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

TEXAS MEDICAL ASSOCIATION, et al.,	)	
	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	Case No. 6:23-cv-00059-JDK
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,	)	
	)	
	)	
Defendants.	)	

BRIEF *AMICUS CURIAE* OF
THE EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOCIATION
IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION AND INTEREST OF *AMICUS CURIAE*

The Emergency Department Practice Management Association ("EDPMA") submits this Brief *Amicus Curiae* in support of Plaintiffs' Motion for Summary Judgment (Dkt. 18).

In a Fee Guidance dated December 23, 2022, the defendant Departments announced a surprise, and entirely arbitrary, *sevenfold* increase in the nonrefundable administrative fee each party must pay to access the Independent Dispute Resolution ("IDR") process under the No Surprises Act ("NSA"), 42 U.S.C. § 300gg-111.[1] As recently as October 2022, the Departments had concluded that $50 was the appropriate administrative fee for Calendar Year 2023. In December, however, the Departments suddenly raised that amount to $350. The December 2022 Fee Guidance, together with the Departments' September 2021 Rule regarding "batching" of claims for IDR,[2] will make accessing IDR cost-prohibitive for many physicians, including emergency physicians. The Departments' actions will thereby deprive physicians of the only recourse left to them to obtain fair and reasonable reimbursement for their services.

EDPMA is a physician trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes, as well as billing, coding, and other professional support organizations that assist physicians in our nation's emergency departments. EDPMA's members provide direct patient care and/or support the provision of care for approximately half of the 146 million patients that visit emergency departments each year. For more than 25 years, EDPMA has advocated for the rights of emergency medicine physicians, physician groups, and their patients at

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[1] *Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process under the No Surprises Act: Change in Administrative Fee*, available at https://www.cms.gov/cciio/resources/regulations-andguidance/downloads/amended-cy2023-fee-guidance-federal-independentdispute-resolution-process-nsa.pdf (Ex. 1).

[2] 86 Fed. Reg. 55,980 (Oct. 7, 2021); 45 C.F.R. § 149.510.

the state and federal levels, including with respect to the NSA.

EDPMA strongly supports the NSA's goal of protecting patients from "surprise" healthcare bills—bills for emergency medical services furnished by out-of-network physicians and facilities, or non-emergency services furnished by out-of-network physicians at in-network facilities. The NSA accomplishes this goal by prohibiting physicians from "balance-billing" patients—charging them more than what they would have paid had those services been furnished in-network. At the same time, the NSA recognizes the importance of ensuring fair reimbursement for physicians.

Accordingly, the NSA establishes a process whereby patients are removed from billing disputes. Instead, out-of-network physicians and payers must negotiate among themselves to arrive at a reasonable payment for the physicians' services. Should those negotiations fail, either party may invoke the IDR process, a "baseball-style" arbitration in which the arbitrator must choose one party's offer, and the losing party must pay the arbitrator's fee. To invoke the IDR process, IDR participants must pay a nonrefundable administrative fee. This fee is paid to the government, not the IDR entity. The Departments have now increased this administrative fee from $50 to $350. That sevenfold increase is the subject of this lawsuit.

The Departments' fee increase is the latest in a series of regulatory actions that have thwarted the intent of Congress in enacting the NSA.[3] In *TMA I* and *TMA II*, this Court invalidated the Departments' September 2021 Rule and August 2022 Final Rule regarding how the IDR entity must assess the statutory factors in determining the out-of-network reimbursement amount. The Court held that these Rules conflicted with the NSA because they treated the Qualifying Payment

[3] *Texas Med. Ass'n v. United States Dep't of Health & Hum. Servs.*, 587 F. Supp. 3d 528 (E.D. Tex. 2022) ("*TMA I*"); *Tex. Med. Ass'n v. United States Dep't of Health & Human Servs.*, No. 6:22-cv-372, 2023 WL 1781801 (Feb. 6, 2023) ("*TMA II*"); *Texas Med. Ass'n v. United States Dep't of Health & Hum. Servs.*, No. 6:22-cv-00450-JDK (E.D. Tex.) ("*TMA III*").

