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

TEXAS MEDICAL ASSOCIATION, DR. ADAM CORLEY, and TYLER REGIONAL HOSPITAL, LLC, 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. 6:22-cv-00450-JDK Lead Consolidated Case

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

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4. PCP Contracting Practices and Qualified Payment Amount Calculation Under the No Surprises Act (Avalere Health Aug. 2, 2022), available at https://www.emergencyphysicians.org/globalassets/emphysicians/all-pdfs/2022-8-15-avalere-qpa-whitepaper_final.pdf

5. "Neal Opening Statement at Markup of Surprise Medical Billing, Hospice, and Health Care Investment Transparency Legislation" (Feb. 12, 2020) (as prepared for delivery)

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13. American Society of Anesthesiologists, "BlueCross BlueShield of North Carolina Abuses No Surprises Act Regulations to Manipulate the Market Before Law Takes Effect"(Nov. 22, 2021) (including sample letter), available at https://www.asahq.org/about-asa/newsroom/news-releases/2021/11/bcbs-abuses-no-surprises-act-regulations#/

14. Becker's, "4 Disputes Involving UnitedHealth, Physician Staffing Firms" (July 22, 2020), available at https://www.beckershospitalreview.com/payer-issues/4-disputes-involving-unitedhealth-physician-staffing-firms.html

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INTRODUCTION AND INTEREST OF *AMICUS CURIAE*

The Emergency Department Practice Management Association ("EDPMA") submits this Brief in support of the TMA Plaintiffs' Motion for Summary Judgment (Dkt. 25). The July Rule that Plaintiffs challenge is directly contrary to the unambiguous language of, and congressional intent behind, the No Surprises Act ("NSA"), 42 U.S.C. § 300gg-111. *See* 45 C.F.R. § 149.140; 86 Fed. Reg. 36,872 (July 13, 2021), *as amended*, 87 Fed. Reg. 52,618 (Aug. 26, 2022).

The methodology set forth in the Rule for calculating a component of the reimbursement rate to out-of-network physicians—the Qualifying Payment Amount, or "QPA"—conflicts with the NSA in several key respects, skewing the QPA unfairly downward. This deviation from the command of Congress has resulted in unwarranted decreases in payments for the services of out-of-network physicians—with a concomitant reduction in the ability of these physicians to care for patients. For example, out-of-network payments to emergency physicians have decreased *92% of the time* compared to pre-NSA rates, with an average decrease in payment of more than 32% for each emergency room visit. The July Rule has exacerbated the existing crisis in the emergency medical delivery system and the availability of emergency medical physicians in this country. If the Rule is allowed to stand, the system will reach a breaking point that cannot readily be repaired.

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 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 insurers and out-of-network physicians from charging patients 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 compensation for physicians.

Accordingly, the NSA establishes a process whereby patients are removed from billing disputes, and physicians and payors negotiate among themselves to arrive at a reasonable payment for the unreimbursed services. Should those negotiations fail, either party may invoke the Independent Dispute Resolution ("IDR") process, a "baseball-style" arbitration. The IDR process is, as the name suggests, supposed to be "independent," and not biased in favor of either party. The IDR entity must consider each of the statutory factors and examine the particular facts of the claim to determine a fair and reasonable out-of-network rate.

This Court invalidated the October 2021 Interim Final Rule ("IFR") regarding the IDR process, holding that the IFR conflicted with the NSA because it "treat[ed] the 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." *Texas Med. Ass'n v. U.S. Dep't of Health & Human Servs.*, 587 F. Supp. 3d 528, 543 (E.D. Tex. Feb. 23, 2022) ("*TMA I*"). This lawsuit challenges another aspect of the Departments' implementation of the NSA: the July Rule's provisions regarding calculation of the QPA and the attendant disclosures insurers must make to physicians to enable them to evaluate the insurer's calculation of the QPA.

The QPA is the insurer's median contracted (*i.e.*, in-network) amount for the service provided by physicians of the same or similar specialty in the same geographic region. The QPA

is calculated exclusively by the insurer, is not subject to scrutiny by the IDR entity or meaningful oversight by the Departments, and has been the subject of widespread insurer noncompliance.[1]

The July Rule violates the NSA through a series of provisions that artificially depress the QPA. Among other things, the July Rule (1) allows insurers to include in the calculation of the QPA non-negotiated, unreasonably low contracted rates for services that are not actually provided by the contracting physician, typically because the services are outside his or her specialty ("ghost rates"), and "zero-pay payments," used by insurers to lower the median rate; (2) excuses insurers from incorporating the rates of providers in the same specialty; (3) requires insurers to exclude from the rates used to calculate the QPA risk-sharing, bonus, and other incentive-based or retrospective payments, which sometimes form a significant portion of the ultimate amount paid to the physician under the contract; and (4) allows self-insured group health plans, at their option, to calculate QPAs based on the (lower) contracted rates of *other* plans administered by the same entity. Each of these provisions improperly allows payors to manipulate the QPA downward and reimburse for out-of-network services at amounts that are grossly below-market and that ultimately will undermine the emergency medical delivery system.

