UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

ASSOCIATION OF AIR MEDICAL SERVICES, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEPARTMENT OF LABOR, DEPARTMENT OF THE TREASURY, OFFICE OF PERSONNEL MANAGEMENT, and the CURRENT HEADS OF THOSE AGENCIES IN THEIR OFFICIAL CAPACITIES, Defendants.	Case No. 1:21-cv-03031-RJL

UNOPPOSED MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* BY THE LEUKEMIA & LYMPHOMA SOCIETY, FAMILIES USA ACTION, THE MENDED HEARTS, INC., AND THE UNITED STATES PUBLIC INTEREST RESEARCH GROUP, INC. IN SUPPORT OF DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT

Under Local Civil Rule 7(o), The Leukemia & Lymphoma Society ("LLS"), Families USA Action, The Mended Hearts, Inc. ("Mended Hearts"), and the United States Public Interest Research Group, Inc. ("U.S. PIRG") (collectively, "*Amici*") respectfully move this Court for leave to file a brief as *amici curiae* in support of Defendants' Cross-Motion for Summary Judgment, ECF No. 10. Plaintiff and Defendants consent to this motion.

Amici are patient and consumer advocacy organizations that represent or work on behalf of millions of patients and consumers across the country, including those facing serious, acute, and chronic health conditions. The organizations are committed to ensuring that all Americans

have a high-quality health care system and access to comprehensive, affordable health insurance to prevent disease, manage health, cure illness, and ensure financial stability.

LLS is the world's largest voluntary health agency dedicated to fighting blood cancer and ensuring that the more than 1.3 million blood cancer patients and survivors in the United States have access to the care they need. LLS's mission is to cure leukemia, lymphoma, Hodgkin's disease, and myeloma, and to improve the quality of life of patients and their families. LLS advances that mission by advocating that blood cancer patients have sustainable access to quality, affordable, coordinated health care, regardless of the source of their coverage.

Families USA Action is a 501(c)(4) social welfare organization with the mission of creating a system that delivers the best health and health care for all people in the United States. On behalf of health care consumers, working people, and patients, Families USA Action has led the No Surprises: People Against Unfair Medical Bills campaign since 2019, and has advocated for legislation and rulemaking that fully protect consumers from surprise bills while ensuring health care costs do not inflate overall. The organization's work on these issues emerged from consumers' reports of unaffordable surprise billing, and from reports by consumer advocates of their inability to address these issues in the past.

Mended Hearts is a community-based, international nonprofit whose mission is to inspire hope and improve the quality of life for heart patients and their families through ongoing peer-to-peer support, education, and advocacy. Cardiovascular disease is the leading cause of death in men and women, and congenital heart disease is the number one birth defect. Patients and their families, across the lifespan, require access to lifelong care, low-cost medications, and affordable health coverage to reduce the burden of disease and improve the quality of life.

U.S. PIRG is a not-for-profit organization that advocates for the public interest, working to win concrete results on real problems that affect millions of lives, and standing up for the public against powerful interests when they push the other way. It employs grassroots organizing and direct advocacy for the public on many different issues including healthcare, preserving competition, and protecting consumer welfare.

District courts grant motions for leave to file amicus briefs where, *inter alia*, "the amicus has unique information or perspective that can help the court beyond the help that the lawyers for the parties are able to provide." *Jin v. Ministry of State Sec'y*, 557 F. Supp. 2d 131, 137 (D.D.C. 2008) (internal quotes omitted). An amicus brief is appropriate where it "present[s] ideas, arguments, theories, insights, facts[,] or data that are not . . . found in the parties' briefs." *Wash. All. of Tech. Workers v. U.S. Dep't of Homeland Sec.*, 518 F. Supp. 3d 448, 453 n.2 (D.D.C. 2021) (quoting *N. Mariana Islands v. United States*, No. 08-CV-1572, 2009 U.S. Dist. LEXIS 125427, 2009 WL 596986, at *1 (D.D.C. Mar. 6, 2009)).

Here, *Amici* have extensive knowledge of the subject matter of this litigation that may assist the Court in understanding the relevant background of the Rules and the potential harm to patients and consumers if Plaintiff's challenge to the Rules succeeds. Many patients and consumers served by *Amici* are among the one in six Americans who have received a surprise medical bill. *Amici* LLS and Mended Hearts joined community principles for surprise billing reforms and worked with Congress to develop the bipartisan, bicameral No Surprises Act of the 2021 Consolidated Appropriations Act (the "No Surprises Act" or the "Act"), Pub. L. No. 116-250, 134 Stat. 1182. With these community principles as their guide, *Amici* were heavily engaged throughout the legislative process leading to passage of the No Surprises Act and Defendants' rulemaking to implement the Act, including promulgation of the two interim final

rules that Plaintiff challenges in this case: *Requirements Related to Surprise Billing; Part I*, 86 Fed. Reg. 36,872 (Jul. 13, 2021) and *Requirements Related to Surprise Billing; Part II*, 86 Fed. Reg. 55,980 (Oct. 7, 2021) (collectively, the "Rules").

Based on their experience advocating for patients and consumers during the legislative and rulemaking processes, *Amici* are uniquely positioned to explain to the Court how the challenged provisions of the Rules are faithful to the text of the No Surprises Act and further Congress' two primary goals in enacting the Act: (1) protecting patients from the most pervasive types of surprise out-of-network bills, including bills from air ambulance providers; and (2) lowering health care costs overall. In addition, based on their work on behalf of millions of patients and consumers across the United States, *Amici* can provide the Court an important perspective on the nature and extent of the harms to patients and consumers that would likely result from Plaintiff's requested *vacatur* of the challenged provisions of the Rules.

