UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

REACH AIR MEDICAL SERVICES, LLC, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	)	Case No.: 3:22-cv-01153-TJC-JBT

AMICUS CURIAE AMERICA'S HEALTH INSURANCE PLANS'S MOTION FOR LEAVE TO SUBMIT _AMICUS CURIAE_ BRIEF IN SUPPORT OF DEFENDANT KAISER FOUNDATION HEALTH PLAN, INC.'S MOTION TO DISMISS

Under Local Rule 3.01, America's Health Insurance Plans, Inc. (AHIP) moves for leave to file a brief as *amicus curiae* in support of Defendant Kaiser Foundation Health Plan, Inc.'s Motion to Dismiss. The proposed *amicus* brief is attached as an Exhibit to this motion. Counsel for AHIP has conferred with counsel for all parties. Defendants consent to the motion. Plaintiff opposes the motion. In support of its motion, AHIP states:

1. America's Health Insurance Plans, Inc. (AHIP) is the national trade association representing the health insurance community. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and

innovation. AHIP's members have extensive experience working with nearly all health care stakeholders to ensure that patients have affordable access to needed medical services and treatments. That experience gives AHIP broad first-hand knowledge and a deep understanding of how the nation's health care and health insurance systems work.

2. AHIP has frequently been granted leave to file *amicus* briefs in cases of importance to the health insurance community, including in cases about the interpretation and implementation of the No Surprises Act. *See, e.g.*, *Tex. Med. Ass'n v. U.S. Dep't of Health & Human Servs.*, 587 F. Supp. 3d 528 (E.D. Tex. 2022); *Am. Med. Ass'n v. U.S. Dep't of Health & Human Servs.*, No. 1:21-cv-3231 (D.D.C.); *Ass'n of Air Med. Servs. v. U.S. Dep't of Health & Human Servs.*, No. 1:21-cv-3031 (D.D.C.).

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

4. Congress, after significant debate, ultimately arrived at a bipartisan solution in the No Surprises Act to protect consumers from out-of-network payment disputes and surprise bills. The Act does this by encouraging health plans and providers to resolve out-of-network payments through negotiation and establishing Independent Dispute Resolution (IDR) as a streamlined baseball-style arbitration process. Congress intended IDR to promptly and conclusively resolve payment disputes in what should be rare instances where the parties do not agree on fair payment rates.

5. AHIP agrees with Defendants' legal arguments, but its proposed *amicus* brief does not repeat them. Rather, AHIP writes separately to explain how accepting a limitless conception of judicial review under the Act would undercut the efficiency and finality that the Act's procedures are designed to achieve and ultimately harm consumers by driving up administrative and health care costs that Congress intended to constrain.

Memorandum of law

The Federal Rules of Civil Procedure do not specifically provide for the filing of *amicus curiae* briefs at the district court level. Nevertheless, the Eleventh Circuit has stated that district courts have inherent authority to appoint "friends of the court" to assist them in cases. *In re Bayshore Ford Truck Sales, Inc.*, 471 F.3d 1233, 1249 n.34 (11th Cir. 2006). Courts "typically grant *amicus* status where the parties 'contribute to the court's understanding of the

matter in question' by proffering timely and useful information." *Ga. Aquarium, Inc. v. Pritzker*, 135 F. Supp. 3d 1280, 1288 (N.D. Ga. 2015) (quoting *Conservancy of Sw. Fla. v. U.S. Fish & Wildlife Serv.*, No. 2:10-cv-106, 2010 U.S. Dist. LEXIS 94003, *3 (M.D. Fla. Sept. 9, 2010)). "Generally, courts have exercised great liberality in permitting an *amicus curiae* to file a brief in a pending case." *United States v. Davis*, 180 F. Supp. 2d 797, 800 (E.D. La. 2001).

The Court exercises "broad discretion" whether to grant leave to file an *amicus* brief, but courts in this district sometimes consider four factors: (1) whether "the petitioner has a 'special interest' in the particular case"; (2) whether "the petitioner's interest is not represented competently or at all"; (3) whether "the proffered information is timely and useful"; and (4) whether "the petitioner is not partial to a particular outcome in the case." *Conservancy of Sw. Fla.*, 2010 U.S. Dist. LEXIS 94003, at *4 (quoting *Liberty Resources, Inc. v. Philadelphia Housing Auth.*, 395 F. Supp. 2d 206, 209 (E.D. Pa. 2005)). These factors are met here.

AHIP has a special interest in this case because its membership, and its members' enrollees—Americans who purchase health insurance—will be affected by the way the No Surprises Act is interpreted. *See, e.g.*, *City of S. Miami v. Desantis*, No. 19-cv-22927, 2020 U.S. Dist. LEXIS 175462, *3 (S.D. Fla. Sept. 24, 2020) (finding proposed *amici* had a "special interest" where their "members, clients, and constituencies are affected by the implementation of"

the law at issue). In particular, as explained in AHIP's proposed *amicus* brief, the scope of judicial review of IDR decisions under the Act will directly affect the administrative costs faced by AHIP's membership and the employers and consumers to whom AHIP's members provide health coverage.