The July Rule also violates the NSA's disclosure and transparency requirements by failing to require insurers to share with physicians material information regarding the calculation of QPAs. Thus, physicians are unable to make informed decisions in the negotiation process (including the amounts of the offers to submit, or even whether to initiate the IDR process at all) and in the decision whether to submit a complaint to the agencies pursuant to the statutory complaint process. The July Rule thus effectively forecloses review into whether the QPAs

[1] *See* 86 Fed. Reg. 55,980, 55,996 (October 7, 2021) ("[I]t is not the role of the certified IDR entity to determine whether the QPA has been calculated by the [insurer] correctly.").

calculated by insurers comply with the NSA.

Each of these provisions was designed for the exclusive benefit of insurers, without regard to the devastating effect on physicians, their patients, and the healthcare system. The July Rule's one-sided procedure tilts the IDR process decidedly in favor of insurers and, necessarily, toward out-of-network reimbursement rates that are inadequate and below-market—indeed, significantly below pre-NSA rates. All healthcare physicians have been materially and adversely affected by the July Rule, 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 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. 1 at 2.)

The NSA was enacted in part to address these problems, but the July Rule serves only to exacerbate this already bleak picture. Fair reimbursement of physicians—a key purpose of the NSA—is critical to the viability of our healthcare system, particularly the delivery of emergency medical care. But implementation of the Rule has driven reimbursement down to artificially low, below-market rates—not only for out-of-network services, but for in-network services as well.

Key congressional architects of the NSA 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. It could also have a broad impact on reimbursement for in-network services, which could

exacerbate existing health disparities and patient access issues in rural and urban underserved communities." (Ex. 2 at 2.) Indeed, the Departments themselves recognized the perils of physician undercompensation: "[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.

What members of Congress feared has already come true. EDPMA's members have received notices from insurers threatening to terminate their contracts (and in some cases terminating their contracts) unless they agree to substantial discounts to their contracted rates. Those notices specifically cited the Departments' rules as the legal justification for their actions. Absent vacatur of the July Rule, the situation will only deteriorate, with devastating consequences for patients and the emergency physicians who serve them.

ARGUMENT

I. The July Rule Directly Conflicts with the NSA's Unambiguous Language.

The NSA prohibits balance-billing patients for emergency services in excess of their in-network cost-sharing. *See* 42 U.S.C. § 300gg-111(a)(1)(C)(ii), (b)(1)(A). Accordingly, out-of-network physicians must turn to the patient's insurer for payment of unreimbursed amounts. Under the NSA, insurers are obligated to pay these physicians a reasonable fee, called the "out-of-network rate," less the patient's cost-sharing. *Id.* §§ 300gg-111(a)(1)(C)(iv)(II), (b)(1)(D). The out-of-network rate is defined 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 applicable Agreement or state law, by the amount determined through a 30-day open negotiation process culminating, if necessary, in IDR. *Id.* § 300gg-111(a)(3)(K).

Under the NSA, the IDR entity must consider a detailed list of factors in determining the

out-of-network rate, including the QPA; five "additional circumstances," such as the provider's training, experience, and market share; and any information the arbitrator requests or the parties provide. 42 U.S.C. §§ 300gg-111(c)(5)(C)(i)(I)-(II). As this Court held, the October 2021 IFR conflicted with the NSA by treating the QPA as the default reimbursement amount. The Departments' second attempt to regulate IDR did not cure these deficiencies, and is currently the subject of "*TMA II*," *Texas Med. Ass'n v. U.S. Dep't of Health & Human Servs.*, No. 6:22-cv-00372 (E.D. Tex.). Under the new IDR rule, arbitrators must consider the QPA first and may not give weight to any of the other mandated factors unless other criteria are met—once again improperly making the QPA the benchmark for out-of-network rates. *See* 87 Fed. Reg. at 52,652.

