No. 23-40605

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Texas Medical Association; Tyler Regional Hospital, L.L.C.; Dr. Adam Corley,
Plaintiffs-Appellees/Cross-Appellants,

v.

United States Department of Health and Human Services; Office of Personnel Management; United States Department of Labor; United States Department of Treasury; Xavier Becerra, Secretary, U.S. Department of Health and Human Services, in his official capacity; Kiran Ahuja, in her official capacity as the Director of the Office of Personnel Management; Janet Yellen, Secretary, U.S. Department of Treasury, in her official capacity; Julie A. Su, Acting Secretary, U.S. Department of Labor, in her official capacity;
Defendants-Appellants/Cross-Appellees.

LifeNet, Incorporated; Air Methods Corporation; Rocky Mountain Holdings, L.L.C.; East Texas Air One, L.L.C.
Plaintiffs-Appellees/Cross-Appellants,

v.

United States Department of Health and Human Services; Office of Personnel Management; United States Department of Labor; United States Department of Treasury; Xavier Becerra, Secretary, U.S. Department of Health and Human Services, in his official capacity; Kiran Ahuja, in her official capacity as the Director of the Office of Personnel Management; Janet Yellen, Secretary, U.S. Department of Treasury, in her official capacity; Julie A. Su, Acting Secretary, U.S. Department of Labor, in her official capacity;
Defendants-Appellants/Cross-Appellees.

On Appeal from the United States District Court
for the Eastern District of Texas

BRIEF FOR APPELLANTS

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CERTIFICATE OF INTERESTED PERSONS

A certificate of interested persons is not required, as defendants-appellants/cross-appellees are all governmental parties. 5th Cir. R. 28.2.1.

s/ Leif Overvold
Leif Overvold

STATEMENT REGARDING ORAL ARGUMENT

In 2020, Congress enacted the No Surprises Act to shield consumers from the often-devastating effects of surprise medical bills. Invoking that Act's express delegation of rulemaking authority and the government's existing authorities, the government promulgated the regulations at issue in this case. The district court entered a universal vacatur of several of the challenged provisions of the regulations, which address important aspects of the Act's implementation. Given the importance of the issues raised, the government believes that oral argument would assist the Court.

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INTRODUCTION

In 2020, Congress enacted the No Surprises Act (the Act) to shield patients from the often-crippling effects of surprise medical bills. Prior to the Act, if a patient received care from a medical or air ambulance provider outside the patient's health insurance network, the patient could face a ruinous surprise medical bill even if the care was delivered under circumstances where the patient had no opportunity to select an in-network provider. Not only are surprise medical bills financially disastrous for the patient, but the market distortion created by certain providers' ability to engage in such billing resulted in increased health care costs for the public at large. The Act addresses these problems by capping patients' potential liability for emergency and certain other care provided by out-of-network providers. The Act also allows medical providers to obtain compensation from their patients' health plans and, if the provider and health plan cannot agree on a payment amount, allows for an arbitrator to determine the fair value of the services.

The Act specifies that, absent an otherwise applicable cap, the maximum liability a patient can face for covered items and services is generally a function of what the Act terms the "qualifying payment amount" or "QPA," a figure designed to approximate the total amount that a provider would have received for a particular service under the terms of a patient's health plan had the provider been in-network. The Act also specifies that the QPA is one factor to be considered by an arbitrator when the value of a service is disputed between the provider and the patient's health

plan. The Act itself includes a definition of the QPA, specifying that it is generally "the median of the contracted rates recognized by" the health plan on January 31, 2019 (before the Act was enacted), adjusted for inflation. 42 U.S.C. § 300gg-111(a)(3)(E)(i). But Congress understood that this definition was incomplete and set a deadline by which the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (the Departments) were to "establish through rulemaking" the "methodology" that plans "shall use to determine the qualifying payment amount." *Id.* § 300gg-111(a)(2)(B)(i).

This case arises from a challenge to the July 2021 interim final rule through which the Departments fulfilled this rulemaking mandate, among others imposed by the Act. Plaintiffs, who are medical and air ambulance providers, disagree with an array of methodological determinations made by the Departments regarding how the QPA should be computed. For example, the air ambulance plaintiffs believe that the QPA must include certain one-off payments that health plans sometimes make to providers, often as a result of the market failure that existed prior to the Act that the Act was specifically designed to address. Plaintiffs also object to certain other aspects of the rule, including a provision that specifies when a health plan's statutory deadline for responding to an air ambulance provider's demand for payment is triggered.

The district court concluded that several of the challenged provisions were inconsistent with the Act and ordered universal vacatur of those provisions. But in so doing, the district court misconstrued the Act and failed to give due accord to

Congress's determination that the Departments are best positioned to specify the methodology for administering the Act. The court accordingly erred in invalidating provisions that are consistent with the plain terms of the statute and reasonable in light of the nature and purpose of the statute to protect patients from surprise medical bills and to set up an efficient system for determining the payments to be made for covered items and services, without carrying forward the market distortions that Congress acted to eliminate.

STATEMENT OF JURISDICTION

Plaintiffs invoked the district court's jurisdiction under 28 U.S.C. §§ 1331, 1346(a), 2201-2202 and 5 U.S.C. §§ 701-706. ROA.33, ¶ 33; ROA.13369, ¶ 18. The district court entered judgment for plaintiffs in part and for the government in part on August 24, 2023. ROA.13241-43, 13479-81. The government timely appealed on October 20, 2023. ROA.13244-45, 13482-83. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether the district court erred in invalidating certain provisions of the Departments' regulations establishing a methodology for determining QPAs.

2. Whether the district court erred in invalidating a provision of the Departments' regulations implementing a statutory deadline for health plans to make an initial payment or denial of payment.

3. Whether the district court erred in entering a universal vacatur of the challenged provisions.

STATEMENT OF THE CASE

A. Statutory Background

1. Medical services are not provided under uniform pricing models, and the amount different providers may charge a particular patient for the same service may vary substantially. In particular, the amount that a provider will charge for care to a given patient often depends on whether the patient has health insurance and, if so, whether the provider has entered into a contract with the patient's health plan agreeing to provide services to the plan's members at particular pre-negotiated rates.[1]

The pre-negotiation of rates between plans and providers is a common feature of the health care market, and most health plans have a network of providers who have contractually agreed to accept pre-negotiated payment amounts for particular items or services. *See Requirements Related to Surprise Billing; Part* I, 86 Fed. Reg. 36,872, 36,874 (July 13, 2021) (ROA.768-881). Plans encourage their members to receive care from these "in-network" providers, and when they do so, patients' financial obligations are limited by the terms of their health plans. When, however, a patient receives care from an out-of-network provider, the provider generally will not have

[1] For ease of reference, this brief generally uses "health plans" or "plans" to refer to both group health plans and health insurance issuers, and generally uses "providers" to refer to providers (including providers of air ambulance services) and health care facilities.

agreed to accept a particular negotiated rate for the item or service, and the patient's health plan may decline to pay the provider or may pay an amount lower than the provider's billed charges. *See id.* In that circumstance, the patient may be responsible for the balance of the bill, and because the rate charged was not pre-negotiated by the patient's health plan, this practice of "balance billing" may result in the patient being personally held responsible for immensely more than the same item or service would have cost had a pre-negotiated rate been applicable.