Although AHIP has a special interest in the implementation of the No Surprises Act, it is not "partial to a particular outcome in this case." *Conservancy of Sw. Fla.*, 2010 U.S. Dist. LEXIS 94003, at *4. Consistent with its role as the national trade association representing the health insurance community, AHIP's Board of Directors is comprised of executives from companies that provide health and supplemental benefits coverage, including from Kaiser Permanente. As a nonprofit corporation whose members have no ownership interests, however, AHIP has no pecuniary or other interest in the resolution of the specific payment dispute and IDR decision under review. The amount of the payment for one patient's air ambulance transport is a discrete issue in which AHIP has no stake. It is thus not partial to any specific outcome here. Even when an *amicus* has "a side to which it was partial"—which is common—"there is no rule … that *amici* must be totally disinterested." *Liberty Res., Inc.*, 395 F. Supp. 2d at 209 (omission in original); *see, e.g.*, *Craig Air Ctr., Inc. v. City of Jacksonville*, No. 3:10-cv-48-J-32, 2012 U.S. Dist. LEXIS 107335, *2 n.1 (M.D. Fla. Aug. 1, 2012) (Corrigan, J.) (considering *amicus* brief by

homeowners in support of city's motion for summary judgment defending limitation on local airport's runway length).

Because AHIP's proposed *amicus* brief presents "ideas, arguments, theories, insights, facts, or data that are not to be found in the parties' briefs," its participation is *amicus* is appropriate even though "it cannot be said that [the parties are] inadequately represented by counsel." *Chavez v. Credit Nation Auto Sales, Inc.*, No. 1:13-CV-00312, 2014 U.S. Dist. LEXIS 199641, *7-*8 (N.D. Ga. June 5, 2014). Courts frequently grant leave to file *amicus* briefs "when the *amicus* has unique information or perspective that can help the court beyond the help that lawyers for the parties are able to provide." *Dibbs v. Hillsborough County*, No. 8:12-cv-2851, 2014 U.S. Dist. LEXIS 206038, *2 (M.D. Fla. Dec. 4, 2014). AHIP's proposed *amicus* brief provides that unique perspective and offers timely and useful information.

The Court has not yet held a hearing on Defendant's Motion to Dismiss; the hearing is scheduled for May 16, 2023. Per Local Rule 3.01(c), Plaintiff's response to this motion for leave is due by May 12, so Plaintiff will have an opportunity to respond and the motion will be fully briefed before the hearing.

As an organization with extensive experience in the nation's health care and health insurance systems, AHIP can provide a unique perspective on the broader implications of the parties' competing interpretations of the No Surprises Act, as well as useful background regarding the market dynamics

for air ambulance and other medical services before and after the Act. This sort of broader perspective and useful background is a common basis for *amicus* participation. *See, e.g.*, *Adams v. Sch. Bd. of St. Johns Cty.*, 318 F. Supp. 3d 1293, 1298 n.14 (M.D. Fla. 2018) (Corrigan, J.), *rev'd on other grounds*, 57 F.4th 791 (11th Cir. 2022) (granting leave to file *amicus* brief "for helpful explanations of biological and medical terminology" and "the position of these medical associations as to the appropriate standard of care"); *Fishing Rights Alliance v. Pritzker*, No. 8:15-cv-1254, 2016 U.S. Dist. LEXIS 203232, *7 (M.D. Fla. June 8, 2016) (granting environmental organization leave "to file an *amicus* brief to address its perspectives on [the issue] from a conservation standpoint"). In addition, AHIP"s proposed brief provides unique data about the implementation of the IDR system that would be useful to the Court's consideration of the issues. Courts have "found the participation of an *amicus* especially proper" where "an issue of general public interest is at stake." *Liberty Res., Inc.*, 395 F. Supp. 2d at 209. AHIP's proposed *amicus* brief explains why this is just such a case, and how its resolution will affect not just one specific payment dispute, but also shape the system for resolving out-of-network payments more generally, with implications for the health care system writ large.

Conclusion

For the foregoing reasons, AHIP respectfully requests that this motion be granted and that it be permitted to file the proposed *amicus* brief.

Local Rule 3.01(g) certification

Per Local Rule 3.01(g), counsel certify they have conferred with counsel for all parties herein in a good faith effort to resolve the issues raised in this motion. On April 26, 2023, Hyland Hunt emailed counsel for all the parties. Counsel for Defendants indicated by return emails that Defendants did not oppose the motion. Counsel for Plaintiff indicated by return email that they would oppose this motion.

Respectfully submitted,

/s/ Thomas Burns

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on April 28, 2023, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system, which will send a notice of electronic filing to all counsel of record.