Amount ("QPA")—"an insurer-determined number—as the default payment amount and impose[ed] on any provider attempting to show otherwise a heightened burden of proof that appears nowhere in the statute." *TMA I*, 587 F. Supp. 3d at 543; *see TMA II*, 2023 WL 1781801, at *10-14.[4]

TMA III concerns the Departments' July 2021 Rule regarding calculation of the QPA itself. The QPA is the payer's median contracted (i.e., *in-network*) rate, anchored to 2019 but adjusted annually for inflation.[5] Rather than serving to increase the QPA as required by the NSA, the July 2021 Rule has skewed that rate *downward* by giving payers unchecked latitude over the QPA calculations, with no real disclosure to physicians or oversight by the Departments. Emboldened by the Departments' rulemaking, payers have gamed the system by offering reimbursement to providers based on those artificially low, below-market, and payer-manipulated QPAs. Indeed, out-of-network payments to emergency physicians have decreased 92% of the time compared to pre-NSA rates, with an average decrease of more than 32%. These dramatic reductions in reimbursement rates have forced providers to invoke IDR in numbers far exceeding earlier estimates, resulting in a backlog of cases and delays in payments.[6]

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[4] On February 10, 2023, HHS announced a temporary halt to reimbursement decisions, as well as a vacatur of decisions reached after February 6, 2023, pending review of this Court's ruling in *TMA II* invalidating the August 2022 Final Rule. (Ex. 2.) The announcement is an implicit admission that IDR entities have been applying the Final Rule's improper presumption in favor of the QPA. But the IDR entities should not have been applying the Final Rule at all. The Final Rule applies to claims for dates of service on or after October 25, 2022. Because it takes several months from the date of service to IDR submission, the IDR entities should have been applying the April 2022 Guidance, not the improper presumption in favor of the QPA in the Final Rule. (*See* Ex. 3.)

[5] Unlike Defendants, other governmental agencies have recognized that the QPA must be adjusted upward for inflation. For example, in December 2022, the Internal Revenue Service released specific calculations associated with inflationary adjustments for 2023 QPAs. (Ex. 4.)

[6] From April 15–September 30, 2022, disputing parties initiated 90,078 disputes through the Federal IDR portal, significantly more than the number of disputes the Departments initially

The December 2022 Fee Guidance will now foreclose many providers from accessing IDR at all by making IDR economically untenable. The newly increased $350 administrative fee might be tolerable if providers could "batch" a large number of claims against the same payer into a single IDR proceeding. As explained below, however, payers do not provide physicians with the information necessary to determine which claims can be batched. Consequently, physicians are faced with the prospect of invoking IDR for a single claim for services to an individual patient—often for amounts in dispute less than the nonrefundable $350 administrative fee. Requiring a payment of $350 to collect less than that amount completely undercuts congressional intent.

The Departments purport to justify this fee increase by citing to the increased costs of IDR eligibility determinations—that is, determining whether a claim is even subject to IDR—due to the unanticipated number of IDR cases. But those determinations are supposed to be made by the *IDR entities*, not by the government. Indeed, the IDR entities certified that they have the resources and capacity to make such determinations, and they are compensated for those determinations through a separate IDR entity fee paid by the losing party. The Departments thus have improperly shifted the costs of IDR eligibility determinations to the parties by imposing on them nonrefundable fees to pay for services for which the IDR entity is already being compensated.

All healthcare physicians have been materially and adversely affected by the Departments' actions, but emergency physicians particularly so. Under the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, emergency physicians and facilities are required to treat and stabilize all emergency room patients, regardless of their insurance status or ability to pay. Indeed, more than two-thirds of uncompensated medical care in this country is provided in

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estimated would be submitted for an entire year. (Ex. 5.)

emergency rooms. The situation has long since passed a crisis point. The burden of uncompensated care is growing, closing many emergency departments and hospitals, and threatening the ability of emergency departments to care for all patients, including the indigent and rural populations, who rely on emergency departments as an important safety net. (Ex. 6 at 2.)

Together with the other actions of the Departments, the December 2022 Fee Guidance will serve only to exacerbate this bleak situation and undermine the intent of Congress to ensure fair reimbursement to physicians, lest needed health care become unavailable, especially in already medically underserved areas. The Departments themselves recognized these perils: "[U]ndercompensation could threaten the viability of these providers [and] facilities . . . . This, in turn, could lead to participants, beneficiaries and enrollees not receiving needed medical care, undermining the goals of the No Surprises Act." 86 Fed. Reg. at 56,044.

The cost-prohibitive administrative fee of $350 will, as a practical matter, deprive emergency physicians of any recourse for obtaining fair reimbursement for their services to their patients. It also will further incentivize payers to make even lower reimbursements, knowing that IDR will not be a viable solution for these physicians. For these reasons, as explained in greater detail below, the arbitrary sevenfold increase in fee to access the IDR procedure should be vacated.