Yet even if there were no such presumption in favor of the QPA, the IDR process would still result in out-of-network rates significantly below fair compensation as a result of the July Rule's requirements for calculation of the QPA. The NSA directed the Departments to promulgate rules establishing "the methodology" that insurers "shall use to determine" the QPA. 42 U.S.C. § 300gg-111(a)(2)(B)(i). Congress further charged the Departments with 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. *Id.* § 300gg-111(a)(2)(B)(ii), (iv). The July Rule fails to implement the NSA in all these respects.

A. The July Rule's Methodology for Determining the QPA Violates the NSA.

The NSA defines the QPA as "the median of the contracted rates recognized by the plan or issuer . . . as the total maximum payment . . . for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished" as of 2019, adjusted for inflation. *Id.* § 300gg-111(a)(3)(E)(i)(I). If the insurer "does not have sufficient information to calculate the median of

the contracted rates," the QPA must be calculated by reference to an independent database, such as a state all-payor claims database, that reflects "allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region." *Id*. § 300gg-111(a)(3)(E)(iii). Thus, insurers must calculate the QPA based on rates for services that are *actually provided* by physicians in the same specialty and in the same geographic region; if insurers do not have this information, they must calculate the QPA based on an appropriate database. The July Rule violates these clear statutory directives in a series of QPA provisions, each of which alone drives down the QPA, but when combined, result in dramatically insufficient QPAs.

1. Inclusion of "Ghost Rates" and "Zero-Pay" Payments

The July Rule provides that contracted rates are the total amounts that the insurer "has contractually agreed to pay a participating provider." 45 C.F.R. § 149.140(a)(1). Thus, contrary to the NSA requirement that QPAs be based on services *actually provided*, the July Rule allows insurers to include all "contracted" rates, regardless of whether the service was actually provided. *See* 86 Fed. Reg. at 36,889 (NSA "envisions that each contracted rate for a given item or service be treated as a single data point when calculating a median contracted rate . . . *regardless of the number of claims paid at that contracted rate*") (emphasis added).

The July Rule therefore allows for the inclusion of "ghost rates"—rates that are included in contracts, but are for services not actually performed by that provider. Providers who do not perform a particular service have little to no incentive to negotiate a fair and reasonable reimbursement rate for that service. As a result, ghost rates are lower than they would have been had the rates been negotiated by providers who actually performed the service. Indeed, these ghost rates, combined with other disingenuous calculations like zero-pay payments, can be as low as $0.

The Departments recognized that the July Rule allowed for the inclusion of these rates in

the calculation of QPAs. In a series of "FAQs" published in August 2022, the Departments acknowledged that inclusion of these rates "may artificially lower the QPA, as these providers have little incentive to negotiate fair reimbursement rates" for these services and sometimes even accept "$0 as their rate." (Ex. 3 at 16, FAQ 13.) Yet while the Departments stated that "$0 amounts" should not be used in calculating the QPA, they did not prohibit altogether the use of non-negotiated rates, thereby allowing such rates in the amounts of even $1. (*Id.* at 17 n.29, FAQ 14.)

2. Inclusion of Out-of-Specialty Rates

Although the NSA requires that QPAs be calculated according to the rates of providers "in the same or similar specialty," 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I), the July Rule permits insurers to disregard this directive when it is not "consistent with the plan's or issuer's usual business practice." 45 C.F.R. § 149.140(a)(12). The Departments recognized this departure from the clear statutory language, and even considered requiring insurers to "calculate separate median contracted rates for every provider specialty," as provided in the NSA. 86 Fed. Reg. at 36,891. Yet the Departments rejected such a provision based entirely on the convenience of insurers.

The Departments justified this departure from the NSA by asserting the need to provide insurers with "flexibility" to calculate the QPA; to reduce the "burden associated with calculating the QPA"; and to avoid "instances in which the plan or issuer would not have sufficient information to calculate the QPAs using its contracted rates." *Id*. The NSA, however, expressly provides a method for calculating the QPA when the insurer does not have sufficient information: an independent claims database. 42 U.S.C. § 300gg-111(a)(3)(E)(iii). The Departments cited a supposed "statutory goal" of limiting the times an insurer uses this express statutory alternative. 86 Fed. Reg. at 36,888. Nothing in the NSA suggests that this was a "statutory goal."