"A balance bill may come as a surprise for the individual." 86 Fed. Reg. at 36,874. Surprise billing may occur when a patient receives care from a provider whom the patient could not have chosen in advance, or whom the patient did not have reason to believe would be outside the network of the patient's plan. For example, a patient in an emergency situation will often be unable to choose which emergency department she goes to (or is taken to) or whether to receive care from an in-network provider even if the emergency department happens to be in-network. *Id.* This situation arises frequently in connection with air ambulance providers, as individuals generally do not have the ability to select an air ambulance provider and consequently have little to no control over whether the provider is in-network. As a result, surprise billing concerns have been particularly evident in this context. *See id.*; *see also* Erin C. Fuse Brown et al., *The Unfinished Business of Air Ambulance Bills*, Health Affairs Forefront (Mar. 26, 2021) (*Unfinished Business of Air Ambulance Bills*) (ROA.3448-50). Likewise, even patients who try to receive non-emergency services at

an in-network facility (like a hospital) will sometimes nonetheless receive care from an out-of-network provider (such as a radiologist or anesthesiologist) furnishing services at the in-network facility. *See* 86 Fed. Reg. at 36,874.

In such circumstances, a patient's inability to choose an in-network provider created a pronounced market distortion: these providers have little incentive to join health plan or insurance networks, negotiate fair prices in advance for their services, or moderate their charges for out-of-network care. These circumstances have led to the widespread phenomenon of surprise billing, a problem that was becoming more common and more costly for patients before Congress acted. *See* 86 Fed. Reg. at 36,874. One notable study found that, from 2010 to 2016, the incidence of out-of-network billing in connection with emergency department visits increased from 32.3% to 42.8%, while the average potential amount of such bills to patients increased from $220 to $628. *Id.*; *see also* Eric C. Sun et al., *Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospital*, 179 JAMA Internal Med. 1543, 1544 (2019) (ROA.5180) (reporting these results); Erin L. Duffy et al., *Prevalence and Characteristics of Surprise Out-of-Network Bills from Professionals in Ambulatory Surgery Centers*, 39 Health Aff. 783, 785 (2020) (ROA.1995) (finding 81% increase in the average amount of patient liability in connection with surprise bills at ambulatory surgical centers from 2014 to 2017). For inpatient admissions, the incidence of such billing rose from 26.3% to 42.0%, while the average potential amount of the bills rose from $804 to $2040. 86 Fed. Reg. at 36,874.

Under these circumstances, a patient with health insurance could receive a potentially crippling surprise medical bill. *See* 86 Fed. Reg. at 36,874. Indeed, "[t]he financial liability imposed on patients by surprise medical bills can be staggering." H.R. Rep. No. 116-615, pt. 1, at 52 (2020) (ROA.933). As Congress recognized, "[t]hese unexpected medical bills can result in financial ruin, as nearly four in ten American adults are unable to cover a $400 emergency expense, yet the average surprise balance bill by emergency physicians in 2014 and 2015 was an estimated $620 greater than the Medicare rate for the same service." ROA.933 (footnote omitted). The potentially devastating effects on patients are well documented. *See, e.g.*, ROA.933 (referring to a "shocking" example of "a spinal surgery patient who received a bill of $101,000 despite having confirmed that her surgeon was in-network"); *Unfinished Business of Air Ambulance Bills* (ROA.3449) (noting that "[m]edian charges for a rotary-wing air ambulance transport spiked over the past decade, nearly tripling from $12,500 to $35,900 between 2008 and 2017"). Air Methods Corporation, a plaintiff here, took particular advantage of the market distortion giving rise to surprise billing, increasing its prices for medical transports by 283% from 2007 to 2016, with an average price of $49,800 charged per transport in 2016. Loren Adler et al., *High Air Ambulance Charges Concentrated in Private Equity-Owned Carriers*, USC-Brookings Schaeffer on Health Policy (Oct. 13, 2020) (ROA.5378).

Beyond the financial consequences in individual cases, the market distortion created by surprise billing has had the broader effect of driving up health care costs

generally. As Congress recognized, the surprise billing phenomenon represents a market failure whose "presence . . . in certain provider specialties is strongly supported by evidence reflecting the highly inflated payment rates for these services." H.R. Rep. No. 116-615, pt. 1, at 53 (ROA.934). "[T]he ability to surprise-bill" for particular services such as emergency care "creates leverage that enables . . . providers" in practice areas conducive to surprise billing "to obtain higher in-network payments." Erin L. Duffy et al., *Policies to Address Surprise Billing Can Affect Health Insurance Premiums*, 26 Am. J. Managed Care 401, 401 (2020) (ROA.1987). The result is that surprise billing can systematically cause health care costs to spiral upward for all consumers, including those who do not themselves receive out-of-network services. *See* ROA.1989 (finding that the leverage provided "has broader effects on health care spending—resulting in commercial health insurance premiums as much as 5% higher than they otherwise would be in the absence of this market failure"); *see also* H.R. Rep. No. 116-615, pt. 1, at 53 (ROA.934) (noting that costs associated with surprise billing are felt by "all consumers who share in rising overall health care costs through higher premiums").

The leverage offered by a provider's ability to surprise bill could also induce a plan to agree to cover on a case-specific basis the potentially exorbitant cost of a service already provided by an out-of-network provider. For air ambulance providers in particular, "many insurers appear to place a high value on preventing enrollee surprise bills," given the infrequency with which the services are provided and their

very high costs. *Unfinished Business of Air Ambulance Bills* (ROA.3449). A study based on 2014-2017 data thus found that 77% of the most common air ambulance transports were out of network, and plans paid an out-of-network air ambulance provider's full billed charges in 48% of such cases, compared to only 7% when the provider was in-network. *See* 86 Fed. Reg. at 36,923; *see also Unfinished Business of Air Ambulance Bills* (ROA.3449) (noting that this study "f[ound] that insurers allowed out-of-network air ambulances' full charges for about half of transports, without any clear relation to the magnitude of the charge"). Reflecting the leverage that providers could otherwise exert, 40% of cases in which a bill was not paid in full resulted in a potential balance bill to a patient, with an average amount of $19,851. Erin C. Fuse Brown et al*., Out-of-Network Air Ambulance Bills: Prevalence, Magnitude, and Policy Solutions*, 98 Milbank Q. 747, 757, 764 (2020) (ROA.3465, 3472).