/s/ Thomas Burns
Thomas A. Burns

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
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REACH AIR MEDICAL SERVICES, LLC, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	)	Case No.: 3:22-cv-01153-TJC-JBT

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANT KAISER FOUNDATION HEALTH PLAN'S MOTION TO DISMISS

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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 extensive experience working with nearly all health care stakeholders to ensure that patients have affordable access to needed medical services and treatments. That experience gives AHIP broad first-hand knowledge and a deep understanding of how the nation's health care and health insurance systems work.

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

[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.

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

AHIP agrees with Defendants' legal arguments that Plaintiff's conclusory and *ipse dixit* complaint must be dismissed. Such generalized allegations fall far short of what is necessary to plausibly allege a basis for vacating an IDR determination under the exceedingly narrow grounds permitted by the No Surprises Act and its incorporation of Federal Arbitration Act standards. AHIP writes separately to explain how accepting Plaintiff's limitless conception of judicial review under the Act would undercut the efficiency and finality that the Act's procedures are designed to achieve and ultimately harm consumers by driving up administrative and health care costs that Congress intended to constrain.

INTRODUCTION AND SUMMARY OF ARGUMENT

The No Surprises Act addressed the urgent need to protect Americans from surprise medical bills and spiraling out-of-network costs, particularly for

medical specialties where patients lack the opportunity to choose their provider. The need to protect patients was particularly acute for air ambulance services, due to a broadly written federal statute that was found by courts to preempt state efforts to address otherwise unconstrained pricing, a business model based on refusing to join networks, and an influx of private equity firms—all of which led to sky-high and ever-escalating air ambulance charges. Before the Act, when air ambulances could send surprise bills to patients, health insurance providers routinely faced pressure to pay exorbitant air ambulance charges—completely divorced from the cost to provide the service or reasonable market rates negotiated *ex ante*—and did so to protect patients from what would otherwise be astronomical surprise bills. Although paying the charges protected individual patients from medical bills running to tens of thousands of dollars, all Americans paid for unconstrained air ambulance charges in the form of higher premiums.

Congress shielded Americans from this market dysfunction by prohibiting surprise bills and establishing IDR as a streamlined process for resolving out-of-network payments when a reasonable payment was declined or negotiations were unproductive. Central to Congress's solution is the Qualifying Payment Amount (QPA), which reflects a health insurance provider's median negotiated rate for a given service in the local area. Patients' cost-sharing is based on the QPA, health insurance providers must disclose the

QPA when making payments for out-of-network claims, and IDR entities must consider the QPA when choosing one of two offers to conclusively resolve the out-of-network payment amount. For any questions about QPA calculations, Congress contemplated an agency-led complaint process, together with agency audits of QPA calculations for accuracy and compliance.

Congress did not authorize IDR entities to recalculate QPAs. IDR entities may not re-examine the QPA, because to do so would duplicate the agencies' audit function and risk uncertainty and confusion caused by multiple disparate QPA (re-)calculations in case-by-case decisions. Instead, IDR entities are meant to take the accuracy of a QPA as a given, and follow a simple, speedy, and final process for choosing between two offers.

Interpreting the Act to permit judicial review and vacatur of ostensibly final IDR determinations based on conclusory assertions that the QPA was miscalculated or misrepresented cannot be squared with the Act's structure or purpose. As Defendant Kaiser Foundation Health Plan explains, Plaintiff's interpretation of the Act would wrongly convert exceptionally circumscribed judicial review criteria into truck-sized loopholes. *See* Kaiser Mot., Doc. 30, at 13-20. It would also lead to the unlikely outcome that Congress, without saying so, effectively created a new right for medical providers to sue insurance providers whenever they are dissatisfied with out-of-network payments. This even though providers before the Act could not sue insurance providers that

they declined to contract with. The statute that Congress wrote allows only limited federal baseball-style arbitration in IDR, with extremely circumscribed judicial review; it is not an open invitation to federal court.

Besides being legally untenable, the anything-goes pitch for judicial review is disastrous from a practical standpoint, especially given the unexpectedly high IDR volume experienced over the Act's first year. Interpreting the Act to condone re-opening of IDR determinations based on conclusory allegations of "undue means" or "partiality" would contravene congressional design, and substitute laborious, costly, and frequent litigation for the speedy, low-cost, and rare arbitral decision-making that Congress intended. Americans would pay the price in unnecessary administrative costs—the exact opposite of Congress's central goal of protecting patients from unpredictable, inflated medical costs.

ARGUMENT

I. The No Surprises Act Aims To Remedy Market Dysfunction Where Patients Have No Opportunity To Choose Their Providers—A Particular Concern For Air Ambulances.

