IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION and DR. ADAM CORLEY,

Plaintiffs,

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. 6:21-cv-00425-JDK

BRIEF *AMICI CURIAE* OF
THE AMERICAN BENEFITS COUNCIL, BUSINESS GROUP ON HEALTH, COUNCIL OF INSURANCE AGENTS AND BROKERS, DFW BUSINESS GROUP ON HEALTH, ERISA INDUSTRY COMMITTEE, HOUSTON BUSINESS COALITION ON HEALTH, HR POLICY ASSOCIATION, NATIONAL ALLIANCE OF HEALTH CARE PURCHASER COALITIONS, NATIONAL RETAIL FEDERATION, PURCHASER BUSINESS GROUP ON HEALTH, SELF-INSURANCE INSTITUTE OF AMERICA, TEXAS BUSINESS GROUP ON HEALTH, AND UNITE HERE
IN SUPPORT OF DEFENDANTS' CROSS MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO PLAINTIFFS' SUMMARY JUDGMENT MOTION

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INTEREST OF THE AMICI CURIAE[1]

Amici are a group of entities comprised of trade organizations, employer and industry groups and coalitions, and labor organizations that collectively represent thousands of employers and labor organizations and that together provide health insurance coverage for many millions of employees and their families. In fact, *Amici*, which include both national and Texas-based organizations, are involved in some way in the provision of health insurance coverage for nearly all Americans covered by employer-sponsored group health plans.[2]

As payers of health care services, *Amici* have an immense interest in the implementation of the No Surprises Act. Surprise medical bills can be financially and emotionally devastating to participants already dealing with the challenges of a medical emergency or serious health condition. They are often complex and very hard to understand and decipher particularly since individuals often have no meaningful way to avoid surprise bills, especially with respect to emergency care. The financial burden imposed by surprise bills can be extraordinary and is often borne, in part, by plan sponsors (such as *Amici* and their members) who step in to provide financial protection for the individual. Moreover, the occurrence of surprise billing practices by providers undermines plans' efforts to develop high-quality, cost-effective network designs as some provider groups and types have been incented to remain out-of-network with plans and issuers. This, in turn, results in unnecessary and increased costs for the health care system generally, but most specifically, for plan sponsors (such as *Amici* and their members) and the individuals enrolled in the related plans, through higher premium contributions, reduced benefits,

[1] No party's counsel authored this brief either in whole or in part, and no party or party's counsel, or person or entity other than *Amici*, their members, and their counsel, contributed money intended to fund preparing or submitting this brief. Counsel for both parties have consented to the filing of this brief. *See* Fed. R. App. 29(a)(2), (a)(4)(E).
[2] See the attached appendix for a more detailed description of each amicus.

or both. Moreover, *Amici* have substantial interests in the independent dispute resolution ("IDR") process set out under the No Surprises Act, not only because plan sponsors will be a party to the IDR and impacted by the associated administrative costs and burdens, but also because the IDR process will impact the willingness of providers to go or stay in-network and the in-network rates providers will accept. All of these elements play a large role in determining access to and the cost of employer-sponsored coverage.

Collectively, *Amici* have expended considerable efforts to support a federal solution to the scourge of surprise medical bills—with the twin goals of eliminating surprise medical bills to participants and reducing overall health care costs to the system caused by surprise billing practices. Many of the *Amici* have engaged with Congress, including its individual members and various committees, for over three years regarding a potential federal legislative solution and were extensively involved in the legislative process that resulted in the No Surprises Act. *Amici* not only worked with members of Congress to develop and refine federal legislation, including, specifically the No Surprises Act, they also testified before congressional committees regarding the harmful effects of surprise medical billing on group health plans and their participants, the need for a comprehensive and effective solution to surprise bills, and how a well-designed and implemented solution could help bring down health plan costs caused by surprise billing practices.[3] *Amici* also advocated on behalf of their members and employees during the rulemaking process that followed the enactment of the No Surprises Act. For all these reasons,

[3] *See Testimony of Ilyse Shuman before the House of Representatives Comm. on Educ. and Labor, Subcommittee on Health, Emp., Labor, and Pensions* (Apr. 2, 2019), https://edlabor.house.gov/imo/media/doc/2019-04-02%20HELP%20Hearing%20Schuman%20Testimony.pdf; *Witness Statement of James Gelfand for Testimony before House Ways and Means Health Subcommittee* (May 21, 2019), https://docs.house.gov/meetings/WM/WM02/20190521/109508/HHRG-116-WM02-Wstate-GelfandJ-20190521.pdf.

Amici are uniquely positioned to assist the Court by providing insight into the requirements under the statute and its impact on the American people.

INTRODUCTION[4]

In promulgating the Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (the "IFR"), the United States Department of Labor, Department of the Treasury, and Department of Health and Human Services (the "Tri-Agencies") charted a staid and reasonable course in establishing the details of the IDR process required by the No Surprises Act. H.R. 133 - The Consolidated Appropriations Act, Division BB ("NSA"). As is specifically relevant here, the Tri-Agencies established that the IDR entity should begin its assessment of the parties' competing offers by first looking to the Qualifying Payment Amount ("QPA"), generally the plan's or issuer's median contracted rate for the medical item or service. Then, the IDR entity is to consider certain other information if it is credible and shows that the appropriate out-of-network rate materially deviates from the QPA.

The IFR closely adheres to the NSA's statutory language and structure. Not only is the QPA identified as the first factor to consider in the statute, it is also a carefully calculated amount that reflects the objective arms-length negotiations between plans and providers. Congress recognized the value of the QPA in designing a federal solution to surprise medical bills and by design the QPA plays a central and recurring role with respect to the NSA and its surprise billing protections. In addition to its role in the IDR process, the QPA is the basis upon which the participant's cost-sharing (*i.e.*, coinsurance) is to be determined by the group health plan or issuer. And in recognition of the importance of the QPA to all parties involved—including

[4] While Plaintiffs challenged the rule being issued as an IFR, *see* ECF No. 1 at 10–14, we are addressing only the merits from a policy perspective, as the DOJ has ably addressed that issue in its own briefing. *See* ECF No. 62 at 29–35.

participants, payers and providers—the statute sets forth a separate audit process by the relevant federal agencies to ensure the reliability of the QPA determinations that are made by plans and insurers. The QPA is also a key element of the public reporting that the Tri-Agencies will provide on an ongoing basis regarding the IDR process. The relative importance of the QPA to the IDR entity's review process is informed by reading the statute in its entirety, in which case the central role of the QPA to the NSA becomes clear.