2. In 2020, Congress enacted the No Surprises Act to combat the growing crisis of surprise medical bills. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. at 2757-2890 (codified in relevant part at 42 U.S.C. § 300gg-111 *et seq.*).[2] The Act protects insured patients from unexpected liabilities

[2] For ease of reference, this brief cites the Act's amendments to the Public Health Service Act and the regulations implemented by HHS. The Act made parallel amendments to the Employee Retirement Income Security Act (administered by the Department of Labor) and the Internal Revenue Code (administered by the Department of the Treasury), and the implementing regulations likewise contain parallel provisions implemented by the different Departments. The Act also affects the Office of Personnel Management (OPM) by requiring, in a provision not directly

arising from common forms of balance billing. As described further below, in circumstances where it applies, the Act caps an individual patient's share of liability to an out-of-network provider at an amount comparable to what the individual would have owed had she received care from an in-network provider.[3] The Act also creates procedures that allow the provider to seek further compensation from the patient's health plan. Those separate procedures further Congress's goal of "taking the consumer out of the middle" of billing disputes. *See* H.R. Rep. No. 116-615, pt. 1, at 55 (ROA.936) (quotation marks omitted).

Because provider rates are usually not standardized, and because the Act specifically addresses circumstances in which the provider and health plan have not pre-negotiated the applicable rates, Congress devised distinct means for establishing the amounts that could be recovered by the provider from the individual patient and the health plan respectively.[4] Congress determined that a relevant consideration in

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at issue in this case, that OPM's contracts with the Federal Employees Health Benefits Program require the carrier to comply with applicable provisions of the No Surprises Act. *See* 5 U.S.C. § 8902(p).

[3] The circumstances where these protections apply include: (1) when an insured patient receives emergency care from an out-of-network provider, *see* 42 U.S.C. § 300gg-131; (2) when an insured patient receives certain non-emergency services at an in-network facility but is nevertheless treated by an out-of-network provider, such as an anesthesiologist or radiologist, *see id.* § 300gg-132; and (3) when an insured patient is transported by an out-of-network air ambulance provider, *see id.* § 300gg-135.

[4] In some circumstances, the No Surprises Act looks to applicable state law or to a state All-Payer Model Agreement under 42 U.S.C. § 1315a to supply the relevant payment rates. *See* 42 U.S.C. § 300gg-111(a)(3)(H)(i), (iii), (a)(3)(K)(i), (iii).

calculating both the patient's and health plan's liability would be what the statute terms the "qualifying payment amount" or "QPA," which is generally "the median of the contracted rates recognized by" a health plan on January 31, 2019 (before the Act was enacted) for a particular item or service, adjusted for inflation. 42 U.S.C. § 300gg-111(a)(3)(E)(i). The QPA essentially approximates the total amount that the provider would have received under the terms of the patient's health plan had the provider been in-network. It is typically derived from the amounts that the relevant health plan actually agreed to pay its in-network providers for the relevant service before the Act's protections against surprise billing took effect, selecting from those amounts a representative value (the median), and adjusting that representative value for inflation.

The QPA is generally a factor in determining the respective payment obligations of both patients and health plans under the No Surprises Act, but it is used differently in these two determinations. For patients, the QPA plays a dispositive role in determining the patient's cost-sharing responsibility. A patient's cost-sharing requirement must be calculated as if the total charge was no greater than the QPA, and the patient's cost-sharing requirement cannot exceed the requirement that would apply if the services had been provided by an in-network provider. 42 U.S.C. § 300gg-111(a)(1)(C)(ii)-(iii), (3)(H)(ii), (b)(1)(A)-(B).[5] For example, if the QPA

[5] Separate provisions of the Act create a parallel process applicable to air ambulance providers. 42 U.S.C. § 300gg-112. Many of the parallel statutory requirements are identical in relevant part. For air ambulance services, the Act

for a given service is $1,000 and the patient's plan would have required her to pay a coinsurance of 20% for receiving that service in-network, the patient's responsibility would be capped at $200, assuming she had met any applicable deductible.

The Act's procedures for determining a health plan's payment obligation include additional steps, while also using the QPA as a required consideration. After a provider submits a bill for a covered out-of-network service to the health plan, the plan must respond within 30 days by either issuing an initial payment or a notice of denial of payment; if the provider is dissatisfied with the plan's response, the provider may initiate a "30-day period" of "open negotiation." 42 U.S.C. § 300gg-111(a)(1)(C)(iv), (b)(1)(C), (c)(1)(A). If the dispute remains unresolved after the open negotiation period, the plan and provider may proceed to an independent dispute resolution (IDR) process, where an arbitrator working for an entity certified under a government-established process will determine how much the plan is to pay the provider. *Id.* § 300gg-111(c)(1)(B), (4)(A). The Act relies on "baseball-style" arbitration: the provider and the health plan each offer a payment amount, along with their justification, and the arbitrator is required to select one of the two offers. *Id.* § 300gg-111(c)(5)(A)(i).

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specifies that a patient's cost-sharing responsibilities are calculated based on the rates "that would apply" to in-network air ambulance services, *id.* § 300gg-112(a)(1), and the Departments have specified by regulation that the QPA should be used as the maximum rate that would apply when determining the patient's responsibility for air ambulance services, 45 C.F.R. § 149.130(b)(2).

Congress directed that in determining which of the two offers to select, arbitrators "shall consider—(I) the [QPAs] for the applicable year for items or services that are comparable" to the item or service at issue; "and (II) . . . information on any circumstance described in" a list of "[a]dditional circumstances," as well as any information "relating to" a party's offer that is either requested by the arbitrator or submitted by the party. 42 U.S.C. § 300gg-111(c)(5)(B)(i)(II), (B)(ii), (C)(i)-(ii). The list of "[a]dditional circumstances" for arbitrators to consider includes, for example, the provider's level of training and experience, measurements of the quality and outcomes achieved by the provider or facility, and the acuity of the patient or complexity of the procedure. *Id.* § 300gg-111(c)(5)(C)(ii).[6] The arbitrator's decision is binding on the parties and not subject to judicial review except under circumstances described in the Federal Arbitration Act. *Id.* §§ 300gg-111(c)(5)(E)(i), 300gg-112(b)(5)(D). Once a final amount has been identified, the health plan must pay the provider that amount, offset by the patient's cost-sharing obligation and any amounts already paid by the plan. *Id.* § 300gg-111(a)(1)(C)(iv)(II), (b)(1)(D).

B. Regulatory Background

The No Surprises Act charges the Departments with the responsibility to issue regulations implementing the Act's provisions. In particular, the statute directs the

[6] The list of "[a]dditional circumstances" for arbitrators to consider in resolving disputes regarding air ambulance services differs somewhat, though there is some overlap. *See* 42 U.S.C. § 300gg-112(b)(5)(C)(ii).