Amici's proposed brief discusses the relevant legislative history and the harms to patients and consumers from surprise medical bills from air ambulance services in a manner not fully addressed by the Parties' briefs. *Amici*'s brief conforms to Local Civil Rule 5.4, Federal Rule of Appellate Procedure 29(a)(4), and the page limitation and other requirements of Rule 7(o). *See* L. Civ. R. 7(o)(2)-(5).

For the foregoing reasons, the Proposed *Amici* respectfully request that the Court grant this motion and enter the attached proposed order.

DATED: January 25, 2022

Respectfully submitted,

/s/ Joseph J. Wardenski

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UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

ASSOCIATION OF AIR MEDICAL SERVICES, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEPARTMENT OF LABOR, DEPARTMENT OF THE TREASURY, OFFICE OF PERSONNEL MANAGEMENT, and the CURRENT HEADS OF THOSE AGENCIES IN THEIR OFFICIAL CAPACITIES, Defendants.	Case No. 1:21-cv-03031-RJL

BRIEF OF THE LEUKEMIA & LYMPHOMA SOCIETY, FAMILIES USA ACTION, THE MENDED HEARTS, INC., AND UNITED STATES PUBLIC INTEREST RESEARCH GROUP, INC. AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT

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As required by Rule 7.1 of the Federal Rules of Civil Procedure, *Amici* The Leukemia & Lymphoma Society ("LLS"), Families USA Action, The Mended Hearts, Inc., and United States Public Interest Group state the following:

The Leukemia & Lymphoma Society is a non-profit entity that does not have a parent corporation. No publicly held corporation owns 10 percent or more of stock in The Leukemia & Lymphoma Society.

Families USA Action is a non-profit entity that does not have a parent corporation. No publicly held corporation owns 10 percent or more of stock in Families USA Action.

The Mended Hearts, Inc., is a non-profit entity that does not have a parent corporation. No publicly held corporation owns 10 percent or more of stock in The Mended Hearts, Inc.

The United States Public Interest Research Group is a non-profit entity that does not have a parent corporation. No publicly held corporation owns 10 percent or more of stock in the United States Public Interest Research Group.

INTRODUCTION

Effective implementation of the No Surprises Act of the 2021 Consolidated Appropriations Act, Pub. L. No. 116-260, 134 Stat. 1182 (2020) (the "No Surprises Act" or the "Act") is necessary to reduce the financial burden of illness on patients and help contribute to longer, healthier lives. Through two interim final rules, *Requirements Related to Surprise Billing; Part I*, 86 Fed. Reg. 36,872 (Jul. 13, 2021) (the "July Rule"), and *Requirements Related to Surprise Billing; Part II*, 86 Fed. Reg. 55,980 (Oct. 7, 2021) (the "September Rule") (collectively, the "Rules"), Defendants have promulgated reasonable, uniform standards to implement the No Surprises Act to (1) protect patients from higher cost sharing when payers calculate the qualifying payment amount ("QPA") for out-of-network services, which is based on the median in-network rate for similar services, and (2) prevent abuse of the Act's independent dispute resolution ("IDR") process for resolving payment disputes between out-of-network providers and payers. The Rules are consistent with the statute and will protect patients and consumers from surprise medical bills for air ambulance services and high health costs.

Because the patients and consumers served by The Leukemia & Lymphoma Society, Families USA Action, The Mended Hearts, Inc., and the United States Public Interest Research Group, Inc. (collectively, "*Amici*") have a strong interest in the outcome of this litigation, *Amici* respectfully submit this brief in support of Defendants' Cross-Motion for Summary Judgment ("Defs.' Cross-Motion"), ECF No. 10.

IDENTITY AND INTEREST OF *AMICI CURIAE*[1]

Amici are patient and consumer advocacy organizations that represent or work on behalf of millions of patients and consumers across the country, including those facing serious, acute, and chronic health conditions. *Amici* are committed to ensuring that all Americans have a high-quality health care system and access to comprehensive, affordable health insurance to prevent disease, manage health, cure illness, and ensure financial stability. Many patients served by *Amici* are among the one in six Americans who have received a surprise medical bill.[2] The patients and consumers served by *Amici* have a significant interest in the outcome of this case, as *vacatur* of the challenged provisions of the Rules will expose them to higher out-of-pocket costs and increased health costs overall.

The Leukemia & Lymphoma Society ("LLS") is the world's largest voluntary health agency dedicated to fighting blood cancer and ensuring that the more than 1.3 million blood cancer patients and survivors in the United States have access to the care they need. LLS's mission is to cure leukemia, lymphoma, Hodgkin's disease, and myeloma, and to improve the quality of life of patients and their families. LLS advances that mission by advocating that blood cancer patients have sustainable access to quality, affordable, coordinated health care, regardless of the source of their coverage.

Families USA Action is a 501(c)(4) social welfare organization with the mission of creating a system that delivers the best health and health care for all people in the United States.

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[1] All parties have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the brief. No person other than *amici curiae* made a monetary contribution to the preparation or submission of this brief.

[2] *See* Lunna Lopes *et al*., *Data Note: Public Worries About And Experience With Surprise Medical Bills* (Feb. 28, 2020) [Admin. Rec. 4040-45].