Including out-of-specialty rates drives QPAs downward. As the Departments themselves

recognized, many insurers "establish contracted rates by offering most providers the same fee schedule for all covered services, and then it is up to the providers to negotiate increases to the rates for the services that they are most likely to bill." (Ex. 3 at 16, FAQ 14.) For example, an insurer may contract with a primary care physician ("PCP") to provide anesthesiology services, even though the PCP does not actually provide such services, and therefore will not attempt to negotiate those rates with the insurer. (In this respect, such non-specialty rates are a species of "ghost rates.") One study found that many PCPs, who significantly outnumber other specialties, "are contracting with insurers for services the providers rarely or never provide"; that most such PCPs do not actively negotiate payment rates for those services; and that the inclusion of such PCP-contracted rates "do[es] not reflect payments typically accepted by in-network providers" of that specialty. (Ex. 4 at 1, 6.) Including such non-specialty rates when determining QPAs is yet another way the July Rule skews QPAs downward and away from market rates for that specialty.

3. Exclusion of Risk-Sharing, Bonus, and Other Retrospective Payments

The July Rule provides that insurers must exclude from rates used to calculate QPAs "risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments." 45 C.F.R. § 149.140(b)(2)(iv). The NSA, however, requires QPAs to be based on the "total maximum payment" recognized by the insurer, 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I), and these incentive and retrospective payments are often critical components of a contracted rate.

Indeed, the Departments recognized that insurers and providers sometimes agree that payments will be "reconciled retrospectively to account for utilization, value adjustments, or other weighting factors that can affect the final payment," and that insurers and providers will sometimes "agree to certain incentive payments during the contracting process." 86 Fed. Reg. at 36,894. In some contracts, risk-sharing amounts can total 10-15% of the total payments. The contracted rates

are then adjusted *downward* to reflect the potential for receiving such bonuses or incentives. But if providers do not believe that they will receive such additional payments, they will demand higher fixed rates for that service. Thus, excluding these payments or payment adjustments from the QPA calculation necessarily will result in a lower QPA. The Departments provided no statutory justification for excluding such payments from the rates used to calculate the QPA. There is none.

4. Using Rates from All Self-Insured Plans Administered by the Same Entity

The July Rule allows a self-insured group health plan, "at the option of the plan sponsor," to calculate its own QPAs using rates from all contracts administered by the same entity, even the contracted rates of a different plan sponsor. 45 C.F.R. § 149.140(a)(8)(iv). The NSA, however, expressly requires that QPAs be "determined with respect to all such plans *of such sponsor*." 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I) (emphasis added). Given the option of using their own rates or those of other plans, plans will certainly chose the lower amount. The July Rule thus again results in lower reimbursement rates than what would have been authorized under the NSA.

B. The July Rule Fails to Require Adequate Disclosure of the Basis for the Insurer's Calculation of the QPA.

The July Rule also fails to implement the NSA's statutory directive that insurers provide meaningful disclosure of how the QPA was calculated. The Departments acknowledged the need for "transparency" in this regard. But again citing their goal of "minimizing administrative burdens on plans and issuers," 86 Fed. Reg. at 36,898, the July Rule requires insurers initially to provide only the most minimal of information: the QPA itself and a statement certifying that the QPA was calculated in accordance with the NSA. 45 C.F.R. § 149.140(d)(1). Only if the provider presses for more information is the insurer obligated to do so, but even then is required to provide only limited additional information. *Id.* The July Rule does not require insurers to disclose critical

information underlying the calculation of the QPA, including the "contracted rates used in determining the median rate; the specialties of the providers who contracted for those rates; whether the insurers used the rates of other plans administered by the same administrator; or the amounts of the incentive-based or retrospective payments the insurers excluded when calculating the QPA. The July Rule therefore leaves physicians entirely in the dark when it comes to assessing whether the QPA is consistent with the NSA.

II. The Departments' Implementation of the NSA Has Resulted in Serious Adverse Consequences for the Delivery of Emergency Care to Patients.

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. 5.) The predicted effects have already become reality.

First, the reimbursement rates for physicians have declined dramatically since the Departments' implementation of the NSA. 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. 6 at 1.)[2] Furthermore, when insurers *do* disclose the QPA, *see infra* pp. 13-14, the QPA

[2] 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. 6 at 2 n.4.)

is equal to the insurers' allowed amount at least 93% of the time, demonstrating that insurers are using problematic QPAs as the basis for reimbursement, notwithstanding the NSA's intent that the QPA should not be a "benchmark" payment standard. (*Id.* at 2; *see* 87 Fed. Reg. at 52,625 n.29 ("many plans and issuers make initial payments that are equivalent to or are informed by the corresponding QPA for the item or service at issue").)