ARGUMENT

I. The Departments' Actions Are Arbitrary and Capricious and Contrary to Law.

The out-of-network reimbursement rate that an IDR entity must determine is defined by the NSA as (1) the amount determined by an All-Payer Model Agreement under the Social Security Act; or (2) if there is no such Agreement, by a "specified state law"; or (3) if there is no specified state law, by the amount determined through a 30-day "open negotiation" process culminating, if necessary, in IDR. *Id.* § 300gg-111(a)(3)(K). Thus, to determine whether to invoke

the "open negotiation" process and IDR, physicians must know if the NSA actually applies to those charges—in other words, whether the claim is "eligible" for IDR.

Physicians who invoke the IDR process must be prepared to pay two sets of fees. First is the fee at issue in this case: the nonrefundable[7] administrative fee—paid by both parties—which is intended to compensate the government for its costs in the IDR process. *Id.* § 300gg-111(c)(8). The second is the fee that compensates the IDR entity. That fee is paid only by the losing party. *Id.* § 300gg-111(c)(5)(F).

Congress recognized that the costs of arbitration may become prohibitive, particularly if the amounts at issue are relatively small. But Congress intended that all appropriate claims be permitted to proceed to IDR, no matter how small. In fact, Congress rejected bills that would have restricted the IDR process to claims satisfying a minimum dollar amount—in one case, $750; in another, $1,240. (*See* Dkt. 18 at 4.) Significantly, to make the arbitration of small claims economically viable, Congress authorized "batching" of certain related claims for resolution in a single IDR proceeding "for purposes of encouraging the efficiency (including minimizing costs) of the IDR process." 42 U.S.C. § 300gg-111(c)(3)(A).

The Departments' December 2022 Fee Guidance, and their rules regarding "batching" of claims for IDR, were issued without the notice and comment required by the APA. As demonstrated in Plaintiffs' summary judgment brief, there was no lawful basis for bypassing notice and comment. Moreover, in announcing the sevenfold increase in fees to access the IDR process, the Departments did not disclose the data they used to justify the increase. Nor did the Departments even consider how the increased fees would affect the regulated parties, or how $350 in

[7] The administrative fee is nonrefundable even if the IDR entity "determines that the case does not qualify for the Federal IDR process." 86 Fed. Reg. at 56,001.

nonrefundable administrative fees would render IDR cost-prohibitive for many providers, or whether there were other, less draconian alternatives to such an increase. Plaintiffs' brief addresses these legal issues. EDPMA provides below additional information for the Court's consideration.

A. The December 2022 Fee Guidance Improperly Shifts to the Parties the Costs of Services That the IDR Entities Certified They Would Provide and for Which They Will Be Paid.

The NSA authorizes the Departments to set the amounts of nonrefundable administrative fees. The statute, however, explicitly provides that those administrative fees are intended to compensate solely the government—not the IDR entity—for its expenses. The administrative fee must be "equal to the amount of expenditures estimated to be made *by the Secretary* for such year in carrying out the IDR process":

> (8) Administrative fee
>
> (A) In general. Each party to [an IDR] determination . . . shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.
>
> (B) Amount of fee. The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated *to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process*.

42 U.S.C. § 300gg-111(c)(8) (emphasis added).

The stated rationale of the December 2022 Fee Guidance was that the sevenfold increase in administrative fees was necessary to cover the increased costs of IDR eligibility determinations that *the government* would incur as a result of the unanticipated flood of IDR claims. But as the Departments previously acknowledged, these eligibility determinations are supposed to be made *by the IDR entity*, not by the government. The IDR entity is already being compensated for those very services by the "loser pays" IDR entity fee. Thus, the costs on which the Departments are

basing the extraordinary fee increase should not be costs of the government at all.

The December 2022 Fee Guidance is directly contrary to prior agency statements. Concurrently with the September 2021 Rule, CMS issued a fee guidance setting the IDR entity and administrative fees for Calendar Year 2022. (Ex. 7.) CMS set the IDR entity fees at a range of $200-$500 for single determinations and $268-$670 for batched determinations. The agency noted that it had considered a number of factors, including ensuring that the fees would not make "participating in the Federal IDR process . . . cost-prohibitive, especially for smaller providers and facilities." *Id.* at 3. CMS therefore set the nonrefundable administrative fee for 2022 at $50, based on "review of anticipated expenditures *by the Departments* in carrying out the Federal IDR process for 2022." *Id*. (emphasis added).