On behalf of health care consumers, working people, and patients, Families USA Action has led the No Surprises: People Against Unfair Medical Bills campaign since 2019, and has advocated for legislation and rulemaking that fully protect consumers from surprise bills while ensuring health care costs do not inflate overall. The organization's work on these issues emerged from consumers' reports of unaffordable surprise billing, and from reports by consumer advocates of their inability to address these issues in the past.

The Mended Hearts, Inc. is a community-based, international nonprofit whose mission is to inspire hope and improve the quality of life for heart patients and their families through ongoing peer-to-peer support, education, and advocacy. Cardiovascular disease is the leading cause of death in men and women, and congenital heart disease is the number one birth defect. Patients and their families, across the lifespan, require access to lifelong care, low-cost medications, and affordable health coverage to reduce the burden of disease and improve the quality of life.

The United States Public Interest Research Group, Inc. ("U.S. PIRG") is a not-for-profit organization that advocates for the public interest, working to win concrete results on real problems that affect millions of lives, and standing up for the public against powerful interests when they push the other way. It employs grassroots organizing and direct advocacy for the public on many different issues including healthcare, preserving competition, and protecting consumer welfare.

Given the impact of surprise bills on those served by *Amici*, *Amici* LLS and The Mended Hearts, Inc. joined community principles for surprise billing reforms.[3] With these community principles as their guide, *Amici* worked with Congress to develop the bipartisan, bicameral No

[3] *See* ALS Ass'n *et al.*, *Surprise Medical Billing Principles* (Feb. 2020), https://bit.ly/356VtHe.

Surprises Act. *Amici* were heavily engaged throughout the legislative process leading to the Act's passage and Defendants' subsequent rulemaking to implement the Act.

Based on their experience advocating for patients and consumers during the legislative and rulemaking processes, *Amici* are uniquely positioned to explain to the Court how the Rules are faithful to the text of the No Surprises Act and further Congress' two primary goals in enacting the Act: (1) protecting patients from the most pervasive types of surprise out-of-network bills, including bills from air ambulance providers; and (2) lowering health care costs overall. In addition, based on *Amici*'s work on behalf of millions of patients across the United States, *Amici* can provide the Court an important perspective on the nature and extent of the harms to patients and consumers that would likely result from Plaintiff's requested *vacatur* of the challenged provisions of the Rules.

ARGUMENT

I. SURPRISE AIR AMBULANCE BILLS RESULT IN HIGHER OUT-OF-POCKET COSTS FOR PATIENTS AND INFLATED HEALTH COSTS THAT CONTRIBUTE TO INCREASED HEALTH INSURANCE PREMIUMS.

As Congress recognized in passing the No Surprises Act, surprise medical bills can impose "staggering" financial burdens on patients and their families.[4] Patients receive out-of-network bills through no fault of their own when they unknowingly receive care from a provider that is not in their insurance network. This is especially true during an emergency when patients have no way to choose their air ambulance provider, physician, or hospital. Patients with chronic or serious conditions, such as those at risk of a heart attack or with chronic respiratory diseases,

[4] *See* H.R. Rep. No. 116-615, pt. 1, at 52 (2020) [Admin. Rec. 278-428].

face an elevated risk of receiving out-of-network bills from air ambulance providers.[5] In fact, nearly 70 percent of air ambulance transports are likely to be out of network.[6]

A. Surprise Medical Bills from Air Ambulance Providers Have Harmed Patients and their Families Across the United States.

Surprise bills are common and have resulted in significant out-of-pocket costs for directly affected patients and higher premiums for privately insured consumers.[7] This is especially true for patients who are injured or critically ill and must rely on emergency transportation from an air ambulance provider. While air ambulance services often reduce transport time for patients during life-threatening situations and are a critical component of successful treatment for individuals experiencing serious health events, patients in these situations generally have no choice over whether to use an air ambulance or who provides the service, often resulting in surprise bills.

There are many harrowing stories from patients who have received surprise five-figure bills for air ambulance services. For example, after being bucked off a horse in North Dakota, Sonna Anderson, a 60-year-old judge, was taken to a nearby hospital by an air ambulance helicopter, a trip that left her with an exorbitant bill.[8] Within minutes of calling 911, a ground ambulance arrived, stabilized Anderson, and planned to take her to a hospital less than an hour's

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[5] Fair Health, Inc., *Air Ambulance Services in the United States: A Study of Private and Medicare Claims* (Sept. 28, 2021), https://bit.ly/3tYAO2m.

[6] *See* H.R. Rep. No. 116-615, pt. 1, *supra* note 4, at 52.

[7] *See* H.R. Rep. No. 116-615, pt. I, *supra* note 4, at 53 (summarizing the data on surprise billing and noting that the cost of inflated payment rates from certain provider specialties "are directly felt through higher out-of-pocket expenses and exorbitant surprise bills for out-of-network care, as well as by all consumers who share in rising overall health care costs through higher premiums").