The fact that QPAs are artificially low—significantly so—is evidenced by the enormous volume of IDR proceedings. The Departments have reported that the number of IDRs initiated by providers in the first five months of the program was more than the government anticipated for an entire year. (Ex. 6 at 2 & nn. 2-3.) Indeed, IDR requests have exceeded CMS's projections by more than 700%. (Exs. 7-8.) This has caused a severe backlog for arbitration and a significant delay in resolutions. These delays in turn have resulted in negative cash flow for physician groups, resulting in layoffs and hospital closures, to the detriment of patients. In addition, insurers' unwillingness to be transparent in their submission of initial payments has resulted in providers being unable to correctly decipher eligible claims to pursue in IDR. This has compounded the backlogs, as IDR entities must now sort through potentially thousands of ineligible claims that would not have been filed in the first place had insurers provided the necessary information.

Because of the dramatic and unexpected reduction in out-of-network reimbursements by commercial payors, previous subsidizing cross-funding that 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 shouldering the brunt of these costs, potentially crippling this country's healthcare safety net. (Ex. 6 at 2.) Moreover, emergency medicine groups are expected

to see a reduction in commercial reimbursement of almost *$1 billion* annually. (*Id.*)[3] If the Departments' implementation of the NSA is upheld, the current understaffing of emergency departments will only grow worse, reducing patient access to emergency care, particularly in underserved and rural communities. (*Id.*)

Second, the Department's implementation of the NSA 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 determining the cost-sharing amount for out-of-network services (the "recognized amount"). (Ex. 9 at 1-5; Ex. 10 at 3-4, 7-9.) 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. 9 at 2-4.)

Furthermore, 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. 6 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

[3] At the same time, commercial payors are seeing record earnings. (*See, e.g.*, Ex. 11.)

stabilizing the patient. (Ex. 9 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.

As the Departments themselves acknowledged, prompt and meaningful insurer disclosure of the QPA and the factors that went into calculating it is an essential component of the process. Without it, providers are unable accurately to assess patient responsibility for the charge, whether the allowed amount is subject to the IDR process at all (or if a specified state law applies instead), whether to initiate the IDR process, the type of offers they should submit, and whether to institute a complaint with the Departments. (Exs. 6, 9-10.) To make matters worse, while the Departments are authorized to audit insurers' QPA calculations, 42 U.S.C. § 300gg-111(a)(2), there has been no meaningful agency action on that front.

Third, underpayments to physicians—and the post-NSA amounts are egregiously below market—cause the contraction of provider networks and the narrowing of healthcare choices for patients.[4] For emergency physicians, the problem is even more acute. In the experience of EDPMA and its members, the EMTALA requirements lead health plans to be even less inclined to maintain emergency physicians in-network. Insurers recognize that their policyholders are able to receive emergency care regardless of their insurance status or ability to pay. Insurers therefore have no incentive to enter into fair contracted rates with emergency physicians.

Fourth, the Departments' implementation of the NSA already has had the effect of narrowing provider networks and thereby reducing the availability of healthcare to patients.

[4]For example, California enacted a benchmark payment rate, but it ultimately became the default payment rate for out-of-network and even in-network services, resulting in narrowed networks and jeopardizing patient access to care. (Ex. 12.)

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. Some of those termination letters even cited the Rules as justification. (*See* Ex. 13; *see also* Exs. 14, 15.) The only recourse for physicians who are forced out-of-network is the flawed IDR process, and its even more problematic QPA determinations.

Finally, the Departments' assumption that lower reimbursement rates will translate into lower costs to patients is without any basis. The Departments have stated that the IDR rules would "help limit the indirect impact on patients that would occur from higher out-of-network rates if plans and issuers were to pass higher costs on to individuals in the form of increases in premiums." 86 Fed. Reg. at 55,996. There is no evidence, however, that insurers pass their savings from lower reimbursement rates onto their insureds. In fact, when states provide for fair reimbursement (like New York and Connecticut), the resulting insurance premiums are actually *lower* than the national average. One study examined premiums in New York, Connecticut, and nationwide. In 2019, the percentage growth in premiums was 73% nationwide, but only 50% in New York and 35% in Connecticut. (Ex. 16.) In other words, there is no evidence of a relationship between higher insurance premiums and laws that improve emergency physician reimbursement. Continued implementation of the July Rule will result in a host of negative consequences for physicians and their patients without any of the hoped-for positives in the form of lower insurance premiums.

CONCLUSION

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

DATED: January 31, 2023

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CERTIFICATE OF SERVICE

I hereby certify that on January 31, 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
Jack R. Bierig