For most medical services, rates are set in advance through negotiation between health insurance providers and health care providers. Health plans typically work together with providers to offer networks that provide Americans access to affordable, high-quality care. *See* AHIP, *Charges Billed by Out-of-Network Providers: Implications for Affordability*, 3 (Sept. 2015),

https://tinyurl.com/3k8mfr98. Such networks benefit patients, providers, 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, *Provider Networks*, https://tinyurl.com/2p94p4xz. The goal is to achieve the highest value for patients, considering factors such as quality of care, breadth of choice, and legal requirements for network adequacy, along with cost. *See* Gary Claxton et al., *Employer strategies to reduce health costs and improve quality through network configuration*, Peterson-KFF Health Sys. Tracker (Sept. 25, 2019), https://tinyurl.com/ydzxn6ux; Nat'l Conf. of State Legislatures, *Health Insurance Network Adequacy Requirements* (Apr. 27, 2023), https://tinyurl.com/sy4cz9hw. The resulting contracts limit the provider to the payment amount the provider has agreed to accept from the plan and prohibit surprise bills to patients. *See* 86 Fed. Reg. 36,872, 36,874 (July 13, 2021).

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

2020), https://tinyurl.com/bddeyrfj (finding average rates for specialties that could balance bill were over three times Medicare rates, compared to one and a half times Medicare rates for specialty unlikely to be able to balance bill).

Before the Act, air ambulance services were an extreme—but significant—example of this skewed market dynamic, resulting in exorbitant surprise bills for patients and higher health care costs for all Americans with health insurance. "[A]voidance of insurance network participation combined with aggressive collection" was "a business strategy of some providers of air ambulance services" before the Act. 86 Fed. Reg. at 36,923. Under that business model, air ambulance providers extracted payments from commercially insured patients well above costs. About 70% of air ambulance revenue came from the roughly 30% of transports covered by commercial insurance, while privately insured patients and their health insurance providers paid more than double the cost of services—by even the industry's estimate. Ass'n of Air Med. Servs., *Presentation to the U.S. Department of Transportation: Air Ambulance & Patient Billing Advisory Committee* 14-15 (Jan. 15, 2020), https://tinyurl.com/r5b2s6b8.

In addition, private equity firms have invested heavily in air ambulance providers, drawn by the ability to aggressively raise prices in part because of

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

Because air ambulance charges were so extremely high, health insurance providers "place[d] a high value on preventing enrollee surprise bills." Brown, *supra*. To help protect their beneficiaries from surprise bills and debt collection suits, health insurance providers often agreed to pay air ambulance providers' full billed charges. *See* 86 Fed. Reg. at 36,923. As the expert agencies implementing the No Surprises Act have recognized, such pre-Act payments to air ambulance providers do not "reflect[] market rates under typical contract negotiations," *id.* at 36,889, but instead result from threats to balance bill a patient for an often excessive amount. The upshot of those inflated payments was higher premiums for everyone who purchased health coverage, not just air ambulance patients.

The Act remedied this acute market dysfunction by taking several steps to protect patients from unpredictable and out-of-control out-of-network costs, including for air ambulance services. First, unless state law provides

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[2] Courts have held that air ambulance billing practices are protected from state regulation by the Airline Deregulation Act. *See, e.g., Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 755 (4th Cir. 2018).

otherwise, the Act sets patients' cost-sharing based on the QPA, which is generally the health plan's median in-network contract rate for the same service in the same area.[3] Medical providers are prohibited from balance billing patients for the rest of their charges.[4] Second, the Act establishes IDR as a streamlined arbitration process to conclusively resolve the amount to be paid for out-of-network services, and requires IDR entities to consider the QPA when making payment determinations.[5] Plaintiff's lawsuit would undermine both aspects of the Act.

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

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

To put an end to the practice of providers hounding patients to collect on surprise bills (and the resulting crushing medical debt), the Act created a new process for resolving the amounts to be paid for covered out-of-network services. Medical providers who are not in-network generally do not have the right "under state common law" to "recover payment directly from insurers for out-of-network services." *Haller v. U.S. Dep't of Health & Human Servs.*, No. 21-CV-7208, 2022 WL 3228262, at *7 (E.D.N.Y. Aug. 10, 2022), *appeal*

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

docketed, No. 22-3054 (2d. Cir. Nov. 30, 2022). Congress therefore created "a distinct claim" and "assign[ed] [its] adjudication to arbitration," "devis[ing] an 'expert and inexpensive method for dealing with a class of questions … particularly suited'" to arbitral resolution. *Id.* at *7-8 (quoting *Stern v. Marshall*, 564 U.S. 462, 494 (2011)).