In addition, the legislative history of the NSA shows that Congress intended for the IDR entity's review process to begin with the QPA and for the QPA to play a central role in that review process. Senator Patty Murray, Chair of the Senate Committee on Health, Education, Labor, and Pensions ("HELP"), and Congressman Frank Pallone, Jr., Chairman of the House Committee on Energy and Commerce, two key architects of the NSA, recently reiterated that the IDR process adopted by the Tri-Agencies comports with the intent of Congress to provide a fair reimbursement, including ensuring that material variations from the QPA are paid when demonstrated by credible evidence to be more appropriate, while eliminating surprise balance bills and reducing overall health care costs. Decl. of R. Temme, Ex. A, Jan. 7, 2022 Letter from Sen. Murray and Rep. Pallone to Xavier Becerra, Sec. of U.S. Department of Health and Human Services ("Murray-Pallone Letter") at 5.

Also, the Tri-Agencies' implementing regulations effectuate the important public policy goal of the NSA to not just protect patients from surprise bills but also to lower health care costs, which is vital for employers, other plan sponsors and employees alike. Importantly, the NSA eliminates the market distortion caused by surprise balance bills that incentivized providers to avoid network participation or to seek inflated in-network rates from health care payers, leading to higher premiums for employees and their families. The IDR process in the IFR supports this

key element of the NSA by ensuring that the IDR process cannot be abused in such a way that providers can continue to inflate in-network rates, which should lead to lower costs for plan sponsors and lower premiums for plan participants. *See Congressional Budget Office ("CBO") Estimate for Divisions O through FF of H.R. 133, Consolidated Appropriations Act 2021* (Jan. 14, 2021), https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf (identifying reductions in premiums in most markets of between 0.5 and 1 percent as a result of the NSA's surprise balance billing provisions). The predictability promoted by the IFR also drives down the costs associated with arbitration by encouraging negotiated resolutions (or avoidance of IDR altogether) which reduces the IDR-related administrative costs and the likelihood that more costly arbitration is required as part of the payment process, which is key for employers and other plan sponsors. Furthermore, the IDR process promotes fairness in the IDR determinations by preventing claims for the same or similar service from being reimbursed at materially different rates for the same plan in a given geography, absent credible evidence to the contrary. For these reasons, the court should not modify the Tri-Agencies' implementing regulations which mirror the statutory text, the Court's best evidence of Congressional intent, and are essential to meeting Congress's goal of lower health care costs for employees and their families.

ARGUMENT

I. The Tri-Agencies' Authority for the IDR Process in the IFR Is Clear and Should Receive Deference.

In enacting the NSA, Congress included an express direction to the Tri-Agencies to engage in rulemaking with regard to the specifics of the NSA's IDR process. Furthermore, in requiring the Tri-Agencies to promulgate rules, Congress anticipated that those rules would benefit from the deference given to the Tri-Agencies by well-established case law. Any effort to

undermine the regulations issued pursuant to that explicit rulemaking authority would undermine the unassailable intent of Congress, and should be avoided.

It is well understood that agencies have authority to interpret ambiguities or gaps in statutes. "The power of an administrative agency to administer a congressionally created . . . program necessarily requires the formulation of policy and the making of any rules to fill any gap left, implicitly or explicitly, by Congress." *Chevron USA, Inc. v. Nat. Res. Def. Council*, 467 U.S. 837, 843 (1984), *reh'g denied*, 468 U.S. 1227 (1984); *see also Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 980 (2005) (holding agency's subsequent interpretation of an ambiguous statute is binding on courts, notwithstanding a court's earlier, contrary, interpretation.). Where a statute is silent or ambiguous with respect to a specific issue, the only question is whether "the agency's answer is based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843. If so, then the agency's construction is controlling, even if the agency's construction is not the only plausible reading of the statute—or even the reading that a court would adopt. *Id.* at n.11.

Here, Section 103 of the NSA explicitly directs the Tri-Agencies to issue regulations developing an IDR process to decide the out-of-network payment amount for certain services that cannot be settled via negotiation between out-of-network providers and group health plans and issuers. *See* 42 U.S.C. § 300gg-111(c)(2)(A). More specifically, it states that "[n]ot later than 1 year after December 27, 2020, the [Tri-Agencies] shall establish by regulation one independent dispute resolution process…."

While the NSA includes numerous details about the IDR process including, for example, specifying the period of negotiations required prior to the initiation of the IDR process,[5] the

[5] 42 U.S.C. § 300gg-111(c)(1)(A).

batching of medical claims in the IDR process,[6] the selection and certification of IDR entities,[7] the submission of offers by the parties,[8] and the factors to be considered (and not considered) by the IDR entity,[9] some details remain undefined, including the specific process to be applied by the IDR entity in making its determination or guidelines to structure the IDR entity's decision making, which the Tri-Agencies addressed in the IFR. Given the directive to the Tri-Agencies per Section 103 of the statute, Congress clearly understood there would be a necessary role for the Tri-Agencies in promulgating rules to develop a fulsome and comprehensive IDR review process in accord with the statutory text, policy goals of the statute and Congressional Budget Office score, including by addressing those aspects of the statutory scheme that warrant additional detail.[10] Thus, the statute itself supports the Tri-Agencies' proper use of regulatory authority in implementing the challenged portions of the IFR.

