n; Letter from Rep. Frank Pallone, Jr. & Sen. Patty Murray to Secretary Becerra (Jan. 7, 2022). Lower premiums benefit consumers directly and reduce government health care expenditures for premium tax credits. *See* 86 Fed. Reg. at 56,059.

Contrary to the assertions of Plaintiffs and their *amici*, greater predictability and affordability does not sacrifice fair reimbursement to providers. The QPA is the median of negotiated rates that fairly reflect service characteristics that can increase costs, including medical specialty, geographic area, and patient acuity and case severity, all captured in different billing codes. *See* AHIP, Comment Letter, at 7, https://tinyurl.com/2crxsv52. The QPA is the product of rates negotiated and agreed to between plans and providers—not unilaterally dictated by health insurance providers. And additional credible information presented by either party must factor into the decision when that information demonstrates a material difference. 45 C.F.R. § 149.510(c)(4)(iii)(B)-(D). But centering the IDR process around the fair and competitively

negotiated QPA rates reduces the likelihood and costs of resolving disputes, furthers predictability and efficiency, and makes health coverage more affordable.

III. Predictable Out-Of-Network Costs Foster, Rather Than Impair, Patients' Access To Quality Networks.

Plaintiffs and their *amici* contend that more affordable out-of-network services will harm patients, theorizing that health insurance providers will cut providers from their networks if plans can count on paying QPA rates for out-of-network services. *See, e.g.*, Pls.' Summ. J. Br., Dkt. 3, at 34-35; Amicus Br. of Physicians Advocacy Inst. et al., Dkt. 30, at 13-15; Amicus Br. of Emergency Dep't Practice Mgmt. Ass'n, Dkt. 46, at 14-15. But this contention rests on a fundamental misunderstanding of how such networks are built.[6] In building networks, cost is *not* the only concern. Other key factors that health plans must consider to enhance their products' marketability include quality and proximity of needed services, breadth of choice, and market demand.

Legal network adequacy requirements set a floor that restrict health insurance providers from simply slashing their networks on the theory that out-of-network payments will be lower. Depending on the plan type, the adequacy of a plan's provider networks must satisfy federal and/or state standards. *See, e.g.*, 42 U.S.C. § 18031(c)(1)(B) (discussing network-adequacy standards for certification as a "qualified health plan"); Nat'l Conf. of State Legislators, *Insurance Carriers and Access to Healthcare Providers: Network Adequacy* (Feb. 2018), https://tinyurl.com/ym824jvb (surveying state laws). These standards often require a certain ratio of providers to plan enrollees,

[6] It also rests on a flawed premise that narrower networks harm patients. Narrower networks can provide equal-quality care, at lower cost, than broader ones. *See, e.g.*, Jonathan Gruber & Robin McKnight, *Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees*, Nat'l Bureau Econ. Res. Working Paper 20462 (Sept. 2014), https://tinyurl.com/4t3z78hk (finding that a group of Massachusetts employees who selected a narrow network option spent 40% less on health care, with no evidence of a decrease in quality for even the sickest patients).

or that patients need not travel farther than a certain distance or wait longer than a certain time for an appointment. Justin Giovanelli et al., *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks*, at 4, Commonwealth Fund (May 2015), https://tinyurl.com/pkwkybs2.

Because health insurance providers' product is their network, the breadth of most networks far exceeds these legal minimums. Employers' preferences are especially critical because they pay for health benefits on behalf of over 150 million Americans. "Health plans design their provider networks so that they have options that will be attractive to their employer clients." Gary Claxton et al., *Employer strategies to reduce health costs and improve quality through network configuration*, Peterson-KFF Health System Tracker (Sept. 25, 2019), https://tinyurl.com/ydzxn6ux. Employers, in turn, overwhelmingly favor broad networks, with only 5% of employers reporting in a 2019 survey that they offer their employees a narrow-network plan. *Id*. They favor broad networks because "employers still need to balance potential cost savings against the risk of worker dissatisfaction," especially in a "tight labor market," and they value employee access and convenience. *Id.* The preference for broader networks is so strong that large employers rate both network breadth and quality as more important than cost when choosing among networks, and small employers rate the three factors roughly equally. *Id.*

Moreover, in building networks, health insurance providers recognize that competitive market rates are appropriately higher for certain types of services, e.g., specialized facilities like pediatric hospitals and teaching hospitals. For that reason, there is a range of rates for any given service, of which the QPA is only the median. There is no reason to suppose that health insurance providers, which may pay above-QPA rates to certain specialty facilities, will start offering median-or-below rates to such facilities, especially given the market imperative of offering

networks that include prominent hospitals and specialty care.

Finally, health insurance providers need predictability. If health insurance providers were to insist on unreasonable provider reimbursement rates, they would increase the number of providers who opt to remain out-of-network. The result would be more providers likely to dispute out-of-network payments in negotiations and IDR. At scale, this is unsustainable. Although each health care provider may work with only a handful of plans, plans with nationwide networks process claims from over a hundred thousand providers. *See* 86 Fed. Reg. at 56,051 (reporting number of active physicians in most affected specialties). Data show that more predictable out-of-network dispute resolution processes encourage greater network participation. *See* Loren Adler et al., *California saw reduction in out-of-network care from affected specialties after 2017 surprise billing law*, USC-Brookings Schaeffer Initiative for Health Policy (Sept. 26, 2019), https://tinyurl.com/32cyyany.

Health insurance providers thus have every incentive to move more providers into networks. If network agreements cannot be reached based on reasonable market rates, however, then structured decision-making—where competitive, negotiated rates like the QPA (which itself reflects a range of market rates) provide an anchor for resolving disputes—protects consumers from premium increases tied to skyrocketing out-of-network charges by ensuring more predictable out-of-network payments.

CONCLUSION

The Court should deny Plaintiffs' motion for a stay or summary judgment and grant Defendants' cross-motion for summary judgment.

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Respectfully Submitted,

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CERTIFICATE OF SERVICE

On January 31, 2022, I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, District of Columbia, using the electronic case filing system of the court. I hereby certify that I have served counsel for all parties of record electronically or by another manner authorized by Federal Rule of Civil Procedure 5(b)(2).

/s/Hyland Hunt
Hyland Hunt