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

1. For starters, the Act encourages prompt, voluntary resolution of out-of-network payment disputes within a few months of a claim. Health insurance providers must pay or deny claims within 30 days of receiving a sufficient claim, followed by up to 30 days to initiate a 30-day open negotiations period.[6] If the parties still cannot agree, then one may initiate IDR, but only if it does

[6] 42 U.S.C. § 300gg-112(a)(3), (b)(1)(A) (governing air ambulance claims); *see also id.* § 300gg-111(c) (materially same process for medical providers).

so within 4 days.[7] Even after IDR is initiated, however, the parties may continue negotiations and settle at any time before the IDR entity makes a decision.[8] Moreover, the certified IDR entity is limited to selecting one of the two offers submitted by the parties.[9]

These features, often called "baseball-style" arbitration due to the historical association with Major League Baseball salary disputes, have long been recognized as reducing costs by encouraging settlement. *See* Jeff Monhait, *Baseball Arbitration: An ADR Success*, 4 J. Sports & Ent. L. 105, 131 (2013) ("[T]he system lowers costs by encouraging the parties to negotiate reasonably, and it incentivizes settlement prior to a hearing."). "In nearly every sector that has been studied, … the presence of a [baseball-style arbitration] clause often leads to a negotiated settlement prior to the need for a hearing." Erin Gleason & Edna Sussman, *Final Offer/Baseball Arbitration: The History, The Practice, and Future Design*, 37 Alt. to High Costs Litigation, Jan. 2019, at 8, 9. Baseball-style arbitration is so effective at encouraging settlement because it "leads to a convergence of offers." Monhait, *supra*, at 133. It does so because—unlike more open-ended arbitration, where the arbitrator might be expected to split the difference—parties have incentives to land on a more reasonable final offer, rather than an "aspirational" number. *Id.* at 132.

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[7] *Id.* § 300gg-112(b)(1)(B).
[8] *Id.* § 300gg-112(b)(2)(B).
[9] *Id.* § 300gg-112(b)(5)(A)(i).

2. If the parties do not settle, Congress crafted IDR to be an expeditious yet well-informed process to arrive at an expert payment decision, not a drawn-out enterprise. IDR entities must have "sufficient medical, legal, and other expertise and sufficient staffing to make determinations ... on a timely basis."[10] To ensure timeliness, the Act requires parties to submit offers within 10 days, and the IDR entity to choose one of the offers within 30 days.[11] The IDR entity must consider the QPA (*i.e.*, the median network rate) when making its choice, and select the offer that "best represents the value of the … item or service."[12]

As with baseball-style arbitration generally, cost-effectiveness and speed are key features of the IDR process. *See* Monhait, *supra*, at 131 (finding "the [baseball] system lowers the costs of resolving salary disputes and avoids holdouts, comporting with cost-benefit analysis"). Congress's choices reflect its intent that IDR be efficient and minimize costs. *E.g.,* 42 U.S.C. § 300gg-111(c)(3)(A) (requiring batching to "encourag[e] … efficiency (including minimizing costs) of the IDR process"). All told, IDR should resolve payment disputes within about four months of a claim. Unfortunately, the system has yet to live up to its promise, largely due to the overwhelming volume of claims initiated by a tiny minority of providers and further stymied by repeated

[10] 42 U.S.C. § 300gg-111(c)(4)(A)(i).
[11] *Id.* § 300gg-112(b)(5)(A)-(B).
[12] *Id.* § 42 U.S.C. § 300gg-111(a)(1)(C)(iii), (a)(3)(E), (b)(1)(B); 300gg-112(b)(5)(C)(i)(I); 45 C.F.R. § 149.510(c)(4)(ii)(A); *id.* § 149.520(b)(1) (generally applying § 149.510 to air ambulance determinations).

provider-initiated litigation. *See* pp. 17-19, *infra*.

3. Congress intended that payment disputes would be conclusively resolved by the well-informed, streamlined IDR process. IDR results are "binding upon the parties involved" except for a "fraudulent claim or evidence of misrepresentation of facts" to the IDR entity regarding "such claim."[13] They "shall not be subject to judicial review" except in the constrained circumstances of the Federal Arbitration Act,[14] which are "among the narrowest known to the law." *Bamberger Rosenheim, Ltd. (Isr.) v. OA Dev., Inc. (U.S.)*, 862 F.3d 1284,1286 (11th Cir. 2017). Moreover, IDR decisions preclude further IDR proceedings between the same parties about the same service for 90 days.[15]

Considering IDR design as a whole, "the congressional goal of promoting efficient dispute resolution" is clear. *See Commodity Futures Trading Comm'n v. Schor*, 478 U.S. 833, 837 (1986) (describing Congress's purpose in adopting administrative dispute system in lieu of litigation). As designed, IDR offers all the benefits of arbitration: "lower costs, greater efficiency and speed, and the ability to choose expert adjudicators to resolve specialized disputes." *Stolt-Nielsen S. A. v. AnimalFeeds Int'l Corp.*, 559 U.S. 662, 685 (2010).[16] Congress's

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[13] 42 U.S.C. § 300gg-111(c)(5)(E); *id.* § 300gg-112(b)(5)(D) (incorporating § 300gg-111(c)(5)(E) for air ambulances).
[14] *Id.* § 300gg-111(c).
[15] 42 U.S.C. § 300gg-111(c)(5)(E)(ii).
[16] Although the agency may assign an IDR entity if the parties do not jointly select one, 42 U.S.C. § 300gg-111(c)(4)(F), the certification criteria ensure that all IDR entities are expert adjudicators of these specialized disputes.

choice of baseball-style arbitration—a particularly efficient process that is now used in a host of different commercial and government contexts, Gleason & Sussman, *supra*, at 10—is essential to reducing IDR administrative costs.