II. The Tri-Agencies' Reasonable Interpretation of the Statute Is Consistent with the Text and Structure of the NSA.

Under the IFR, when choosing between the two competing proposed amounts, an IDR entity is to first look to the QPA, and then to consider additional factors, information the IDR entity requested, and other information provided by either party, provided the information is

[6] *Id.* at § 300gg-111(c)(3).
[7] *Id.* at § 300gg-111(c)(4).
[8] *Id.* at § 300gg-111(c)(5)(B).
[9] *Id.* at § 300gg-111(c)(5)(C)–(D).
[10] Indeed, analogous regulations have been promulgated in circumstances similar to those present with respect to the NSA. For example, the statutory language comprising the Health Insurance Portability and Accountability Act ("HIPAA") also includes an administrative review procedure as part of its enforcement regime. *See* 42 U.S.C. § 300gg-22. While those procedures cross-reference 5 U.S.C. § 554, no standard of review is specified in the statute. *Id.* When the Tri-Agencies promulgated implementing regulations for HIPAA, *see* 42 U.S.C. § 300gg-92, the regulations included a burden of proof provision as well as a standard of review provision. *See* 45 C.F.R. § 150.443. The IDR process established by the Tri-Agencies addresses similar omissions.

credible and clearly demonstrates the QPA is materially different from the appropriate out-of-network rate. These guidelines are fully consistent with the text and structure of the NSA.[11]

Interpretation of the statutory language involves not only assessing the plain language of the statute itself, but also interpreting the meaning of that language in light of the act as a whole. *See e.g.*, *K Mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 291 (1988) (holding "in ascertaining the plain meaning of the statute, the court must look to the particular statutory language at issue, as well as the language and design of the statute as a whole"); *Richards v. United States*, 369 U.S. 1, 11 (1962) (holding "[w]e believe it fundamental that a section of a statute should not be read in isolation from the context of the whole Act, and that in fulfilling our responsibility in interpreting legislation, 'we must not be guided by a single sentence or member of a sentence, but (should) look to the provisions of the whole law, and to its object and policy'") (footnote omitted).

Here, the QPA, which is the first item the IDR entity is to consider and which is central to the IDR process, was very carefully designed by Congress to be an objective, commercially reasonable rate. As such, the QPA provides a reasonable starting point from which the IDR entity should begin its evaluation as part of the IDR process. Per the statute, the QPA generally is the median of the contracted rates recognized by the plan or issuer on January 31, 2019 for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation. 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I); 45 CFR § 149.140(b).[12] Because the QPA is set by the

[11] It is also fully supported by the legislative history, but because that is already amply addressed by other briefs, we have omitted that discussion here. *See* Murray-Pallone Letter.

[12] There are provisions that address the situation where a plan either has insufficient information or is newly covering an item or service that utilizes, among other things, publicly available databases of charge amounts. *See* 42 U.S.C. § 300gg-111(a)(3)(E)(iii); 45 CFR § 149.140(c)(2).

median of contracted rates for the same or similar services, and accounts for factors such as provider specialties and geography, it provides an objective assessment of what providers of similar services in similar geographic areas accept for the particular service at issue.

Also, the QPA amount is subject to audit by the Department of Health and Human Services, which further ensures its accuracy, 42 U.S.C. § 300gg-111(a)(2), and is the amount on which participant cost-sharing is to be based under the NSA. *Id.* at § 300gg-111(a)(1)(C). This further demonstrates why the QPA was so carefully designed by Congress and will be carefully audited by the Tri-Agencies. In addition, the central role of the QPA in the IDR process is made clear in the elements that the Tri-Agencies are to report about the IDR process publicly each quarter, including the number of times the payment amount determined by the IDR entity exceeds the QPA, the amount of each offer in each IDR expressed as a percentage of the QPA, and the offer that was chosen by the IDR entity expressed as a percentage of the QPA. *Id.* at § 300gg-111(c)(7)(B)(iv).

Moreover, the NSA provides specific factors to be considered by the IDR entity during the IDR process and places them into a specific order in the statute. The statute first lists the QPA as an item that must be considered by the IDR entity. In a separate, subsequent paragraph, the text goes on to require that the IDR entity consider any of the "additional circumstances" listed in the NSA that might be applicable, information requested by the IDR entity, and any information relating to the offer submitted by either party. This ordering in the statutory text supports the process adopted by the Tri-Agencies for how the IDR entity is to evaluate the parties' offers. In addition, as evidenced by the use of the term "additional" in the header to the statute, the additional circumstances, while an important part of the review process, presupposes that prior information is being added to and is necessarily secondary to the QPA in the process.

Accordingly, it is clear from the statute itself that Congress intended for the IDR entity to first consider the QPA as part of its review process and for the QPA to play a central role in that process.

Lastly, we note for the Court's attention that the additional circumstances that the IDR entity may consider are in many cases subsumed within the QPA calculation itself. The NSA specifies that the QPA calculation promulgated by the Tri-Agencies "may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities." 42 U.S.C. § 300gg-111(a)(2)(B)(iv). And the Tri-Agencies did account for those elements by including the use of service codes and modifiers when calculating the QPA. 45 CFR § 149.140(b)(2)(ii). The Tri-Agencies explained that

> A service code is a unique identifier, typically consisting of a string of numeric digits or alphanumeric characters, that corresponds to a standardized description, which is used to identify with specificity the item or service that was furnished to a patient. *Different codes may be assigned to the same general service on the basis of certain variations in the provider's method or approach, the complexity of the procedure or medical decision-making, and patient acuity level.* Payers, providers, and facilities understand these service codes and commonly use them for billing and paying claims (including for both individual items and services, and for items and services provided under a bundled payment arrangement).

86 Fed. Reg. 36872, 36890-91 (emphasis added). In light of the foregoing, in many instances the additional factors will already be accounted for in the QPA determination itself. Thus, it makes plain sense to provide in regulation, as Congress did by statute, for the QPA to be the first step in the IDR process, and for deviation from the QPA to occur only when credible evidence exists showing a material difference in the circumstances supports a payment rate that is higher or lower than the QPA.

Ultimately, the IDR entity is tasked in the statute with identifying the most reasonable of the two offers presented. However, this does not mean that the IDR entity must consider all of the factors equally or that immaterial variances from the QPA be recognized as part of the process. For all of the foregoing reasons, Congress clearly intended for the QPA to be the starting point of the IDR entity's evaluation of the offers and for the QPA to continue to play a central role in that process. Given the central and recurring role that Congress assigned to the QPA throughout the statute, and given the potential costs to the system associated with excessive and unnecessary use of the IDR process, the statute fully supports the IFR's requirement that a deviation from the QPA be material and shown to be credible. Such an interpretation is also supported by sound public policy, as discussed below, and well-established principles of judicial economy.