On October 31, 2022, CMS issued fee guidance for Calendar Year 2023. (Ex. 8.) This guidance raised the IDR entity fees $200-$700 for single determinations and $268-$938 for batched determinations. *Id.* at 6. The Departments stated that this increase in the IDR entity fees was necessary given the high volume of disputes and complex eligibility determinations. *Id.* at 5. The guidance, however, left the $50 nonrefundable administrative fee in place, concluding that existing data did not require a change for 2023. *See id.* at 3-4.

Yet not even two months later, the Departments increased the administrative fees to $350, allegedly because of the *government's* increased costs in conducting eligibility reviews:

> [T]here is a *significant backlog of disputes pending eligibility determinations* before certified IDR entities which has continued to grow since the publication of the prior 2023 guidance [a mere two months earlier]. To address this issue, the *Departments have engaged a contractor and government staff to conduct pre-eligibility reviews,* which include outreach and technical assistance in support of the certified IDR entities' eligibility determinations.

(Ex. 1 at 3 (emphasis added).)

But the Departments' justification flatly contradicted their previous statements, which required that, as a condition of certification, potential IDR entities represent that *they* have the capacity and ability to make these IDR eligibility determinations. For example, in the September 2021 Rule, the Departments set forth the services IDR entities must provide to receive certification:

> In order to be certified, an IDR entity must possess (directly or through contracts or other arrangements) and demonstrate sufficient arbitration and claims administration of health care services, managed care, billing, coding, medical, and legal expertise. With regard to medical expertise, where the payment determination depends on the patient acuity or the complexity of furnishing the qualified IDR item or service, or the level of training, experience, and quality and outcome measurements of the provider or facility that furnished the qualified IDR item or service, the IDR entity should have available medical expertise with the appropriate training and experience in the field of medicine involved in the qualified IDR item or service. Additionally, *the IDR entity must employ (directly or through contracts or other arrangements) sufficient personnel to make determinations within the 30 business days allowed for such determinations.* To satisfy this standard, the written documentation the IDR entity submits must include a description of its organizational structure and capabilities, including an organizational chart and the credentials, responsibilities, and number of personnel employed to make determinations.

86 Fed. Reg. at 56,002 (emphasis added).

The Departments also expressly stated that the IDR entities' ability to provide such services—including eligibility determinations—will be factored into the *IDR entity fee*, not into the nonrefundable administrative fee that is paid to the government:

> The Departments will also consider the anticipated time and resources needed for certified IDR entities to meet the requirements of these interim final rules, such as the time and resources needed to obtain certification, making payment determinations *(including determining whether the dispute belongs in the Federal IDR process)*, data reporting, and audits. The Departments will also consider factors such as the anticipated volume of payment determinations under the Federal IDR process and adequacy of the Federal IDR process capacity to efficiently handle the volume of IDR initiations and payment determinations. The Departments will review and update the allowable fee range annually based on these factors and the impact of inflation and other cost increases. The Departments seek comment on these factors and any additional factors that should be considered *when determining the range for allowable certified IDR entity fees*.

Id. at 56,005 (emphasis added).

Accordingly, the entire basis for the $350 administrative fee—the government's alleged increased costs in making eligibility determinations—is contradicted by the Departments' previous acknowledgement that such determinations are the province of the IDR entity, which will be paid for those determinations through the IDR entity fee. The Departments have failed to give any explanation for this about-face, and there is no lawful basis for the December 2022 Fee Guidance.

In fact, the fee increase was entirely unnecessary. All information needed to determine claim eligibility for the federal IDR process is in the possession of the payers. The Departments needed merely to require payers to provide clear and readily decipherable eligibility information to physicians with the initial payment (or denial) remitted. In that way, physicians could easily be able to identify eligible claims for the federal IDR process, as opposed to claims subject to other state statutes and regulations. Physicians would therefore present only eligible claims for consideration by the IDR entities. This time- and money-saving solution would benefit all concerned by eliminating claims that proceed to IDR but are only later determined to be ineligible. Thus far, however, the Departments have refused to impose on payers this minimal obligation.

B. The Departments' "Batching" Provisions Are Not a Viable Solution.

Congress recognized that the costs of IDR—the nonrefundable administrative fee, together with the IDR entity's fee—could make IDR effectively unavailable to physicians if they have to arbitrate one claim at a time. When the potential reimbursement obtained through IDR will be less than the costs of attempting to obtain it, IDR makes no economic sense.