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

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

1. Preserving IDR finality is critical for the Act to work as Congress intended, especially given high IDR volume.

The benefits of arbitration generally depend upon finality, and IDR is no different. The "primary purpose served by the arbitration process is expeditious dispute resolution." *Univ. of Notre Dame (USA) in England v. TJAC Waterloo, LLC*, 49 F.4th 13, 21 (1st Cir. 2022). "Arbitration loses some of its luster, though, when one party refuses to abide by the outcome and the courts are called in after all." *Id.*; *see IBEW, Local Union 824 v. Verizon Fla., LLC*, 803 F.3d 1241, 1246 (11th Cir. 2015) (describing "the very strong federal policy in favor of finality for arbitration awards").

For this reason, the Federal Arbitration Act's limited grounds for vacating an arbitration award—incorporated by reference into the No

Surprises Act—"substantiat[e] a national policy favoring arbitration with just the limited review needed to maintain arbitration's essential virtue of resolving disputes straightaway." *Hall St. Assocs., L.L.C. v. Mattel, Inc.*, 552 U.S. 576, 588 (2008). Any other approach would "open[] the door to the full-bore legal and evidentiary appeals that can rende[r] informal arbitration merely a prelude to a more cumbersome and time-consuming judicial review process, and bring arbitration theory to grief in postarbitration process." *Id.* (citations omitted; second alteration in original).

a. Plaintiff's theory of no-limits judicial review would invite just such post-arbitration grief and interfere with the carefully reticulated process that Congress designed to maximize efficiency.

If Plaintiff were correct that each IDR can be converted into a court case on nothing more than "information and belief" that a health plan miscalculated and therefore "misrepresented" the QPA, or mere assertion that an IDR entity was "partial" because it selected the offer closest to the QPA, *see* Compl., Doc. 1, ¶¶37-38, IDR determinations would no longer be final or binding in any meaningful way. IDR would be nothing more than a way station on the way to court. That result is startling because medical providers and air ambulance services generally had no pre-Act common law right to hale health insurance providers into court to seek payment for out-of-network services. *See Haller*, 2022 WL 3228262, at *7-8. It would be passing strange if by creating a novel

federal process for recovering payments from insurance providers, circumscribed by an expeditious arbitration system with exceptionally narrow judicial review, Congress in effect invited providers to sue health insurance providers whenever they are dissatisfied with out-of-network payments.

Final payment determinations would also inevitably be delayed under Plaintiff's approach—if the system did not break down altogether. Whenever a dissatisfied provider in search of higher payment runs to court, Congress's intended few-month process could be extended by a year or more. *See* Admin. Office of U.S. Courts, *Civil Judicial Business* (2022), Table C-5, https://tinyurl.com/j9u9smpe (median time of 11.8 months from filing to disposition for cases filed in district court and resolved before pre-trial stage). The overwhelming volume of IDR proceedings and associated backlog are already severely taxing the resources of the agencies tasked with overseeing the IDR process and hampering IDR entities' ability to resolve disputes.

What's more, lawsuits against the arbitrators themselves—whom Plaintiff has included in its many cookie-cutter suits proceeding across the country, *see* Kaiser Mot., Doc. 30, at 6—are likely to discourage an already limited pool of qualified entities from serving as certified IDR entities or from issuing IDR decisions involving frequent litigants. Indeed, AHIP has learned that the recent flurry of lawsuits has chilled certain IDR entities' willingness to resolve disputes involving litigious providers, such as Plaintiff and its

affiliates. It is increasingly clear that the pall cast by such suits will only further delay IDR decisions across the board, and risks bringing the processing of IDR claims for certain types of services and providers to a screeching halt.

b. Evidence from the Act's first year confirms the importance of ensuring that IDR works as Congress intended—quickly, cost-effectively, and conclusively. The volume of IDR proceedings has dwarfed the Departments' initial estimates. In the first nearly nine months of the IDR system, over 164,000 proceedings were initiated. Ctrs. for Medicare & Medicaid Servs., *Amendment to the Calendar Year 2023 Fee Guidance for the Federal [IDR] Process under the No Surprises Act: Change in Admin. Fee*, at 4 (Dec. 2022) https://tinyurl.com/mwxerbj7 (IDR Fee Guidance). This is nearly ten times the number of IDR proceedings projected for the entire first year. *Id*. And the avalanche has only begun. The dispute initiation rate has been accelerating, with a single week in November 2022 generating more than half of the IDR proceedings that had originally been projected for the whole year. *Id.* at 5.