III. The IFR Is Consistent with the Policy Goals of Congress in Adopting the NSA.

The IDR process included in the IFR promotes the key public policies behind Congress's adoption of the NSA. First, and vitally, the IDR process as set out in the IFR is essential to effectuating Congress' intent that the NSA lower health care costs.

While protecting patients from surprise balance bills was a primary consideration of the NSA, based in part on testimony of *Amici* and others, Congress also sought to address the cost of coverage more generally through the NSA. In scoring the budgetary impact of the NSA (and its predecessor legislation), the CBO determined that the IDR provision would generate significant savings as the result of lower premium rates (which thus reduces federal tax expenditures through lower tax subsidies). *See CBO Estimate for Divisions O through FF of H.R. 133, Consolidated Appropriations Act, 2021* (Jan. 14, 2021), https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf. The legislative history of the NSA makes clear that Congress

sought to address not only patients' exposure to exorbitant balance billing, but also address the systemic costs associated with providers' demand for inflated in-network rates, which in turn impact participants, employers, and the federal government in the form of increased premiums. S*ee* Murray-Pallone Letter at 4.

The IDR process set out in the IFR is necessary to ensure that the NSA protects against premium increases and results in lower health care costs as Congress intended. This is because the IDR process under the IFR, which like the statute gives the QPA a central role, will help protect against incentives for providers to leave or remain out of networks which in turn will eliminate unnecessary costs and premium increases for the consumer by correcting the market-failure that allowed providers to charge inflated rates, as intended by the NSA. Plans and issuers have worked hard to develop strong provider networks. These networks are essential to the provision of affordable and patient-protective health coverage. Provider networks improve access to coverage for patients; help bring down the cost of care, which in turn reduces premium amounts; and allow for higher-quality, coordinated care across network providers. If the IDR process presented an opportunity for windfall payments from plans and issuers, routinely resulting in payments above the median contracted rate, the incentive for providers to go out of network (or stay out of network) would increase, and the cost of maintaining networks would increase, thus weakening networks, increasing costs and premiums, and preventing employers and patients from benefiting from the health care efficiencies gained through plan networks.

This is borne out by the experience of insurers arbitrating claims under existing state-based surprise billing dispute resolution schemes. One study of the impacts of the State of New York's arbitration effort to address surprise balance bills, under which IDR entities are instructed to consider billed charges rather than in-network rates, noted that "the very high out-of-network

reimbursement now attainable through arbitration will increase emergency and ancillary physician leverage in negotiations with commercial insurers, leading either to providers dropping out of networks to obtain this higher payment, extracting higher in-network payment rates, or some combination thereof, which in turn would increase premiums." *See* Loren Adler, *Experience with New York's arbitration process for surprise out-of-network bills* (Oct. 24, 2019), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/. *See also* ASPE, *Evidence on Surprise Billing: Protecting Consumers with the No Surprises Act* (Nov. 22, 2021), https://aspe.hhs.gov/reports/evidence-surprise-billing.

This evidence demonstrates that the law's focus on the QPA as a key factor in the IDR process is critical to controlling health care costs. The IDR process as set forth in the IFR will reduce incentives for providers to leave health plan networks because business models that rely on being out-of-network and collecting balance bills will no longer be viable and the IDR process will be sufficiently consistent and predictable that providers will understand a windfall is unlikely. This will not just help reduce premium costs but could also expand availability of and access to providers in health plan networks.[13]

Moreover, Congress made clear its desire for strong networks in one of the additional circumstances set out in the NSA which is "good faith efforts (or lack of good faith efforts) … to enter into network agreements" as well as contracted rates for the previous four years. 42 U.S.C.

[13] For example, in California, which implemented an IDR model that utilizes the median in-network rate, the total number of in-network physicians increased 16%, with larger gains in many specialties that have historically been responsible for most surprise bills. AJMC, *Can We Stop Surprise Medical Bills AND Strengthen Provider Networks? California Did* (Aug. 22, 2019), https://www.ajmc.com/view/can-we-stop-surprise-medical-bills-and-strengthen-provider-networks-california-did.

§ 300gg-111(c)(5)(C)(ii)(V). Thus, if credible and material, the IDR entity must consider a provider's decision to go out of network and their prior contracted rates, if any. Conversely, failing to implement the IDR process consistent with the statute will increase incentives for in-network providers to negotiate higher in-network rates to stay in-network, or create incentives for providers to avoid or leave networks, thus driving up the patient cost sharing and balance bills outside of surprise billing situations, increasing overall premium costs for employers and enrollees, and reducing revenues for the federal government—all results Congress clearly sought to avoid.

In addition, the steps established by the IFR foster predictability in the outcome of the IDR process. This is also crucial in controlling health care costs and is essential to employer-sponsored plans because where both parties can accurately evaluate the probable outcome, they are incentivized to reach an economically efficient settlement. With more predictability, the plan and provider will be more likely to avoid IDR altogether, settle during open negotiation, or reach an agreement regarding in-network participation. In these ways, the predictability fostered by the IDR process works to prevent expenditures in arbitrating claims, which would increase plan expenditures on items other than medical care and should be expected to be reflected in higher premium costs for employees and employers alike. The alternative, *i.e.*, an evaluative methodology untethered from any objective payment amount, would incentivize the frivolous use of the IDR process by providers by allowing for more subjective and unpredictable outcomes, to the detriment of plan participants and the plans in which they participate.

Lastly, the IDR process set forth in the IFR plays the important role of providing consistency for plans and providers. The IFR does this by providing that the QPA is the first consideration and deviation occurs only where it is supported by clear and credible evidence that

the payment amount should be materially different. Such an interpretation is not only grounded in the statute but also in sound policy as an unguided IDR process could routinely result in wide variation in reimbursement for identical services in the same geography, which would be unfair and vex plans (and providers) by awarding different amounts from the plan or issuer for the same services provided under nearly identical circumstances. Fostering disparate outcomes for similar claims would produce a result that Congress did not intend when it enacted the NSA, which is designed, in part, to promote consistency for not just patients, but plans and providers. H.R. REP. No. 116-615, Pt. 1, at 57–58 (2020).[14]

CONCLUSION

The IFR is not only fully consistent with the text and structure of the NSA, it is also essential to effectuate Congress's intent that lower health care costs result from the prohibition on surprise bills. The Court should deny Plaintiffs' Motions for Summary Judgment, grant Defendants' Cross-Motion for Summary Judgment, and uphold the IFR.