Departments to, among other things, establish through rulemaking by a statutory deadline of July 1, 2021, the methodology health plans are to use in determining the QPA. 42 U.S.C. § 300gg-111(a)(2)(B)(i). The statute similarly directs the Departments to establish by the same deadline the geographic regions for which QPAs would be calculated and requirements relating to the information health plans must share with providers regarding QPA determinations. *Id.* § 300gg-111(a)(2)(B)(ii)-(iii).[7]

The Departments promulgated an interim final rule pursuant to this statutory directive in July 2021. *See* 86 Fed. Reg. 36,872. That rule, among other things, implemented the Act's provisions barring balance billing and limiting patients' cost-sharing responsibility for out-of-network medical care in covered situations. As particularly relevant here, the rule also set the methodology for determining the QPA, implemented disclosure requirements for health plans concerning the QPA calculation, and implemented a 30-day statutory deadline for health plans to provide

[7] The statute also directed the Departments to issue regulations governing the conduct of the arbitration process. 42 U.S.C. §§ 300gg-111(c)(2)(A), 300gg-112(b)(2)(A). Provisions of the final rule that the Departments issued in discharging that responsibility, *see Requirements Related to Surprise Billing*, 87 Fed. Reg. 52,618 (Aug. 26, 2022), were challenged by a group of plaintiffs that overlap with plaintiffs here, and an appeal in that litigation is currently pending in this Court. *See Texas Med. Ass'n v. HHS*, No. 23-40217 (5th Cir.); *see also Texas Med. Ass'n v. HHS*, 587 F. Supp. 3d 528, 549 (E.D. Tex. 2022) (vacating provisions of a previously issued interim final rule); *LifeNet, Inc. v. HHS*, 617 F. Supp. 3d 547, 563 (E.D. Tex. 2022) (same).

an initial payment or notice of denial of payment after receiving a bill for covered services from a provider. *Id.* at 36,876.

1. a. In discharging their responsibility to establish a methodology for computing a plan's QPA for a given service, the Departments resolved three issues relevant to this appeal. These determinations related to the universe of contracted rates that are to be considered when determining a plan's median contracted rate for a given service. In general, the inclusion of additional higher rates has the effect of raising the QPA, which benefits providers, while excluding such rates or including additional lower rates benefits patients and plans.

First, the Departments concluded that in determining the rates that a plan has contracted to accept, plans should treat each rate negotiated under a contract as a single contracted rate "regardless of the number of claims paid at that contracted rate." 86 Fed. Reg. at 36,899. Thus, for this purpose, the QPA calculation is based on a consideration only of the four corners of a plan's contracts, with each contracted rate receiving equal weight, regardless of how many claims (if any) a given provider actually submitted for the service in question. The Departments recognized, however, that "if a plan or issuer has contracted rates that vary based on provider specialty for a service code, the median contracted rate (and consequently the QPA) must be calculated separately for each provider specialty." FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55 at 16 (Aug. 19, 2022) (Aug. FAQs) (ROA.413); *see also* 45 C.F.R. § 149.140(b)(3)(i) (similar). In

subsequent guidance, the Departments thus clarified that, "[f]or example, if a plan's or issuer's contracted rates for a given anesthesia service are clustered at one rate for anesthesiologists and at another rate for all other provider specialties because those providers do not provide and bill for anesthesia services, the plan or issuer must calculate one median contracted rate for the anesthesia service code for anesthesiologists, and one separate median contracted rate for the same anesthesia service code for all other provider specialties." Aug. FAQs at 17 (ROA.414). And the Departments further clarified that, to the extent that some plans may enter "$0" in a fee schedule as a placeholder "for covered items and services that a provider or facility is not equipped to furnish," that does not represent a contracted rate that should be included in the QPA calculation. *Id.* at 17 n.29 (ROA.414).

Second, the Departments concluded that, for purposes of the QPA calculation, "a single case agreement, letter of agreement, or other similar arrangement between a provider, facility, or air ambulance provider and a plan or issuer, used to supplement the network of the plan or coverage for a specific participant, beneficiary, or enrollee in unique circumstances, does not constitute a contract" that should be considered. 45 C.F.R. § 149.140(a)(1). Instead, the Departments determined that the QPA calculation should look only to the generally applicable rates that a plan has negotiated in advance with providers of the service in question. One-off payments made by plans to providers outside their networks are to be excluded. *See* 86 Fed. Reg. at 36,889. The Departments explained that "[t]he term 'contracted rate' refers only to

the rate negotiated with providers and facilities that are contracted to participate in any of the networks of the plan or issuer under generally applicable terms of the plan or coverage." *Id.* The Departments found that "this definition most closely aligns with the statutory intent of ensuring that the QPA reflects market rates under typical contract negotiations." *Id.*

Third, the Departments directed health plans to consider the "full contracted rate applicable" to the relevant service code, but to exclude from the QPA calculation "risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments." 45 C.F.R. § 149.140(b)(2)(ii), (iv). The Departments explained that this approach was "consistent with how cost sharing is typically calculated for in-network items and services, where the cost-sharing amount is customarily determined at or near the time an item or service is furnished" and not subject to retrospective adjustment based on such payments. 86 Fed. Reg. at 36,894.

b. In addition to the three provisions noted above, the regulations also included certain other provisions regarding the QPA calculation that have been challenged by plaintiffs here but which are not directly relevant to the Departments' present appeal. As described further below, the district court rejected the air ambulance plaintiffs' challenge to a provision that defined the geographic regions in which a QPA must be calculated for air ambulance services. *See* 42 U.S.C. § 300gg-111(a)(3)(E)(i). And the Departments have elected not to appeal the district court's

determination that certain other regulatory provisions are inconsistent with the statute.[8]

2. A separate regulatory provision implemented the statutory requirement that, where an out-of-network provider has provided air ambulance services, a health plan must send to the provider an initial payment or a notice of denial of payment within 30 days of receiving a bill. 42 U.S.C. § 300gg-112(a)(3)(A). The rule specified that the event that triggers this deadline is the plan's receipt of "the information necessary to decide a claim for payment for the services." 45 C.F.R. § 149.130(b)(4)(i). As the Departments explained, that interpretation reflects that a health plan needs to be able to determine whether a claim is covered by the plan to comply with this requirement and aligns the understanding of "bill" under the statute with the concept of a "clean

[8] Specifically, the regulations implemented the statute's requirement that the QPA for a particular service be calculated as the median of a health plan's contracted rates for that service "that is provided by a provider in the same or similar specialty." 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I). The rule defined "provider in the same or similar specialty" as the practice specialty of a provider, as identified by the plan or issuer consistent with its usual business practice, while specifying that, if a plan or issuer has contracted rates for a service code that vary based on provider specialty, the median contracted rate is calculated separately for each specialty. 45 C.F.R. § 149.140(a)(12). The rule also permitted the sponsors of self-insured group health plans to allow their third-party administrators to determine the QPA for the sponsor using the contracted rates recognized by all self-insured group health plans administered by the third-party administrator (not only those of the particular plan sponsor). *See* 86 Fed. Reg. at 36,890. The district court concluded that these provisions, and certain related guidance, were inconsistent with the No Surprises Act. ROA.13209-11, 13214-16. The government does not challenge those holdings on appeal, except to the extent that the district court awarded the remedy of universal vacatur, *see infra* pp. 47-50.

claim," which governs the information that providers must include in a bill to trigger a timely payment requirement under many existing state laws. 86 Fed. Reg. at 36,900.