[8] Jen Christensen, *Sky-high prices for air ambulances hurt those they are helping*, CNN (Nov. 26, 2018), https://cnn.it/3KzcPN8.

drive away.[9] Despite this plan, the air ambulance crew told Anderson's husband that air transport was necessary, so she was transported by helicopter to a more distant hospital.[10] For the 45-minute ride, the air ambulance company charged $54,727.26, only 25 percent of which was paid by her insurer, leaving Anderson's family responsible for the $41,029.53 balance.[11]

In another incident, infant Piper Pence's family was in for a similar shock when she needed immediate heart surgery just hours after her birth and was airlifted from Tulsa to Oklahoma City.[12] Four months later, the Pence family received a bill for nearly $60,000, of which her insurance paid about $20,000, leaving the family to pay the rest. And Tom Saputo, a 63-year-old graphic designer, thought he had contemplated every possible outcome ahead of his double-lung transplant—until he received a surprise bill for his 27-mile air ambulance flight between two California hospitals.[13] The $51,282 bill for the air ambulance (of which Saputo was responsible for $11,524) was more than the total cost of his life-saving transplant surgery.[14]

Other recent examples include a COVID patient on a ventilator who was left with a $52,112 bill for a 20-mile transport between hospitals;[15] a Kansas man injured in a motorcycle accident who faced more than $40,000 in medical bills after a 30-mile air ambulance transport;[16]

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[9] *Id.*

[10] *Id.*

[11] *Id.*

[12] Christina Caron, *Families Fight Back Against Surprise Air Ambulance Bills*, N.Y. Times (Apr. 17, 2020), https://nyti.ms/3qRBgh6.

[13] Anna Almendrala, *The Air Ambulance Billed More Than The Lung Transplant Surgeon*, NPR (Nov. 6, 2019), https://n.pr/3GWrksd.

[14] *Id.*

[15] Sarah Kliff, *A $52,112 Air Ambulance Ride: Coronavirus Patients Battle Surprise Bills*, N.Y. Times (Oct. 13, 2020), https://nyti.ms/3Iwrffs.

[16] Celia Llopis-Jepsen, *A Kansan's $50k Medical Bill Shows That You Don't Always Owe What You're Charged*, KCUR (May 28, 2020), https://bit.ly/3Isp2Bt.

a doctor who crushed his arm on an ATV ride and was told he had to be transported by air ambulance to a trauma center at a cost of $56,603;[17] and a nine-year-old whose family faced a $36,000 bill after the child fell during a hike and was transported to a hospital by helicopter.[18] While some of these bills were later reduced or resolved following media attention, some of these patients still owe thousands of dollars in unexpected bills resulting from these incidents.

These patients are not alone. Several studies confirm that air ambulance providers are a significant source of costly surprise medical bills, with about 40 percent of helicopter air ambulance transports leading to a potential average surprise bill of nearly $20,000.[19] In 2019, the United States Government Accountability Office found that the average cost of air ambulance transport in 2017 was about $36,400 by helicopter and $40,600 by plane, and that complaints about surprise bills from air ambulance providers were almost always more than $10,000.[20] Another study showed that surprise bills from air ambulance companies resulted in median potential surprise bills of $21,698.[21]

The risk that a patient might receive a surprise out-of-network bill from an air ambulance provider has also grown over time. Multiple studies confirm that the prices charged by air ambulance providers—and thus the out-of-network bills that these companies send to patients—

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[17] Alison Kodjak, *Taken For A Ride: M.D. Injured In ATV Crash Gets $56,603 Bill For Air Ambulance Trip*, NPR (Sept. 25, 2018), https://n.pr/35g4DBq.

[18] Rachel Bluth, *In Combating Surprise Bills, Lawmakers Miss Sky-High Air Ambulance Costs*, Kaiser Health News (June 14, 2019), https://bit.ly/3fMJC35.

[19] Erin C. Fuse Brown *et al.*, *Out-of-Network Air Ambulance Bills: Prevalence, Magnitude, and Policy Solutions*, 98 Milbank Q. 747, 764 (2020) [Admin. Rec. 2851-79].

[20] U.S. Gov't Accountability Off., GAO-19-292, *Air Ambulance: Available Data Show Privately-Insured Patients Are at Financial Risk* 17-18 (2019) [Admin. Rec. 3386-3417].

[21] Karan Chhabra *et al.*, *Most Patients Undergoing Ground And Air Ambulance Transportation Receive Sizable Out-Of-Network Bills*, Health Affairs (Apr. 15, 2020) [Admin. Rec. 2958-63].

have increased significantly. According to one study, the use of helicopter ambulances declined by 14.3 percent from 2008 to 2017 while the average price per trip more than doubled, rising 144 percent.[22] Use of airplane ambulances remained steady during this time, even as the average price increased by 166 percent.[23] Multiple studies have documented high and rapidly rising prices for air ambulance transport.[24]

These significant price increases are attributed at least in part to market concentration and greater private equity ownership of air ambulance providers.[25] In 2016, the three largest independent air ambulance providers—two of which are owned by private equity firms—operated 73 percent of the nation's air ambulance helicopters.[26] Studies have shown that private equity-owned air ambulance providers charge much higher prices compared to public companies or companies not owned by private equity firms.[27] These higher prices (and the business decision that many of these companies make not to contract with payers) often result in extraordinarily high surprise bills for patients who need emergency air transport. Indeed, as 35 state insurance commissioners wrote to Congressional leaders, surprise billing for air ambulance services has, for many providers, become "a business model to prey on people during their most vulnerable

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[22] John Hargraves & Aaron Bloschichak, *Air Ambulances – 10 Year Trends in Costs and Use*, Health Care Cost Inst. (Nov. 7, 2019), https://bit.ly/3GXKzSb.