Dated: January 18, 2022

Respectfully submitted,

/s/ Seth T. Perretta

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[14] While the QPA may vary from plan to plan, that variation reflects the results of arms-length negotiations between plans and providers. In seeking to undermine the reasonableness of the QPA, the plaintiffs' position would result in variation that does not reflect market realities regarding the true costs of medical goods and services.

Counsel for Amici

CERTIFICATE OF SERVICE

I hereby certify that on January 18, 2022, a true and correct copy of the foregoing document was served on all counsel of record through this Court's CM/ECF filing system.

/s/ Seth T. Perretta
Seth T. Perretta (*pro hac vice*)

Appendix

Organization	Brief Description
American Benefits Council	The American Benefits Council is a national non-profit organization dedicated to protecting and fostering privately sponsored employee benefit plans. Its approximately 440 members are primarily large, multistate employers that provide employee benefits to active and retired workers and their families. The Council's membership also includes organizations that provide employee-benefit services to employers of all sizes. Collectively, the Council's members either directly sponsor or provide services to retirement and health plans covering virtually every American who participates in employer-sponsored benefit programs. The American Benefits Council regularly participates as amicus curiae in cases affecting employee benefits.
Business Group on Health	Business Group on Health is the leading non-profit organization representing large employers' perspectives on optimizing workforce strategy through innovative health, benefits and well-being solutions and on health policy issues. The Business Group keeps its membership informed of leading-edge thinking and action on health care cost and delivery, financing, affordability and experience with the health care system. The Business Group's over 440 members include 74 Fortune 100 companies as well as large public sector employers, who collectively provide health and well-being programs for more than 60 million individuals in 200 countries.

Organization	Brief Description
Council of Insurance Agents and Brokers	The Council of Insurance Agents & Brokers represents over 200 employee benefits and property/casualty agencies and brokerage firms. Council member firms annually place more than $300 billion in commercial insurance business in the United States and abroad. They place 90 percent of all U.S. insurance products and services as well as administer billions of dollars in employee benefits. Council members conduct business in some 30,000 locations and employ upward of 350,000 people worldwide, specializing in a wide range of insurance products and risk management services for business, industry, government, and the public.
DFW Business Group on Health	The DFW Business Group on Health (DFWBGH) is a regional coalition of 65 large and mid-size DFW area employers committed to improving health care quality, costs and outcomes in North Texas. DFWBGH members spend over $4 billion annually on healthcare for nearly 1 million local employees and their families. DFWBGH's mission is to educate and empower DFW area employers and their employees to make informed healthcare decisions and to encourage healthcare providers to continuously improve their performance.
ERISA Industry Committee	The ERISA Industry Committee (ERIC) is a national nonprofit organization advocating exclusively for large plan sponsors that provide health, retirement, paid leave, and other benefits to their nationwide workforces. With member companies that are leaders in every sector, ERIC advocates on the federal, state, and local levels for policies that promote flexibility and uniformity in administering their employee benefit plans, while fighting against a patchwork of conflicting and burdensome rules. ERIC also fights in federal court against state and local laws that conflict with ERISA and joins legal cases as amicus curiae to support large plan sponsors in litigation impacting critical employee benefit plan design or administration."

Organization	Brief Description
Houston Business Coalition on Health	HBCH is a multi-stakeholder but employer centric coalition. HBCH is the leading resource for Houston employer purchasers and their provider partners dedicated to improving the price, quality and consumer experience in healthcare delivery. HBCH represents more than 70 organizations and 1 million employer-sponsored lives. Our members include many of the largest private, governmental and educational employers in the Houston market. HBCH accomplishes its mission through the collective influence of its member organizations. HBCH's NorthStar strategic inputs consist of the use and promotion transparency tools for hospital costs as a function of its financial sustainability needs, and provider quality. NorthStar outputs include the development and promotion of clinically integrated network models with primary care as their foundation, integrated with behavioral health, and referral to specialists based on value.
HR Policy Association	HR Policy Association is the lead organization representing Chief Human Resource Officers at major employers. The Association consists of over 390 of the largest corporations doing business in the United States and globally, and these employers are represented in the organization by their most senior human resource executive. Collectively, their companies employ more than 10 million employees in the United States, over nine percent of the private sector workforce, and 20 million employees worldwide. These senior corporate officers participate in the Association because of their commitment to improving the direction of human resource policy. hrpolicy.org.
National Alliance of Health Care Purchaser Coalitions	The National Alliance of healthcare purchaser coalitions is an alliance of approximately 45 regional coalitions of employers and other plan sponsors. It supports over 12,000 healthcare purchasers ranging from 60% of the Fortune 100 companies, many midsized companies, public sector employers (cities, states, school districts, federal employees) and union groups (e.g. UAW, 32BJ) who collectively provide health coverage to over 45 million Americans. The National Alliance helps to lead improvements in health, equity and value for organizations and communities across the country.