Closer examination of this volume, however, indicates that it stems from concentrated exploitation of the IDR system by a handful of providers in a tiny fraction of specialties—typically, those that profited the most from surprise billing. Still, most medical providers appear to agree that out-of-network payments around the QPA reflect reasonable market rates, and Congress's choice of baseball-style arbitration to encourage voluntary settlements is

mostly working. In the Act's first year, patients were protected from about 12 million surprise medical bills, and about 97% of out-of-network payments did *not* go to IDR. AHIP, *No Surprises Act Prevents More than 9 Million Surprise Bills Since January 2022* (Nov. 2022), https://tinyurl.com/2syeh838 (finding about 9 million surprise bills avoided in nine months).

The lion's share (over 80%) of non-air-ambulance claims that did go to IDR involved emergency services—another area where patients are often unable to choose their provider, and there is less incentive for providers to join networks—with over half of all IDR disputes relating to just five emergency department visit codes. *See* Ctrs. for Medicare & Medicaid Servs., *Initial Report on the Independent Dispute Resolution (IDR) Process, April 15-September 30, 2022*, at 19 (Dec. 2022), https://tinyurl.com/mtp7kd3k (IDR Report). What's more, a single entity initiated one third of the total non-air-ambulance disputes. *Id.* at 16. Air ambulance volume was similarly driven by a few providers, with three providers (out of more than 50) generating nearly three quarters of IDR proceedings. *Id.* at 26.

The Act's market-rate-oriented approach and dispute resolution process is thus working well for most providers. But the IDR system has started to buckle under the strain caused by the few providers expending extensive resources to exploit the process. Fewer than a third of IDR disputes were resolved within the first half-year that the system was up and running,

notwithstanding a 30-day statutory time limit for issuing determinations. IDR Report, *supra*, at 8. There are growing indications, moreover, that decisions are taking substantially longer than 30 days. Flinging open the courthouse doors to make it ever easier to challenge IDR determinations will only make this already unsustainable dynamic worse, harming the millions of patients and tens of thousands of medical providers for whom the Act is working.

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

Although IDR is streamlined and cost-effective, it is not cost-free. Congress understood that the new system would generate some administrative costs, but designed the Act so those costs would be minimal and more than offset by savings generated by aligning payments for out-of-network services with reasonable, negotiated market rates. *See* Cong. Budget Off., *Cost Estimate: H.R. 2328, Reauthorizing and Extending America's Community Health Act*, at 9 (Sept. 2019), https://tinyurl.com/mryj3nmb (describing how predecessor bill would "create new administrative costs for insurers" but "net effect of all th[e] changes would be lower insurance premiums"). If, contrary to statutory design, providers can effectively sue whenever they are dissatisfied, it would encourage even more IDR proceedings and add on litigation costs. On net, the savings Congress intended to secure for consumers (and taxpayers) would likely evaporate and American consumers and patients would pay for

this statutorily unauthorized litigation campaign.

As it is, the unexpectedly large number of IDR proceedings has already increased administrative costs. Both parties must pay an administrative fee (now $350), and the losing party must pay IDR fees that can reach $700 for a single item, or up to $1,200 for a batched claim with a substantial number of items. IDR Fee Guidance, *supra*, at 6-7. There are also substantial IDR-related staffing and technology expenses. Early experience indicates these costs have been substantially higher than anticipated due to the volume of IDR disputes submitted by providers.

Yet these already high administrative costs pale in comparison to the additional costs generated by vitiating Congress's efficient arbitration process and replacing it with no-limits judicial review. It goes without saying that petitions to vacate arbitral awards are costly and time-consuming to litigate. Administrative costs to litigate the validity of IDR decisions would almost certainly be orders of magnitude higher than IDR costs alone.

The upshot would be increased health care costs for all Americans—without one penny of the increased costs benefiting patients through improved health care value or quality. This wasteful spending, not contemplated (much less authorized) by Congress, directly harms consumers who purchase insurance and indirectly harms taxpayers by increasing expenditures for premium tax credits. *See* 86 Fed. Reg. 55,980, 56,059 (Oct. 7, 2021). Health

plans are subject to premium rate reviews by state or federal regulators, *e.g.*, 42 U.S.C. § 300gg-94, and some plans must be designed to cover a certain percentage of costs. For example, health plans sold on health care exchanges are classified into metal "tiers" based on the percentage of health care costs they cover for the average individual. *The health plan categories: Bronze, Silver, Gold & Platinum*, HealthCare.gov, https://tinyurl.com/z9s6rj76. One such "silver" plan must be designed to cover 70% of health care costs, on average. *Id.*; *see also* 42 U.S.C. § 18022(d). When costs go up, some mix of premiums, deductibles, and cost-sharing must go up, too, to maintain the specified level of coverage.