That certainly is the case with emergency medicine. Emergency physicians deliver specific services in the emergency department setting that correspond to CPT codes describing emergency care evaluation and management (E/M) services (*i.e.*, CPT E/M Codes 99281–99285). Although physician practice reimbursement for these services varies by contract, the total incremental

differential payment rate for an emergency E/M visit between what is generally remitted as the QPA and what historically was remitted to providers before implementation of the NSA, even the highest level visit, is generally less than the $350 administrative fee. This means that the amount in dispute in IDR for a single emergency E/M visit will be even less than $350 administrative fee in the December 2022 Fee Guidance. (Ex. 9.)

Congress provided a solution to this problem. The NSA allows for "batching" of related claims in a single IDR proceeding if (1) the services are provided by the same physician, (2) payments for those services is required to be made by the same plan or issuer; (3) the services are related to the treatment of a similar condition; and (4) the services were furnished within the same 30-day period. 42 U.S.C. § 300gg-111(c)(3)(A)(i)–(iv).

For batching to function properly and achieve the economies of scale envisioned by Congress, payers must provide physicians with sufficient information to determine—at the most fundamental level—whether a claim is even subject to the NSA or, instead, is governed by a "specified state law," *see supra* p. 5, and whether it makes sense to proceed to arbitration, including an analysis whether all the other batching requirements set out in the NSA have been satisfied. But the Department's implementation of the NSA, including their failure to require payers to supply physicians with basic information,[8] has left physicians with no meaningful options for challenging—or even ascertaining the basis of—insurers' reimbursements.

For example, EDPMA has found that insurers routinely fail to comply with the NSA's QPA disclosure requirements. Insurers often do not indicate that the QPA applies for purposes of

[8] Congress charged the Departments with enforcing the transparency requirements of the NSA, including specifying the information that insurers "shall share" with providers when determining the QPA, as well as "a process to receive complaints of violations" of the QPA requirements. 42 U.S.C. § 300gg-111(a)(2)(B)(ii), (iv).

determining the cost-sharing amount for out-of-network services (the "recognized amount"). (Ex. 10 at 1-5; Ex. 11 at 3-4, 7-9; Ex. 12.) When it is unclear whether the cost-sharing amount included in the remittance notice *is* the recognized amount, physicians are unable to verify whether that amount is accurate, resulting in confusion for both patients and providers, and sometimes resulting in patients being billed for incorrect amounts—putting patients right back into the middle of billing disputes, contrary to one of the key purposes of the NSA. (Ex. 10 at 2-4.)

Indeed, EDPMA has found that insurers fail readily to provide the QPA *at all* in 91% of their initial payments or notices of denial, often off-loading it onto separate portals or look-up tools, imposing unnecessary obligations on an already overburdened delivery system. (Ex. 13 at 1.) This dearth of information is particularly problematic in the emergency medicine context. Because of the realities of acute, non-scheduled care, emergency medicine providers often receive little to no information at the time the patient is treated. In fact, because of the unique requirements of EMTALA, emergency medicine groups do not collect billing or cost-sharing information before stabilizing the patient. (Ex. 10 at 1-4.) Instead, emergency medicine practices must wait until after care has been rendered, and then wade through the staggering morass of individual policy benefits, which often requires extensive back-and-forth with the insurer and the patient.

The lack of information is even more problematic when it comes to self-insured/self-funded group health plans. Physicians cannot batch together all such claims by a third-party administrator or a labor union (for example, they cannot batch all self-insured BlueCross claims, or all self-insured Aetna claims). To accurately batch claims from self-insured/self-funded group health plans, providers must engage in a three-part analysis: (1) whether the relevant plan is self-insured (for example, if BlueCross is acting as an insurer or third-party administrator), and, if so, (2) whether it is an employer- or union-sponsored plan, and (3) who is the employer or labor union

sponsor. This basic information is generally not being provided by payers, and when it is, it is not readily accessible or decipherable. (Exs. 9, 12.) As a result, disputes that otherwise would be "batchable" and combined for economic efficiency now must be separated into single-payment determination requests—each of which requires payment of the $350 administrative fee. Without a requirement specifying the information that payers must share with providers, batching cannot be effective, and physicians are left with no means of recovering the fair and reasonable reimbursement that Congress intended.