Organization	Brief Description
National Retail Federation	The National Retail Federation ("NRF") is the world's largest retail trade association, representing all aspects of the retail industry. NRF's membership includes discount and department stores, home goods and specialty stores, Main Street merchants, grocers, wholesalers, chain restaurants, and Internet retailers. Retail is the nation's largest private sector employer, supporting one in four U.S. jobs – 52 million working Americans. Contributing $3.9 trillion to annual GDP, retail is a daily barometer for the nation's economy. NRF regularly advocates for the interests of retailers, large and small, in a variety of forums, including before the legislative, executive, and judicial branches of government.
Purchaser Business Group on Health	PBGH is a nonprofit coalition representing nearly 40 private employers and public entities across the U.S. that collectively spend $100 billion annually purchasing health care services for more than 15 million Americans and their families. PBGH has a 30-year track record of incubating new, disruptive operational programs in partnership with large employers and other health care purchasers. Our initiatives are designed to test innovative methods and scale successful approaches that lower health care costs and increase quality across the U.S.
Self-Insurance Institute of America	The Self Insurance Institute of America, Inc. ("SIIA") is an association of self-insured employers and industry participants, including third-party administrators, captive managers, and excess carriers. See SIIA, About SIIA, https://www.siia.org/i4a/pages/index.cfm?pageid=4451.
Texas Business Group on Health	The Texas Business Group on Health is a statewide association of Texas employers and regional employer-led healthcare coalitions, including DFW Business Group on Health, Houston Business Coalition on Health, and San Antonio Business Group on Health. TBGH represents Texas employers' interests as key purchasers of healthcare for employees and serves its members by promoting innovation, accountability, quality and value in the design, financing, and delivery of health care. TBGH also serves as a valuable resource for employers in health benefits design and purchasing issues, and provides guiding influence and leadership in state healthcare policy development

Organization	Brief Description
UNITE HERE	UNITE HERE is a labor union that represents 300,000 working people across Canada and the United States. Our members work in the hotel, gaming, food service, manufacturing, textile, distribution, laundry, transportation, and airport industries. Our membership is diverse. We are predominantly women and people of color, and we hail from all corners of the planet. Together, we are building a movement to enable people of all backgrounds to achieve greater equality and opportunity.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION and DR. ADAM CORLEY,

Plaintiffs,

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. 6:21-cv-00425-JDK

DECLARATION OF RYAN TEMME IN SUPPORT OF BRIEF OF AMICI CURIAE

Pursuant to section 1746 of Title 28 of the United States Code, I, Ryan C. Temme, declare the following:

1. I am over the age of 18, and I am otherwise fully competent to testify to the matters stated in this Declaration.

2. I am a Principal at Groom Law Group, Chartered in Washington, DC.

3. I represent Amici Curiae American Benefits Council, Purchaser Business Group on Health, Self-Insurance Institute of America, National Retail Federation, Council of Insurance Agents and Brokers, ERISA Industry Committee, Business Group on Health, National Alliance of Health Care Purchaser Coalitions , HR Policy Association, UNITE HERE, Houston Business

Coalition on Health, Texas Business Group on Health, and DFW Business Group ("Amici Curiae") on Health in the above-captioned matter.

4. I make this Declaration in support of the Brief of Amici Curiae that is in support of Defendants' Cross Motion for Summary Judgment and Opposition to Plaintiffs' Summary Judgment Motion.

5. Attached as **Exhibit A** is a true and correct copy of the January 7, 2022 letter from Senator Murray and Representative Pallone to Xavier Becerra, Secretary of U.S. Department of Health and Human Services.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 18, 2021.

/s/ Ryan C. Temme
Ryan C. Temme

EXHIBIT A

Congress of the United States
Washington, DC 20510

January 7, 2022

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

Dear Secretary Becerra,

We write to express our strong support for the interim final rules (IFRs) promulgated by the U.S. Department of Health and Human Services (HHS), the Department of Labor, the Department of the Treasury, and the Office of Personnel Management ("the Departments"), specifically the rule entitled, "Requirements Related to Surprise Billing, Part I" released on July 1, 2021[1] and the rule entitled "Requirements Related to Surprise Billing, Part II" released on September 30, 2021. [2] In particular, we would like to express our belief that three critical aspects of the IFRs are consistent with Congress' intent when it enacted the No Surprises Act: (1) it is appropriate for independent dispute resolution (IDR) entities to consider factors other than the qualifying payment amount (QPA) when there is credible information that the QPA is not an appropriate out-of-network rate; (2) the IDR process does not "pass higher costs on to individuals in the form of increases in premiums"[3]; and (3) it was appropriate for the Departments to issue the regulations as IFRs in order to meet the effective date established by Congress.

The Departments' IFRs implement the No Surprises Act's commonsense protections for patients in the manner that Congress intended. As we wrote in October, the rule, "appropriately implements Congressional intent to ensure that the law lowers health care costs."[4] Furthermore, the IFRs are consistent with Congress' clear directive to implement protections against surprise medical bills as soon as possible.

The current IFRs require consideration of additional factors beyond the QPA, as Congress intended. The IDR entity must consider other statutorily-defined factors when a party submits credible information that can sustain critical analysis. Allowing IDR entities to consider other factors when they are not backed by credible evidence would serve only to increase health care costs and undermine the integrity of the process. As such, requiring IDR entities to consider factors when parties offer no credible evidence to support that the QPA is not the appropriate out-of-network payment rate is the policy that would contradict Congressional intent.

We strongly oppose any changes to the IFRs implementing the No Surprises Act that would lead to higher health care costs. Further, making additional changes to the policy would delay enforcement of parts of

[1] https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i
[2] https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii
[3] ibid
[4] https://www.help.senate.gov/imo/media/doc/Pallone%20Murray%20No%20Surprises%20Act%20IFR%20Comment%20Ltr%2010.20.212.pdf

the law, which Congress intended to be implemented as swiftly as possible. A delay arising from any policy change may also ultimately delay parties' access to the IDR process. The legislative history of the No Surprises Act provides a clear justification for the IFRs as written.

Committee Legislative History

The Senate Health, Education, Labor, and Pensions Committee first considered the issue of surprise medical billing in the 115th Congress. Chair Murray raised the issue at a hearing on June 27, 2018, discussing the case of a constituent who received a surprise medical bill despite going to an in-network facility and getting care from an in-network surgeon. At that hearing, Senator Alexander discussed a similar story about a constituent in Tennessee who received a surprise medical bill when they brought their son to an in-network emergency room following a bicycle accident.[5] The Committee held four additional hearings on the high cost of health care during which Chair Murray, along with other Committee members, raised the issue of surprise medical billing numerous times.[6] The topic of each of these hearings was to examine policies that would reduce health care costs.