[23] *Id.*

[24] *See id.*; Ge Bai *et al.*, *Air Ambulances With Sky-High Charges*, Health Affairs (July 2019) (Abstract), https://bit.ly/33HmVeg; Fair Health, Inc., *supra* note 5.

[25] *See* Loren Adler *et al.*, *High air ambulance charges concentrated in private equity-owned carriers*, Brookings Inst. (Oct. 13, 2020) [Admin. Rec. 4761-85].

[26] U.S. Gov't Accountability Off., GAO-17-637, *Air Ambulance: Data Collection and Transparency Needed to Enhance DOT Oversight* 19 (2017) [Admin. Rec. 3347-85].

[27] Adler *et al.*, *supra* note 25.

time" by "pass[ing] on massive surprise bills to private market consumers and expect[ing] them to make up the claimed difference."[28]

These surprise bills add up. A recent study found that Americans owed more than $140 billion dollars in medical debt and that unpaid medical bills are the largest driver of that debt.[29] Surprise bills can hit low-income consumers the hardest: more than one-fourth of adults are unable to pay their monthly bills or are one $400 financial setback away from being unable to pay them in full.[30] The added burden of an unexpected medical expense—which could total hundreds or thousands of dollars—can spell financial ruin for many families.

B. Surprise Billing Increases Health Insurance Premiums and Overall Health Care Costs for Privately Insured Individuals.

In addition to higher out-of-pocket costs, surprise medical bills increase health care costs, which, in turn, increases premiums for those with private health insurance.[31] According to one study, insurers and employers pay the full amount charged by out-of-network helicopter air ambulance providers nearly half the time.[32] Many payers cover the full cost "with no apparent correlation to the magnitude of the charge," meaning the insurer or employer is simply paying what is often tens of thousands of dollars in charges.[33] While this shields individual patients and their families from a surprise out-of-network bill, these high charges add up and are reflected in

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[28] Letter from Jon Godfread, Comm'r, N.D. Ins. Dep't, *et al.* to Hon. Bobby Scott *et al.* 2 (Nov. 7, 2019), https://bit.ly/33K7DWf.

[29] Raymond Kluender *et al.*, *Medical Debt in the US, 2009-2020*, 326 J. Am. Med. Ass'n 250, 255 (2021), https://bit.ly/3KFqh23.

[30] Bd. of Governors of Fed. Reserve Sys., Economic Well-Being of U.S. Households in 2020, at 4, 33 (May 2021) [Admin. Rec. 2838-42].

[31] Erin Duffy *et al.*, Brookings Inst., *Surprise medical bills increase costs for everyone, not just for the people who get them* (Oct. 2, 2020), https://brook.gs/3FWoXnQ.

[32] Fuse Brown *et al.*, *supra* note 19, at 756.

[33] Adler *et al.*, *supra* note 25.

higher premiums.[34] Even if not all patients receive a surprise bill from an air ambulance provider, everyone pays the price for this practice through higher health costs and premiums.

II. CONGRESS INTENDED FOR THE NO SURPRISES ACT TO PROTECT PATIENTS FROM SURPRISE BILLS AND LOWER HEALTH CARE COSTS.

Protecting patients from surprise medical bills, including those from air ambulance providers, is at the heart of the No Surprises Act. But the law did more than just protect patients from these potentially catastrophic out-of-pocket expenses. The law was also designed to lower health care costs and prevent abuse of the IDR process. The legislative debate over the No Surprises Act and several precursor proposals highlights Congress' consistent and bipartisan objectives of protecting patients from surprise medical bills, reducing health care costs, and, in turn, lowering health insurance premiums. For more than two years, Congress considered four major precursor proposals before ultimately enacting the Act in its current form.[35] While the details and scope of these proposals varied, each bill considered by the committees of jurisdiction would have directly protected patients from many types of surprise medical bills and reduced premiums for consumers. Lowering health care costs was a unifying feature of these proposals, underscoring Congress' intent that any protections should also reduce, or at least not increase, insurance premiums.[36]

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[34] *Id.*

[35] Other bipartisan legislative proposals, including the STOP Surprise Medical Bills Act of 2019 and the Protecting People from Surprise Medical Bills Act of 2020, included an IDR mechanism and would have allowed consideration of commercially reasonable rates or usual and customary charges (instead of the median in-network rate or qualifying payment amount). As those bills were not advanced in committee or scored by the CBO, they are not discussed here.

[36] *See* Letter from Sen. Murray & Rep. Pallone to Hon. Xavier Becerra, Sec'y of Health & Human Servs. (Jan. 7, 2022), https://bit.ly/3qTHv45.

A. Bipartisan Precursor Proposals to the No Surprises Act Shared the Goal of Reducing Out-of-Pocket Costs for Patients and Overall Health Expenses.

1. Lower Health Care Costs Act

Congressional focus on surprise billing began in earnest in 2018 during hearings held by the U.S. Senate Committee on Health, Education, Labor & Pensions ("Senate HELP Committee") on how to reduce health care costs.[37] These hearings led Senate HELP Committee Chair Lamar Alexander (R-Tenn.) and Ranking Member Patty Murray (D-Wash.) to introduce the Lower Health Care Costs Act,[38] which the Congressional Budget Office ("CBO") estimated would reduce premiums by just over one percent relative to current law.[39]

2. No Surprises Act of 2019

At the same time, the U.S. House of Representatives Committee on Energy and Commerce debated its own proposal, the No Surprises Act of 2019, which was introduced by Committee Chair Frank Pallone, Jr. (D-N.J.) and Ranking Member Greg Walden (R-Ore.) in July 2019.[40] Here too, the CBO estimated that premiums would be about one percent lower than projected to be under current law.[41] The bill's sponsors touted the legislation's protections

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[37] *See, e.g.*, *How to Reduce Health Care Costs: Understanding the Cost of Health Care in America: Hearing of the S. Comm. on Health, Educ., Labor & Pensions*, 115th Cong. 832 (June 27, 2018), https://bit.ly/33VO9xD.