3. Finally, the rule imposed various disclosure requirements on health plans relating to the calculation of the QPA. The rule thus specified that health plans must submit to providers a statement certifying that the QPA was determined in compliance with the methodology set out in the rule and, upon request, must disclose additional information, including whether the QPA was based on contracted rates that were not on a fee-for-service basis for the relevant service and whether the health plan had excluded risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments in calculating the relevant QPA.

C. Prior Proceedings

1. Two sets of plaintiffs, comprising a trade association of Texas medical providers, two medical providers, and four air ambulance providers, brought suit under the Administrative Procedure Act (APA) challenging various provisions of the rule. ROA.49-55, 13401-06. The district court consolidated the cases. ROA.128-29.

2. On cross-motions for summary judgment, the district court granted summary judgment to plaintiffs in part and summary judgment to the government in part and entered a universal vacatur with respect to each of the provisions for which it ruled for plaintiffs.

a. The court first addressed plaintiffs' challenge to the Departments' interpretation of the "contracted rates" on which the QPA calculation was based as

reflected in the July 2021 rule and subsequent guidance. While the Departments had determined that a health plan should include all rates for a particular item or service reflected in its contracts with providers in the QPA calculation, the district court concluded that the Act required plans to limit the QPA calculation to "rates for items and services that are actually furnished or supplied by a provider" and to exclude rates that a provider may include in a contract with a health plan without intending to provide the item or service in question. ROA.13206-07. The court reasoned that, by referring to rates for an item or service that is "provided by a provider," the Act "specifies that the QPA should include only *certain* contracted rates" and the Departments' interpretation failed to give effect to this language. ROA.13207-08.

Addressing a challenge brought by the air ambulance plaintiffs, the court also invalidated the rule's exclusion of "case-specific agreements" from the QPA calculation. ROA.13228. In the court's view, amounts reflected in these agreements represented "contracted rates recognized by" an insurer "under such plans or coverage," 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I), notwithstanding the fact that they are not included in plans or coverage generally available to individuals in a particular market, because they are still "contracts between insurers and providers under a plan or policy providing coverage for air ambulance transports." ROA.13229.

The court also concluded that the rule impermissibly required health plans to exclude from the QPA calculation any "risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments," 45 C.F.R.

§ 149.140(b)(2)(iv), made by plans to providers with respect to the item or service in question. ROA.13211-14. The court held that this provision violated the Act's directive to calculate the QPA based on the contracted rate recognized by the plan as "the total maximum payment" for the service provided. ROA.13212. While the Departments had explained that the rule tracked the manner in which cost-sharing amounts are generally determined at the time an item or service is furnished, the court concluded that the cost-sharing amount was only an example of what was included in the statute as part of the total maximum payment a provider received. ROA.13213.

b. The district court further concluded that the rule was inconsistent with the statute in having a plan's deadline for responding to a claim for an air ambulance provider run from the date the plan "receives the information necessary to decide a claim for payment for the services," 45 C.F.R. § 149.130(b)(4)(i). ROA.13223. The court concluded that this regulation permitted plans to indefinitely delay making payment determinations until they had the information deemed necessary to process the claim. ROA.13223. And to the extent the regulation was intended to have the statutory period begin running when a health plan receives a "clean claim" from a provider—which the court noted was an industry term meaning "a claim that has no defect, impropriety, or special circumstances, including incomplete documentation that delays timely payment"—the court concluded that was inconsistent with the statute's use of the term "bill" rather than "clean claim." ROA.13223-24 (quotation marks omitted).

c. The court rejected two additional challenges brought by plaintiffs. First, while plaintiffs had challenged requirements in the rule governing the information health plans must disclose to providers concerning their QPA calculations as insufficient, the court concluded that the statute "gives the Departments wide latitude in issuing a disclosure rule, and the Departments have shown that their rule is the result of reasoned decision making." ROA.13217. Second, the district court rejected a challenge brought by the air ambulance plaintiffs to provisions in the regulation defining the geographic regions for which the QPA would be calculated for air ambulance services, concluding that the Departments had reasonably explained the need for potentially larger geographic regions to calculate air ambulance QPAs given the nature of these services. ROA.13232-33.[9]

d. For each of the provisions that the district court found inconsistent with the Act, it granted plaintiffs' request for universal vacatur. ROA.13234-37, 13239-40. The government appealed, and plaintiffs cross-appealed.

SUMMARY OF ARGUMENT

The No Surprises Act creates protections for patients against potentially staggering surprise medical bills and sets up a framework for providers and health

[9] The court also concluded that certain guidance that the Departments had issued in August 2022 relating to the IDR process had impermissibly required two separate IDR processes for a single air transport billed under more than one service code, notwithstanding statutory language that the court concluded defined each air ambulance transport as a single service subject to one IDR process. ROA.13225-27. The government does not challenge that holding on appeal.

plans to resolve payment disputes without the market-distorting effects of providers being able to surprise bill patients directly. The QPA—a statutorily defined term that serves as a rough proxy for the amount a provider would have received for a given service if a provider had been in a health plan's network—is relevant to both aspects of the statute, and in enacting the Act, Congress expressly charged the Departments with the responsibility to establish through rulemaking the methodology for calculating the QPA. In the challenged rule, the Departments appropriately exercised this delegated rulemaking authority to establish a reasonable methodology and implemented various other aspects of the Act, consistent with the statute's text and purpose.

I. A. The district court erred in invalidating as inconsistent with the Act a provision directing insurers to include all contracted rates for a particular service in the QPA calculation, without considering whether, or how often, a claim had been paid at that rate. The Departments reasonably determined that a rate negotiated under a contract represents a "contracted rate" for purposes of the statute regardless of the number of claims paid at that rate. That understanding is consistent with the general industry practice of negotiating contracts prospectively at a time when a health plan or provider will not know how many times a service will actually be provided and is only underscored by the fact that the statute directs that the QPA be based not on rates paid over a specified period but rather the rates recognized on a statutorily specified date.