Following this series of hearings, the HELP Committee released a discussion draft of the Lower Health Care Costs Act on May 23, 2019, which proposed prohibiting the practice of surprise medical billing. The draft included three options for resolving payment disputes between payers and providers: (1) an in-network guarantee; (2) an IDR process; and (3) a benchmark payment. The IDR process was only available for claims in excess of $750. The only factor listed in the draft text which the IDR entity would use for determining reasonability of offers was the median contracted rate.

The HELP Committee then held a hearing on the discussion draft on June 18, 2019. Consistent with Chair Murray's position throughout the legislative debate that any surprise medical billing policy should not increase costs, the Chair asked expert witnesses about the impact different payment mechanisms would have on health insurance premiums.[7] Ultimately, the Committee marked up legislation using the benchmark approach, which would have set a benchmark payment at the market-based, median contracted rate that insurers would pay to out-of-network providers (with no opportunity for the parties to resolve remaining disputes using IDR).[8] CBO estimated that S. 1895 would reduce health insurance premiums by just over 1 percent relative to current law.[9] The reported bill had an effective date beginning in the second plan year after the date of enactment.

The history of the consideration of the Lower Health Care Costs Act, a precursor to the No Surprises Act, demonstrates clearly that the Committee intended the law to help control the cost of health care, including health insurance premiums. The record also shows that, even in this early version, Congress intended the law to be implemented quickly to relieve patients from high health care costs.

The House Energy and Commerce Committee held a legislative hearing on its surprise billing proposal, a discussion draft of the No Surprises Act, on Wednesday, July 12, 2019. The legislation resolved the payment dispute between providers and insurers by requiring that insurers pay the median contracted

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[5] https://www.help.senate.gov/hearings/how-to-reduce-health-care-costs-understanding-the-cost-of-health-care-in-america

[6] https://www.help.senate.gov/hearings/reducing-health-care-costs-eliminating-excess-health-care-spending-and-improving-quality-and-value-for-patients; https://www.help.senate.gov/hearings/reducing-health-care-costs-improving-affordability-through-innovation.

[7] https://www.help.senate.gov/hearings/lower-health-care-costs-act-

[8] https://www.congress.gov/116/bills/s1895/BILLS-116s1895rs.pdf

[9] www.cbo.gov/system/files/2019-07/s1895_0.pdf

rate.[10] The Energy and Commerce Committee then marked up the No Surprises Act (H.R. 3630, 116th Congress) on July 17, 2019.[11] The reported bill required payers to make an initial benchmark payment (the median contracted rate) to providers, but also enabled parties to access an IDR process for claims over $1,250. The IDR entity would be required to consider the median contracted rate; the training, education, and experience of the provider; and extenuating circumstances relating to patient acuity and complexity. CBO estimated that H.R. 3630 would reduce health insurance premiums by 1 percent relative to current law.[12] The effective date of the bill was January 1, 2021. Again, it is noteworthy that this earlier version of the bill demonstrates that Congress always intended a rapid implementation of the law.

On December 9, 2019, Energy and Commerce and HELP Committee Democratic and Republican leaders announced a compromise policy. [13] The compromise included a benchmark payment (the median contracted rate) but offered an opportunity to access an IDR process for claims over $750. The IDR entity would be required to consider the median contracted rate and other additional factors.[14]

On February 11, 2020, the House Education and Labor Committee marked up its bipartisan bill.[15] The legislation used a benchmark payment (the median contracted rate) with an opportunity to access IDR for claims over $750. The bill would have permitted the IDR entity to consider the median contracted rate, and additional factors such as the education, training, and experience of the provider, the market share held by the provider, and extenuating circumstances relating to patient acuity and complexity. CBO estimated that the bill would reduce health insurance premiums by roughly 1 percent relative to current law.[16] The legislation had an effective date of January 1, 2022 – the same date in the final enacted law, underscoring the urgency of protecting patients from surprise medical bills.

On February 12, 2020, the Ways and Means Committee marked up its legislation. The bill allowed disputing parties to initiate a 30-day open negotiation period to determine a payment amount for items and services. If the dispute was not resolved through open negotiation, the parties were permitted to initiate an IDR process. The IDR entity was required to consider the median contracted rate and any other information submitted by the parties justifying their offers except for usual and customary charges for the items and services. In analyzing the legislation, the Congressional Budget Office (CBO) estimated that premiums would be reduced by between 0.5 and 1 percent based, in part, on the assumption that IDR entities "would be instructed to look to the health plan's median payment rate for in-network care."[17] The bill had an effective date of January 1, 2022. Just like every other version of the bill considered by other committees, the effective date demonstrates that Congress always intended the law to be implemented swiftly.

Numerous other bills were introduced in the 115th and 116th Congresses to address surprise medical bills but ultimately rejected. For example, the Protecting People from Surprise Medical Bills Act (H.R. 3502, 116th Congress) instructed IDR entities to consider the commercially reasonable rate for comparable services or items in the same geographic area, the usual and customary cost for services or items, and other factors submitted at the discretion of either party that included: expertise of the nonparticipating provider, circumstances of the dispute, the provider's quality outcome metrics, the usual charges for

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[10] https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Updated%20HE%20Briefing%20Memo-Surprise%20Billing%20Hearing-061219.pdf

[11] https://www.congress.gov/116/crpt/hrpt332/CRPT-116hrpt332.pdf#page=14

[12] www.cbo.gov/system/files/2019-09/hr2328.pdf

[13] https://energycommerce.house.gov/newsroom/press-releases/bipartisan-house-and-senate-committee-leaders-announce-agreement-on

[14] https://www.help.senate.gov/imo/media/doc/LHCC%20Section-by-Section_FINAL.pdf

[15] https://edlabor.house.gov/imo/media/doc/H.R.%205800%20ANS.pdf

[16] www.cbo.gov/system/files/2020-02/hr5800.pdf

[17] https://www.cbo.gov/publication/56122

comparable services, the individual patient characteristics, other relevant economic and clinical factors. [18] Similarly, the STOP Surprise Medical Bills Act of 2019 (S. 1531, 116th Congress) required payers to make a benchmark payment (the median contracted rate) with the opportunity to access IDR. However, the bill instructed IDR entities to consider the commercially reasonable rate for comparable services or items in the same geographic area and other factors submitted at the discretion of either party that can include: the expertise of the out-of-network provider; the circumstances of the dispute; the market-share held by the parties; the demonstration of good-faith efforts; any other relevant economic aspects. In other words, these bills would have based the IDR process on a different rate – either the commercially reasonable rate or usual and customary charges – instead of the median contracted rate.