[38] S. Comm. on Health, Educ., Labor & Pensions, *Senate Health Committee Leaders Introduce Bipartisan Legislation to Reduce Health Care Costs* (June 19, 2019), https://bit.ly/33Zg3sA.

[39] Cong. Budget Off., *Cost Estimate: S.1895, Lower Health Care Costs Act* 3 (July 16, 2019), https://www.cbo.gov/system/files/2019-07/s1895_0.pdf.

[40] H. Energy & Commerce Comm., *Pallone & Walden on Committee Passage of No Surprises Act* (July 17, 2019), https://bit.ly/3AoucvE.

[41] Cong. Budget Off., *Cost Estimate: H.R. 2328, Reauthorizing and Extending America's Community Health Act* 6 (Sept. 18, 2019), https://www.cbo.gov/publication/55640.

against surprise bills and premium savings, citing the CBO's estimate of $20 billion in savings to the federal government in the first decade after its enactment.[42]

3. Consumer Protections Against Surprise Medical Bills Act

In December 2019, bipartisan leaders of the House Ways and Means Committee—Chair Richard E. Neal (D-Mass.) and Ranking Member Kevin Brady (R-Tex.)—agreed on a strategy to address surprise bills that included an IDR process "[d]esigned to protect against inadvertently raising health care costs."[43] The agreement led to introduction of the Consumer Protections Against Surprise Medical Bills Act in February 2020. The CBO estimated that this legislation would result in insurance premium reductions of between 0.5 and one percent.[44]

4. Ban Surprise Billing Act

In February 2020, the House Education and Labor Committee advanced its own bipartisan legislative proposal, the Ban Surprise Billing Act, introduced by Chair Robert C. Scott (D-Va.) and Ranking Member Virginia Foxx (R-N.C.).[45] In a summary of that proposal, the Committee noted that the IDR process "[p]uts in place several commonsense guardrails to prevent the IDR process from leading to higher health care costs and premiums for consumers

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[42] Reps. Frank Pallone Jr. & Greg Walden, *It's time for Congress to protect patients from surprise medical bills*, The Hill (Nov. 21, 2019), https://bit.ly/33E85FF.

[43] H. Ways & Means Comm., *Ways and Means Committee Surprise Medical Billing Plan* (Dec. 11, 2019), https://bit.ly/3tZAroC.

[44] Cong. Budget Off., *H.R. 5826, the Consumer Protections Against Surprise Medical Bills Act of 2020, as Introduced on February 10, 2020, Estimated Budgetary Effects* (Feb. 11, 2020), https://www.cbo.gov/publication/56122.

[45] H. Educ. & Labor Comm., *Committee Advances Bipartisan Solution to Ban Surprise Billing* (Feb. 11, 2020), https://bit.ly/32pifZW.

and from excessive utilization of the process."[46] The CBO agreed with this effect, estimating that the Ban Surprise Billing Act would reduce premiums by roughly one percent.[47]

B. The No Surprises Act Shared the Earlier Bills' Goal of Reducing Health Costs.

Congress' commitment to protecting patients from surprise medical bills and reducing health care costs culminated in a bipartisan, bicameral compromise that became the version of the No Surprises Act ultimately enacted as part of the 2021 Consolidated Appropriations Act. On December 11, 2020, the chairs and ranking members of the Senate HELP Committee and the House Committees on Energy and Commerce, Ways and Means, and Education and Labor announced this bipartisan agreement.[48] As with the earlier committee bills, lowering health care costs remained a high priority. The joint statement noted that, "We have reached a bipartisan, bicameral deal in principle to protect patients from surprise medical bills and promote fairness in payment disputes between insurers and providers, *without increasing premiums for patients*."[49] The CBO confirmed this intent and estimated that the No Surprises Act would reduce premiums by between 0.5 and one percent.[50]

It was no mystery why these bills would reduce premiums. For each bill, the CBO consistently assumed that premiums would decline because payments to some providers would

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[46] H. Educ. & Labor Comm., *Section-by-Section: The Ban Surprise Billing Act (H.R. 5800)*, at 1-2 (Feb. 11, 2020), https://bit.ly/3Iylvlo.

[47] Cong. Budget Off., *H.R. 5800, the Ban Surprise Billing Act, as ordered reported by the House Committee on Education and Labor on February 11, 2020, Estimated Budgetary Effects* (Feb. 13, 2020), https://www.cbo.gov/publication/56134.

[48] S. Comm. on Health, Educ., Labor & Pensions, *Congressional Committee Leaders Announce Surprise Billing Agreement* (Dec. 11, 2020), https://bit.ly/3rSj1Ht.

[49] *Id.* (emphasis added).