II. The Departments' Actions Will Result in Serious Adverse Consequences for the Delivery of Emergency Care to Patients.

The inability of emergency physicians to obtain fair reimbursement for their services does not harm only physicians. It has serious adverse consequences for the delivery of emergency care to patients in this country.

Key congressional architects of the NSA warned of the devastating consequences for this nation's healthcare system of inadequate physician reimbursement rates:

> [W]e already know insurers are looking for any way they can pay the least amount possible. They will work to push those rates down, regardless of what it means for community providers like physicians, hospitals, and our constituents who they employ. With no federal network adequacy standards, plans can push rates down and drop providers from networks with no consequences, leaving patients holding the bag.

(Ex. 14.) Legislators also specifically warned the Departments that their implementation of the NSA "could incentivize insurance companies to set artificially low payment rates, which could narrow networks and jeopardize patient access to care—the exact opposite of the goal of the law." (Ex. 15 at 2.)

What members of Congress feared has already come true. First, out-of-network reimbursement rates for physicians have declined dramatically since the Departments' implementation of the NSA. This means that emergency physicians must attempt to recover

through IDR greater amounts than ever before—or lose any chance to obtain fair and reasonable reimbursement for their services to their patients.

EDPMA has analyzed data from its members to ascertain the effects of the implementation of the NSA on emergency medicine. In a 2022 survey of its members, EDPMA compared pre-NSA (2021) out-of-network allowed amounts to post-NSA (2022) allowed amounts. EDPMA found that post-NSA out-of-network payments *decreased 92% of the time* compared to pre-NSA amounts, with an average decrease of 32% per emergency room visit. (Ex. 13 at 1.) Furthermore, the allowed amounts for emergency medicine services ranged from a weighted average of 126%-145% of Medicare rates. This represents cuts of at *least* 25-65% from pre-NSA average out-of-network reimbursement levels for emergency medicine. (Ex. 13 at 2 n.4.)

For example, EDPMA reviewed a dataset sample for pre- and post-NSA out-of-network reimbursements for a Level 4 service (CPT Code 99284) and a Level 5 service (CPT Code 99285). Before the NSA, the average out-of-network reimbursement was $413.92 for a Level 4 visit, and $592.50 for a Level 5 visit. (Ex. 16.) After the NSA, the average out-of-network reimbursement for a Level 4 visit declined by 57% ($236.78) down to $177.14; and the average reimbursement for a Level 5 visit declined by 55% ($328.06), down to $264.44. (*Id.*) In both cases, it would make no economic sense for a physician to attempt to recoup those amounts in IDR, when the Departments' new $350 nonrefundable administrative fee alone is greater than the potential recovery. And that is before the physician takes into account the possibility of losing the IDR and therefore having to pay the IDR entity's fees *on top of* the nonrefundable administrative fees.

These adverse consequences have not been limited to out-of-network reimbursements, but have affected in-network reimbursements as well. The Departments' implementation of the NSA already has had the effect of narrowing provider networks and thereby reducing the availability of

healthcare to patients. Numerous physician practices have received from insurers termination notices of longstanding network agreements (including agreements that currently protect patients in rural and underserved communities) or threats to terminate existing agreements unless the physicians agree to substantial discounts from their contracted rates. (Ex. 17.) Some of those termination letters even cited the Rules as justification. (*See* Ex. 18; *see also* Exs. 19, 20.) These factors have exacerbated existing health disparities and patient access issues in rural and urban underserved communities." (Ex. 15 at 2.)

Because of the dramatic and unexpected reduction in reimbursements by commercial payers, previous subsidizing cross-funding that had guaranteed a patient's access to emergency care under EMTALA no longer exists. Instead, hospitals—many of which are already in severe financial distress—are now being asked to shoulder the brunt of these costs, potentially crippling this country's healthcare safety net. (Ex. 13 at 2.) Moreover, emergency medicine physicians as a whole are expected to see a reduction in commercial reimbursement of almost *$1 billion* annually as a result of payers leveraging the unintended consequences of the NSA. (*Id.*)[9] If the Departments' implementation of the NSA is upheld, the current understaffing of emergency departments will only worsen, reducing patient access to emergency care, particularly in underserved and rural communities. (*Id.*)

CONCLUSION

EDPMA requests that the Court grant Plaintiffs' Motion for Summary Judgment.

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Respectfully submitted,
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[9] At the same time, commercial payers are seeing record earnings. (*See, e.g.*, Ex. 21.)

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CERTIFICATE OF SERVICE

I hereby certify that on February 21, 2023, 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/ Jack R. Bierig
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