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

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

Plaintiff's open-ended approach to judicial do-overs for IDR would wrongly undercut finality across the board. Even more destructive to the Act's

structure and operation, however, is the atextual theory that IDR can be re-opened based on an allegedly miscalculated QPA. *See* Compl., Doc. 1, ¶ 37. As the agencies implementing the Act have made clear, IDR entities themselves are not permitted to recalculate the QPA. 87 Fed. Reg. 52,618, 52,627 & n.31 (Aug. 26, 2022). Instead, IDR "payment determinations … should center on a determination of a total payment amount … based on the facts and circumstances of the dispute at issue, rather than an examination of a plan's or issuer's QPA methodology." *Id.* at 52,626. IDR entities cannot look behind a given QPA because the "statute places the responsibility for monitoring the accuracy of plans' and issuers' QPA calculation methodologies with the Departments (and applicable state authorities) by requiring audits." *Id.*

The governing agencies maintain such tight oversight of the QPA because it serves as a lynchpin of the Act, providing a fixed input for several key statutory functions, well beyond the bounds of any individual IDR decision. First, the QPA often establishes the amount owed in patient cost sharing, enhancing the predictability of out-of-pocket costs.[17] Second, the QPA "as defined" by the Act is a mandatory IDR consideration in every case.[18] Finally, the Act requires IDR offers and results to be reported as percentages of the QPA.[19] If each IDR proceeding could recalculate the QPA, a single pull of the

[17] 42 U.S.C. § 300gg-111(a)(1)(C)(iii), (b)(1)(B).
[18] *Id.* § 300gg-111(c)(5)(C)(i)(I).
[19] Id. § 300gg-111(c)(7)(A)(v), (B)(iii)-(iv)..

thread could unravel the important role Congress intended the QPA to serve throughout the Act.

Permitting courts to re-examine QPA calculations as a basis for vacating IDR decisions—when IDR entities cannot (and should not) themselves recalculate the QPA—is *a fortiori* destructive to the QPA's role as a fixed lodestar. And permitting providers to reopen IDR determinations based on a conclusory assertion that a QPA was miscalculated is even worse. Accepting this invitation to impermissibly rewrite the statute would frustrate Congress's considered choice to assign QPA monitoring compliance to expert agencies, not a patchwork of IDR decisions, much less court rulings.

Given the QPA's role in cost-sharing, allowing a court to reopen the calculation of the QPA—or to require an IDR entity to do so—after the consumer already paid a cost-share based on an agency-audited QPA would introduce just the type of uncertainty for consumers that the No Surprises Act was intended to address. It would also introduce a host of questions for implementing the reporting provisions that depend on the QPA, like: which QPA should be used for reporting results? The statutorily defined one, calculated by health insurance providers, used to establish patient cost-sharing, and audited by the Departments? Or the one generated by a court reviewing an IDR decision? What should an insurance provider do if the Departments' audit confirms a QPA is accurately calculated, but a court

decision says otherwise? The statute stops these questions from arising, because it provides for only a single QPA for each insurance provider and service, which neither IDR entities nor courts may recalculate.

In lieu of piecemeal review of IDR decisions through unauthorized judicial re-examination, Congress assigned QPA monitoring and compliance to an express statutory complaint and audit procedure. If Plaintiff believes a QPA was miscalculated, it may file a complaint with the Department of Health and Human Services. *See* 42 U.S.C. § 300gg-111(a)(2)(B)(iv). The Department has set up a portal for that purpose. *See No Surprises Provider Complaint Form*, https://tinyurl.com/5n8htspa. The Department and other regulators may audit QPA calculations based on complaints, and the Act requires them to do so on a random sampling basis. *See* 42 U.S.C. § 300gg-111(a)(2), (a)(3)(E). Such audits are now underway and there is no evidence the Department is failing to respond to any provider's complaint that a QPA may be miscalculated. Allowing courts to perform the audit function that Congress assigned to the Department and other regulators (including state authorities) is contrary to the plain language of the statute and risks undermining oversight efforts already underway. *See* 87 Fed. Reg. at 52,627 & n.31.

Interpreting the Act to permit courts to vacate IDR determinations on allegations of QPA miscalculation would contravene Congress's choice to delegate questions about the accuracy of QPA calculations to expert

administrative judgement, while only creating uncertainty for consumer cost-sharing and other purposes. The No Surprises Act was meant to solve such problems, not create them. Unwanted uncertainty can be avoided by following Congress's vision of preserving the QPA as a fixed calculation wherever it is used in the statute, subject to compliance check through the regulatory audit process, not case-by-case reconsideration.

CONCLUSION

The Court should grant Defendant Kaiser Foundation Health Plan's motion to dismiss.

Dated: April 28, 2023

Respectfully submitted,

/s/ Thomas Burns

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on April 28, 2023, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system, which will send a notice of electronic filing to all counsel of record.

/s/ Thomas Burns
Thomas A. Burns