[50] Cong. Budget Off., *Estimate for Divisions O Through FF H.R. 133, Consolidated Appropriations Act, 2021 Public Law 116-260 Enacted on December 27, 2020* 3 (Jan. 14, 2021) [Admin. Rec. 4906-13].

be lower than current average rates.[51] The same was true of bills with an IDR mechanism, such as the Consumer Protections Against Surprise Medical Bills Act and the Ban Surprise Billing Act. The CBO analyses of these bills reflected the same conclusion: average payment rates for both in- and out-of-network care would move toward the median in-network rate under the proposed laws.[52] Since the median in-network rate tends to be lower than average rates, premiums would be reduced by up to one percent in most affected markets in most years.[53]

Many *Amici* were highly engaged with lawmakers throughout this legislative process. One of the core principles adopted by coalitions of patient and consumer advocates was that new surprise billing protections should "ensure costs are not simply passed along to patients through higher premiums or out-of-pocket costs"[54] and "hold costs down."[55] These principles also emphasized the need to protect patients who utilize emergency transportation since these services are a critical component of successful treatment for those facing a serious health event.[56] This dual focus on out-of-pocket costs and premiums is also reflected in the comments that many *Amici* and others made to Congress.[57] Based on this history, there is no question that Congress'

[51] Cong. Budget Off., *supra* note 39, at 3.

[52] Cong. Budget Off., *supra* note 41; Cong. Budget Off., *supra* note 44.

[53] *Id.*

[54] ALS Ass'n *et al.*, *supra* note 3, at 2.

[55] Letter from Families USA *et al.* to House Speaker Pelosi and House Minority Leader McCarthy, at 2 (July 10, 2019), https://bit.ly/3tQAra6.

[56] ALS Ass'n *et al.*, *supra* note 3, at 3; *see also* Letter from Brian Connell, Exec. Dir. Of Fed. Affairs, Leukemia & Lymphoma Soc'y, to Hon. Xavier Becerra, Sec'y of Health & Human Servs., *et al.* (Oct. 18, 2021), https://bit.ly/3H1BoQM.

[57] *See, e.g.*, *id.*; Letter from Families USA *et al.* to House Speaker Pelosi and Leaders McConnell, McCarthy, and Schumer (Nov. 12, 2019), https://bit.ly/3tWPCP9.

intent in passing the No Surprises Act was both to protect patients from surprise medical bills and lower health care costs.

III. THE RULES PROTECT PATIENTS AND CONSUMERS BY LIMITING OUT-OF-POCKET COSTS, HOLDING DOWN PREMIUMS, AND ENCOURAGING IN-NETWORK NEGOTIATIONS.

The Rules dutifully follow the No Surprise Act's mandate and Congress' intent to rein in health care costs—and, in turn, help limit premiums for patients and consumers. In challenging the Rules, Plaintiff presents an inconsistent and unsound interpretation of the No Surprises Act that would undermine these goals by leading to an inflated QPA calculation and an unpredictable, administratively burdensome IDR system that could award out-of-network providers with payments far above market rates when doing so is not warranted based on the circumstances.

A. The QPA Methodology Is Reasonable, Well Within the Defendants' Discretion, and Will Help Hold Down Patient Cost Sharing and Out-of-Pocket Costs.

Plaintiff's challenge to the July Rule centers on certain components of the methodology adopted by Defendants to calculate the QPA. The No Surprises Act defines the QPA as the median of a payer's contracted (*i.e.*, in-network) rates for a given medical item or service delivered by a provider in the same or similar specialty and geographic region.[58]

Plaintiff appears to argue that the July Rule inappropriately limits patient cost-sharing to the QPA because the statute does not specifically refer to the QPA;[59] that theory would likely increase patient out-of-pocket costs and should be rejected for the reasons Defendants explain in

[58] *See* 42 U.S.C. § 300gg-112(c)(2) (defining the QPA as having the same meaning as the term in 42 U.S.C. § 300gg-111(a)(3)).

[59] *See* Mem. in Support of Pl.'s Mot. Summ. J., at 31-34, ECF No. 5-1 ("Pl.'s Mem.").

their brief.[60] The QPA is central throughout the No Surprises Act, and the Defendants appropriately looked to the QPA to limit the amount that a patient will pay in cost sharing for out-of-network air ambulance transport.[61]

The methodology for calculating the QPA has a direct impact on patients' out-of-pocket costs. While Plaintiff argues Defendants should have used a different QPA methodology (specifically, one that reflected single case agreements, differentiated between hospital-based and independent air ambulance providers, and adopted a narrower geographic region),[62] the July Rule follows the No Surprise Act's mandate that Defendants promulgate rules to establish the methodology that payers must use when calculating the QPA and define the appropriate geographic regions for determining the QPA.[63] In the July Rule, Defendants adopted a QPA methodology for air ambulance providers that is consistent with the statute and reasonable for the reasons identified in that rule's preamble.[64] While Plaintiff disagrees with some of the choices that federal officials made in exercising their discretion when establishing the QPA methodology, Defendants fully explained their rationale for excluding single case agreements from the QPA, for treating hospital-based and independent air ambulance providers as within the "same or similar specialty," and for adopting reasonable geographic regions.[65] In the July Rule,

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[60] *See* Defs.' Mem. in Support of Cross-Mot. Summ J., at 33-35, ECF No. 11-1 ("Defs.' Mem.").

[61] *See* 45 C.F.R. § 149.130(b) (directing payers to calculate cost sharing for air ambulance services as if the total amount that would have been charged were equal to the lesser of the QPA or the billed amount for the services).

[62] *See* Pl.'s Mem. at 2-3.