No Surprises Act

The final enacted law represented a compromise between the committees of jurisdiction. A central component of all the bills from the committees of jurisdiction that remained in the final compromise was the common definition and use of the median contracted rate, known in the statute as the QPA, as an IDR consideration. All previous committee bills determined the QPA to be a reasonable, market-based rate that IDR entities must consider. While additional considerations varied or were excluded, every bill considered by the committees included the QPA as the primary rate that IDR entities should consider when making decisions. Each resulted in significant savings to the Federal government through reduced health insurance premiums, due to the requirement that the IDR entity consider the QPA.[19]

The multi-year, multi-committee legislative history underscores that Congress took great care in crafting compromise legislation that achieves the shared goals of protecting patients from surprise out-of-network bills *and* lowering premiums. An analysis conducted by CBO projected that the No Surprises Act would reduce private health plan premiums by 0.5 to 1 percent on average, and reduce the federal deficit by approximately $17 billion over 10 years, achieving the goal of reducing premiums.[20] Similar to previous policies, CBO understood the QPA to be a central consideration for the IDR entity. We, along with our colleagues, were fully aware of this score as we enacted this historic legislation in December 2020.

The No Surprises Act also maintained the January 1, 2022 effective date used in legislation considered by the committees of jurisdiction and included deadlines in 2021 that were necessary for the law to go into effect in 2022. Congress anticipated that IFRs may be necessary to meet the intended January 1, 2022 deadline and authorized that the funds provided to implement the law may be used for "preparing, drafting, and issuing proposed and final regulations or interim regulations".[21]

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[18] https://www.congress.gov/116/bills/hr3502/BILLS-116hr3502ih.pdf

[19] Congressional Budget Office, *H.R. 5826, Consumer Protections Against Surprise Medical Bills Act of 2020, as Introduced on February 10, 2020 Estimated Budgetary Effects* (Feb. 10, 2020) ("in 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' as such CBO estimated that payment rates in facilities where surprise bills are likely would move toward the median in-network rate leading to reduced premiums and reduced federal deficits"); Congressional Budget Office, *H.R. 5800, Ban Surprise Billing Act* (Feb. 11, 2020) ("CBO and JCT expect that under the bill, in facilities where surprise bills are likely, the average of payment rates for both in- and out-of-network care would move toward the median in-network rate, which tends to be lower than average rates."); Congressional Budget Office, *H.R. 2328, Reauthorizing and Extending America's Community Health Act* (Sept. 18, 2019) ("Under H.R. 2328, CBO and JCT anticipate that in facilities where surprise bills are likely, payment rates would move toward the median and that insurers' payments to providers currently commanding in-network rates well above the median would drop to more typical amounts.").

[20] https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf

[21] Section 118(b)(1) of the No Surprises Act

Implementation

The IFRs are consistent with this legislative history and Congress' intent to lower health care costs. The IFRs appropriately, and consistent with the text of the No Surprises Act, do not incorporate the features of prior bills that were ultimately rejected by Congress. Among other things, the IFRs do not:

- Include an established benchmark payment (as considered in drafts from the HELP Committee, the Energy and Commerce Committee, and the Education and Labor Committee);
- Set a monetary threshold to access IDR (as considered in drafts from the HELP Committee, the Energy and Commerce Committee, and the Education and Labor Committee);
- Require IDR entities to consider commercially reasonable rates (as considered in H.R. 3502 and S. 1531) or usual and customary rates (as considered in H.R. 3502); or
- Authorize access to IDR without defined factors for IDR entities to consider (as considered in drafts from the Ways and Means Committee).

The No Surprises Act was truly the product of bipartisan, bicameral compromise. The IFRs reflect that compromise by requiring IDR entities to consider all statutorily-mandated factors—including any additional information that the parties wish to submit—so long as that information is credible and clearly demonstrates that the QPA is not the appropriate out-of-network rate for a service. As such, the IFRs reflect the enacted law, not other bills introduced in the 116th Congress.

Conclusion

We strongly support the IFRs' specification that, "it is not the role of the certified IDR entity to determine whether the QPA has been calculated by the plan or issuer correct[ly]."[22] Congress specified a detailed mechanism by which payers are intended to calculate the median contracted rate. This mechanism included procedures for determining the appropriate rate for new services and new plans, or for services for which a plan had insufficient information. It also included a detailed audit process, which the Departments must follow to establish that payers are calculating the QPA in compliance with the law. Components of this mechanism were included in every bill reported by the committees of jurisdiction in the 116th Congress. In other words, Congress did not intend to protect the QPA from scrutiny; rather, it specified carefully the means for calculating the QPA in statute and reserved the role of enforcing that calculation for the Departments implementing the policy.

Also, we strongly oppose any change to the IFRs which would allow IDR entities to consider factors when they offer no credible evidence that the QPA is not the appropriate out-of-network payment rate. We also oppose any change which would delay implementation of any part of the law. The record clearly shows that Congress intended that IDR entities consider factors other than the QPA, but there is nothing in the record which indicates that an IDR entity must consider a factor that offers no clear evidence that the QPA is an inappropriate payment rate. To the contrary, there is ample evidence that Congress intended the No Surprises Act to control the cost of health care for patients and families. Any policy that increases the cost of care without providing information to an IDR entity that withstands critical analysis would be inconsistent Congressional intent.

Finally, Congress clearly intended this law to be implemented swiftly. Numerous bills reported by the committees of jurisdiction would have provided the Departments with a similar implementation timeline. As such, we view the use of IFRs to implement the law as an appropriate attempt to meet the tight deadlines set by Congress to protect patients from surprise medical bills.

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[22] https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii

Thank you for your diligent work to implement this important protection for patients.

Sincerely,

Patty Murray
Chair
Senate Committee on Health, Education, Labor, and Pensions

Frank Pallone, Jr.
Chairman
House Energy and Commerce Committee