B. The Departments also reasonably concluded that health plans should exclude from the QPA calculation payment amounts reflected in case-specific agreements that arrange payment for out-of-network providers on an ad hoc basis. Such payment amounts are not naturally understood to be "rates" recognized "under" the plan or coverage offered by an insurer, and the district court's contrary understanding of the statute again cannot sensibly be squared with the statute's direction to look to the rates recognized on a specified date. The Departments' approach, moreover, serves the statutory purpose of having the QPA generally track a plan's in-network rates, rather than one-off arrangements potentially made under the shadow of the very market-distorting effects of surprise billing that the Act sought to remedy.

C. The Departments also reasonably excluded from the QPA calculation risk-sharing, bonus, penalty, and other retrospective payments or payment adjustments. Such payment adjustments are generally made in the context of a non-fee-for-service payment model, with the retrospective payment rarely tied to a specific contracted rate for a particular item or service but instead linked to the overall performance of a provider or facility over a period of time. The Act further directs the Departments to resolve how the QPA methodology should address payments not made on a fee-for-service basis, and the Departments reasonably concluded that such retrospective payments do not represent part of the total maximum payment for the specific service at issue in this context either. And as the Departments also explained, excluding the

payments from the QPA calculation used to determine patient cost-sharing is consistent with industry practice customarily determining cost-sharing amounts at or near the time an item or service is furnished.

II. The Departments also permissibly implemented a statutory deadline requiring plans to send an initial payment or notice of denial of payment within 30 days of receiving a bill for services from a provider, explaining that, to constitute a bill triggering this requirement, a submission must contain the information necessary to allow the plan to decide the claim for payment. That understanding is again consistent with industry practice and reasonably interprets a term that the statute does not define in the context of the provision in which it appears.

III. The district court compounded its errors on the merits by ordering universal vacatur of the provisions it concluded were inconsistent with the Act. Given the disruptive effect of vacating various aspects of the methodology used to calculate QPAs relevant across the scheme Congress created, any relief should have been limited to a remand to the Departments or, at a bare minimum to party-specific relief, rather than a vacatur extending well beyond the specific parties to this lawsuit.

STANDARD OF REVIEW

In challenges to agency action, this Court reviews the district court's grant of summary judgment de novo, applying the standards of the APA. *OnPath Fed. Credit Union v. U.S. Dep't of Treasury, Cmty. Dev. Fin. Insts. Fund*, 73 F.4th 291, 296 (5th Cir. 2023). A court will uphold an agency's action unless it finds it to be "arbitrary,

capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A); *see, e.g.*, *Sierra Club v. U.S. Dep't of Interior*, 990 F.3d 909, 913 (5th Cir. 2021). Agency actions pursuant to an "express delegation of authority" must be "given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Easom v. US Well Servs., Inc.*, 37 F.4th 238, 245 (5th Cir. 2022) (quotation marks omitted).

ARGUMENT

The No Surprises Act creates a framework for protecting patients from the ruinous effects of surprise medical bills. But Congress recognized that the statute alone would be insufficient to ensure that the Act's protections would be operative and administrable. In recognition of that fact, Congress mandated that the Departments responsible for administering the Act issue certain necessary implementing regulations by a statutory deadline. Plaintiffs are dissatisfied with certain decisions that the Departments have made in discharging that responsibility. But Congress entrusted the Departments, not plaintiffs, with responsibility for determining the methodology for calculating the QPA and for implementing the Act's system enabling providers to receive compensation from health plans.

I. The Rule Sets Out a Reasonable Methodology for Calculating the QPA Consistent with the No Surprises Act.

The Act includes a definition of the "qualifying payment amount" used to determine cost-sharing responsibilities under the Act and as a factor that arbitrators

consider in determining the amounts health plans pay to providers for covered services, 42 U.S.C. § 300gg-111(a)(3)(E)(i), and then instructs the Departments to issue regulations that establish the "methodology . . . to determine the qualifying payment amount," *id.* § 300gg-111(a)(2)(B)(i), (iii). The Departments appropriately exercised their rulemaking authority in promulgating "rules that are reasonable in light of the text, nature, and purpose of the statute," *Cuozzo Speed Techs., LLC v. Lee*, 579 U.S. 261, 276-77 (2016), and the district court erred in concluding that three aspects of the methodology established were inconsistent with the Act.

A. The Rule Permissibly Directed Health Plans to Include Contracted Rates in the QPA Calculation Regardless of Whether a Provider Had Provided an Item or Service at that Rate.

The Act defines the QPA in relevant part as "the median of the contracted rates recognized by the plan or issuer[] . . . 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 January 31, 2019, subject to an inflation adjustment. 42 U.S.C. § 300gg-111(a)(3)(E)(i); *see also id.* § 300gg-112(c)(2). The Departments determined that this analysis should be based on the rates appearing on the face of a health plan's contracts, such that plans would not need to look beyond those contracts in an effort to link contracted rates to providers' subsequently submitted claims for reimbursement for particular services. As the Departments explained, "the rate negotiated under a contract constitutes a . . .

contracted rate regardless of the number of claims paid at that contracted rate." 86 Fed. Reg. at 36,889.

That approach is consistent with the ordinary practice in the insurance market, where contracted rates are generally negotiated prospectively, with a provider and a plan typically agreeing in advance to the prices that will be paid by the plan for various items and services furnished during a specified period of time. At the time the contracts are negotiated, neither a provider nor a plan can know for certain how many times a particular service will be provided, or a particular contracted rate paid, but they agree that, any time that that item or service is provided under the contract, the contracted rate will be paid. A provider and a plan may agree to a rate for a service that the provider does not anticipate ever providing but ends up providing several times over the course of the contract. Likewise, a provider may negotiate a rate for a given service in the hope or expectation of providing that service frequently, yet may ultimately do so rarely or never. In both cases, the provider would be paid based on the rate recognized in the contract.

Accordingly, the statute does not impose any minimum number of times an item or service must be provided under a contract for the rates agreed to in that contract to be considered the "contracted rates." 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I). The rates recognized under the plan or coverage are the rates that will apply to a particular item or service—regardless of how many times that item or service may subsequently be provided under that contract. By basing the QPA calculation on the

median of the contracted rates recognized under the plan or coverage, Congress designed a straightforward mechanism for calculating the QPA that can be based entirely on information contained within the four corners of the contracts themselves. *See id.* (contracted rates "determined with respect to all such plans of such sponsor or all such coverage offered by such issuer"). The approach reflected in the Act focuses on the information readily discernible from the plan's contracts, a sensible and administrable system for calculating a QPA for each of the services included within a given plan.