[63] *See* 42 U.S.C. § 300gg-111(a)(2)(B).

[64] July Rule, 86 Fed. Reg. at 36,889, 36,891-93.

[65] *Id.*; *see also* Defs.' Mem. at 26-35.

Defendants emphasized that the QPA methodology focus on patients' needs by not perpetuating harms stemming from historic market failures that prevailed in the air ambulance market.[66]

B. Plaintiff's Preferred IDR Process Would Burden Patients and Families with Higher Premiums, Frustrating a Central Purpose of the No Surprises Act.

As Defendants explain in their brief, Plaintiff specifically objects to the "portions of the September rule that instruct the arbitrator, when choosing between the competing amounts proposed by the provider and the group health plan or health insurance insurer, to look first to the qualifying payment amount."[67] But the September Rule—by instructing arbitrators to select the offer that is closest to the QPA unless there is credible information that this amount is incorrect—is consistent with the statute for the reasons identified in that rule's preamble.[68]

Vacating the challenged portion of the September Rule, as Plaintiff seeks, would result in an unpredictable and administratively burdensome IDR process, the costs of which will be borne directly by patients and their families in the form of higher premiums. Without the September Rule's presumption that the QPA is the appropriate payment amount in most cases, arbitrators would be left without a clear, consistent way to balance the statutory factors. Both providers and payers would lose the uniform expectations that the September Rule's IDR provisions establish, leading to less predictable outcomes and increasing the likelihood of above-market payments to out-of-network providers. Air ambulance providers would then be incentivized to remain out of network and use the IDR process to obtain a higher payment instead of negotiating for a reasonable, market-based payment. These higher payments, combined with the administrative costs associated with the IDR process, would be passed along to patients in the form of higher

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[66] *Id.* at 36,891.

[67] See Defs.' Mem. at 2.

[68] September Rule, 86 Fed. Reg. at 55,984-85, 55,996-98.

premiums. *Vacatur* of the challenged provisions of the September Rule would thus perpetuate the cost crisis that the No Surprises Act was expressly designed to remedy.

C. The September Rule's Emphasis on the QPA is Appropriate and Consistent with Congress' Intent to Lower Health Care Costs.

Nothing in the September Rule prevents IDR arbitrators from considering the statutorily mandated factors and any other information that the parties submit during the IDR process.[69] Rather, the September Rule *requires* that arbitrators consider all these factors so long as that information is credible and clearly demonstrates that the QPA is not the appropriate out-of-network payment for a service given the specific circumstances of an individual case.[70]

Prior to promulgation of the September Rule, it was assumed that Defendants would issue guidance to arbitrators on how to balance the IDR factors consistent with the No Surprise Act's requirements. In its February 11, 2020, analysis of the Consumer Protections Against Surprise Medical Bills Act, the CBO noted that "[i]n determining the most reasonable rates, dispute resolution entities would be instructed to look to the health plan's median payment rate for in-network rate care."[71] Even Plaintiff understood that Defendants would issue such guidance in implementing regulations. In June 2021, Plaintiff wrote a letter to Defendants with several recommendations for implementing the IDR process, urging the agencies to "require IDR entities to give primary weight to the average actual non-contracted paid claims amount submitted by the provider."[72]

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[69] *See* Defs.' Mem. at 21-23.

[70] *See id.* at 15-16; September Rule, 86 Fed. Reg. at 56,128.

[71] *See* Cong. Budget Off., *supra* note 44.

[72] Letter from Cameron Curtis, Pres. & CEO, Ass'n of Air Med. Servs. ("AAMS") & Deborah Boudreaux, Chairman and Region IV Director, AAMS, to Hon. Xavier Becerra, Sec'y of Health & Human Servs., *et al.* 6 (June 15, 2021), ECF No. 5-1.

Plaintiff's mere disagreement with how the agencies weighed the factors is an insufficient basis for challenging the September Rule as arbitrary and capricious.[73] And, as Defendants explain in their brief, Plaintiff's preferred interpretation is at odds with the text and purpose of the No Surprises Act,[74] so Plaintiff's claim that the Rules are contrary to law also fail. The September Rule, unlike Plaintiff's preferred approach, follows the statute by requiring arbitrators to consider the QPA and other factors, and heeds Congress' intent by encouraging health care payers and providers to negotiate, resulting in increased in-network care at more affordable rates for patients and their families.[75]

CONCLUSION

The Rules are consistent with the text and purpose of the No Surprises Act and will benefit patients by implementing a QPA methodology and an IDR process that helps ensure lower health care costs for privately insured Americans. The Court should grant Defendants' Cross-Motion for Summary Judgment, deny Plaintiff's Motion for Summary Judgment, and uphold the Rules.

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[73] *Cf. Hearth, Patio & Barbecue Ass'n v. EPA*, 11 F.4th 791, 805 (D.C. Cir. Aug. 27, 2021).

[74] *See* Defs.' Mem. at 17-26.

[75] *See* Letter from Reps. Bobby Scott & Virginia Foxx to Hon. Martin J. Walsh, Sec'y of Labor, *et al.* (Nov. 19, 2021), https://bit.ly/3rRkVYV; Letter from Rep. Frank Pallone, Jr. & Sen. Patty Murray to Hon. Xavier Becerra, Sec'y of Health & Human Servs., *et al.* (Oct. 20, 2021), https://bit.ly/3tTM54k.

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Respectfully submitted,

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