That understanding of the statutory language is underscored by the fact that the statute directs that the QPA be based not on rates paid over a specified period but rather the contracted rates recognized at a particular date in time, January 31, 2019. *See* 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I). The fact that Congress chose a single date for calculating the QPA demonstrates that it intended to take a snapshot of the contracts as they existed on that date to calculate the QPA for future use (adjusted for inflation). The inclusion of that specific date provides no basis to construe the statute to instead require a given provider to have provided a specific service at some statutorily undefined point before or after January 31, 2019.

The district court nonetheless concluded that the QPA calculation must exclude any contracted rates for items or services that a provider has not provided. Under that interpretation, health plans must look beyond their contracts, potentially digging through troves of data to determine whether a provider had provided or

would provide in the future a given item or service. The court believed this conclusion was compelled by the statute's direction that the QPA should be based on rates for services "provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished." 42 U.S.C. § 300gg-111(a)(3)(E)(i). But by their plain terms, those clauses operate to limit the rates considered in the QPA calculation to the rates of providers in the same or similar specialty and the geographic region in which the service was provided. They do not serve to impose an additional limitation that the QPA be based only on services provided during some unspecified time period. Congress could have written a statute requiring that the QPA be based on services that "have been provided" or based on rates that "have been paid" but instead chose to focus on the "contracted rates" that the parties have agreed in advance will apply to an "item or service that is provided" under the terms of the contract.

To the extent that the district court further grounded its interpretation in a policy concern that a provider might agree to a contracted rate for an out-of-specialty service that was artificially low where the provider did not expect to provide the service in question, *see* ROA.13208, both the Act and the Departments' implementation of it address that concern separately. As noted above, when calculating the QPA, health plans must use contracted rates for providers in the same or similar specialty. *See* 42 U.S.C. § 300gg-111(a)(3)(E)(i). Thus, if a health plan incorporates rates for dermatological services into its contracts with anesthesiologists

(who may agree to below-market rates because they never expect to provide those services), the health plan cannot include these rates when calculating its QPA for a dermatology procedure provided by dermatologists (who are not in the same or similar specialty as anesthesiologists and who have every incentive to negotiate for higher compensation for the applicable service).[10] And as a further safeguard against artificially depressed QPAs, the Departments have clarified that a zero-dollar figure included as a placeholder in a fee schedule for a service a provider is not actually equipped to furnish does not represent a contracted rate that could be included in the QPA calculation. *See* Aug. FAQs at 17 n.29 (ROA.414).[11]

The Departments' methodology is thus entirely consistent with the statutory text, and there is no basis for adopting an atextual limitation to the Act's terms.

B. The Rule Permissibly Directed Health Plans to Exclude One-Off, Case-Specific Agreements from the QPA Calculation.

The district court committed similar error in accepting the air ambulance plaintiffs' argument that the QPA calculation must include one-off, case-specific payments not made under a plan's generally applicable terms. Another district court

[10] As noted previously, the Departments previously required health plans to calculate QPAs separately by provider specialty only when the plan varied its contracted rates by provider specialty. The district court invalidated that provision of the regulations and related guidance that the Departments issued, and the Departments do not challenge that holding here. *See supra* n.8.

[11] This guidance was vacated by the district court on the grounds discussed *supra* n.8.

properly rejected an identical challenge brought by a trade association representing most air ambulance providers in the United States, and the district court here erred in declining to follow that cogent decision. *See Association of Air Med. Servs. v. HHS*, No. 21-3031 (RJL), 2023 WL 5094881, at *3–5 (D.D.C. Aug. 9, 2023).

As noted above, the No Surprises Act directs that the QPA be based on the "median of the contracted rates recognized by" a health plan, determined with respect to all the plans or coverage of the insurer offered within the same insurance market, as the payment "under such plans or coverage" for a given service. The Departments explained that a "contracted rate" as used in this provision "refers only to the rate negotiated with providers and facilities that are contracted to participate in any of the networks of the plan or issuer under generally applicable terms of the plan or coverage." 86 Fed. Reg. at 36,889. That understanding does not encompass case-specific agreements between a health plan and a provider not otherwise generally contracted to participate in any of the plan's networks, such as "an ad hoc arrangement" with a nonparticipating provider "to supplement the network of the plan or coverage for a specific participant, beneficiary, or enrollee in unique circumstances." *Id.*; *see* 45 C.F.R. § 149.140(a)(1).

The Departments' determination that such agreements should not be included in the QPA calculation is consistent with the text and purpose of the Act. The statute specifies that the calculation be based on the "contracted rates" recognized by a health plan "under such plans or coverage" offered within an insurance market. As

the Departments reasoned, that language encompasses rates negotiated in advance with providers contracted to participate in an insurer's network under generally applicable terms. That understanding fits neatly with the dictionary definition of a "rate" as a "a charge, payment, or price fixed according to a ratio, scale, or standard." *Rate*, Webster's Third New International Dictionary 1884 (2002) (Webster's Third); *see also Rate*, Merriam-Webster's Collegiate Dictionary 1032 (11th ed. 2005) (same); *Rate*, Oxford English Dictionary, (online ed. Dec. 2023) ("A fixed charge or payment applicable to each individual instance of a set of similar cases; esp. the amount paid or asked for a certain quantity of a particular commodity, service, etc."). A one-off agreement to pay for a given service cannot similarly be said to establish a recognized rate in this way.

Nor would such a payment be naturally understood to be "under" an insurer's plan or coverage, given that a payment arises "under" a plan or coverage if it is "subject or pursuant to," "governed by," or owed "by reason of the authority of" the terms of the plan or policy. *See Ardestani v. INS*, 502 U.S. 129, 135 (1991) (defining "under" in an analogous context); *see also, e.g.*, *Kirtsaeng v. John Wiley & Sons, Inc.*, 568 U.S. 519, 530-31 (2013) (acknowledging that the term "under" "evades a uniform, consistent meaning" but suggesting that it may literally be read to mean "in accordance with," "in compliance with," or "subject to"); *Under*, Webster's Third 2487 (defining "under" in relevant part as "required by" or "in accordance with"). A payment under such an ad hoc agreement is not dictated by the generally applicable

terms of a plan or policy. *See Association of Air Med. Servs.*, 2023 WL 5094881, at *3-5. If such a payment were so dictated, the provider would be in-network, and no case-specific agreement would be necessary. Instead, plans enter into these case-specific agreements because they have made a business decision that it is a better practice to spare their members, at least some of the time, from the cost of an out-of-network bill, and to pay providers at times exceedingly high rates for out-of-network services, even in the absence of a contractual arrangement providing a legal compulsion to do so. *See* Zack Cooper et al., Surprise! Out-of-Network Billing for Emergency Care in the United States, 128 J. Pol. Econ. 3626, 3633 (2020) (ROA.1677) (describing insurers' business options to pay all, some, or none of a surprise bill for out-of-network medical services).

As to this provision too, moreover, the Departments' interpretation makes sense of the fact that the Act directs health plans to look at rates recognized on a single specified date. *See* 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I) (defining the QPA by reference to contracted rates "on January 31, 2019"). While that language naturally encompasses contracted rates a health plan may have with providers offering services under a plan's generally applicable terms, it does not encompass a rate for a one-off service provided at some point in the past, nor could Congress sensibly have intended to require plans to include in their QPA calculations just the case-specific agreements that happened to be in place on that particular day.

As the Departments recognized as well, this understanding also "most closely aligns with the statutory intent of ensuring that the QPA reflects market rates under typical contract negotiations." 86 Fed. Reg. at 36,889. The basic function served by the QPA, as even the district court acknowledged, is to provide a figure approximating the rate a provider would have received for a given service had the provider been in-network for the relevant plan. *See, e.g.*, ROA.13197 ("The QPA is typically the median rate the insurer would have paid for the service if provided by an in-network provider or facility."). Basing the QPA on the plan's pre-negotiated rates of general applicability does just that. By contrast, prior to the No Surprises Act, ad hoc, case-specific agreements could often be entered into after a service had been provided, and a patient was facing a surprise medical bill that could be financially devastating to the patient and reputationally harmful to the health plan. That dynamic was indeed reflected in plans agreeing to pay the full billed charges for out-of-network air ambulance services in almost half the cases considered in a study based on data from 2014 to 2017. *See* 86 Fed. Reg. at 36,923; *see also supra* pp. 8-9. To incorporate into the QPA the rates that health plans agreed to pay under those circumstances would carry forward precisely the market distortion that Congress sought to eliminate through the No Surprises Act, resulting in QPAs based not on market rates but rather on the number of times a particular plan happened to be subjected to this exercise of leverage by air ambulance providers in the past.

Indeed, for air ambulance providers like the plaintiffs raising this challenge, Congress recognized that a substantial majority of services were furnished by out-of-network providers and that these providers' ability to remain out-of-network created a "market failure" that permitted the providers to charge far more than the price that they would be able to command in a fair and functioning market, causing prices for certain health care providers and services to skyrocket. *See* H.R. Rep. No. 116-615, pt. 1 at 52-53 (ROA.933-34). Indeed, if anything, the in-network rates recognized for air ambulance services are themselves highly inflated, since they reflect the ability that these providers had prior to the enactment of the Act to refuse to join provider networks and to rely solely on balance billing to seek payment after the fact for services already provided. Congress understood that "[t]he presence of this market failure in certain provider specialties is strongly supported by evidence reflecting the highly inflated payment rates for these services[]," with air ambulance providers being some of the biggest offenders of these highly inflated payment rates. ROA.933-34; *see also Unfinished Business of Air Ambulance Bills* (ROA.3447). Congress accordingly sought to remedy the market distortion reflected in air ambulance payment rates by at least limiting patients' cost-sharing responsibilities for out-of-network air ambulance services to the requirements that would apply if the service were provided in-network. *See* 42 U.S.C. § 300gg-112(a)(1). The Departments reasonably chose a methodology that furthered this statutory purpose by excluding from the QPA case-specific

agreements that may be the product of the very surprise billing whose effect the Act was designed to remedy.

The district court concluded that case-specific agreements for air ambulance services are contracted rates recognized under an insurer's plans or coverage because they are "contracts between insurers and providers under a plan or policy providing coverage for air ambulance transports." ROA.13229. But the fact that such an agreement may represent a contract or that a plan may include benefits for air ambulance transports does not mean that a one-off agreement to pay an out-of-network provider for such services establishes a "rate" for the service "under" such a plan or policy, where the payment is not fixed according to that policy or otherwise made pursuant to it but rather set only on an ad hoc basis, in some cases potentially after the service has already been provided. And the district court provided no basis to square its interpretation of the Act with either the requirement that health plans calculate the QPA based on the rates recognized on a specific date or the Act's purpose to address the market distortion caused by providers using the leverage of balance billing to force health plans to agree to higher payment amounts after the fact.

C. The Rule Permissibly Directed Health Plans to Exclude Bonus and Incentive Payments from the QPA Calculation.

The Departments further determined that the QPA calculation should "[e]xclude risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments." 45 C.F.R. § 149.140(b)(2)(iv). The Departments

explained that excluding these payments and payment adjustments from the QPA, which is used to "determine [the patient's] cost sharing" obligation, is "consistent with how cost sharing is typically calculated for in-network items and services." 86 Fed. Reg. at 36,894. The "cost-sharing amount is customarily determined at or near the time an item or service is furnished, and is not subject to adjustment based on changes in the amount ultimately paid to the provider or facility as a result of any incentives or reconciliation process." *Id.* This determination was a reasonable exercise of the Departments' rulemaking authority.

The district court nonetheless determined that this provision conflicts with a provision of the No Surprises Act that directs that the QPA for a particular item or service be based on the rates recognized by a health plan as "the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) . . . for the same or a similar item or service." 42 U.S.C. § 300gg-111(a)(3)(E)(i). The district court believed that the statute's reference to "the total maximum payment" required the QPA to include any bonuses that a provider might be able to obtain and that the Departments could not exclude retrospective adjustments that could raise the provider's compensation—even though the Departments also excluded penalties that could lower the provider's compensation.

This analysis is contrary to both statutory text and the realities of the health care market. In context, the "total maximum payment" referenced in the statute is the

highest value the plan has contracted to pay for a given "item or service," including both the cost-sharing amount to be paid by the patient and the amount to be paid by the plan. 42 U.S.C. § 300gg-111(a)(3)(E)(i). And as the Departments explained, *see* 86 Fed. Reg. at 36,893-94, bonus and incentive payments are rarely tied to specific contracted rates for particular items and services; they are more often paid as an annual lump-sum, based on the overall performance of a provider or a facility over time. Neither plaintiffs nor the district court have shown how it would be possible to calculate the impact of bonus and incentive payments on the rate for a particular item or service when the provider and plan have agreed to rates established on a fee-for-service model.

The Departments have also recognized that "many types of alternative reimbursement models exist that are not standard fee-for-service arrangements." 86 Fed. Reg. at 36,893. But here, too, the district court's conclusion regarding the incorporation of bonus payments is erroneous. The Act directs the Departments to account through rulemaking for "payments that are made by [a plan] . . . that are not on a fee-for-service basis." 42 U.S.C. § 300gg-111(a)(2)(B); *see also id.* (indicating that the Departments "may account for relevant payment adjustments that take into account quality or facility type . . . that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities"). Pursuant to that directive, the Departments established a methodology pursuant to which plans with such payment arrangements would generally use an underlying fee schedule rate

or similar "derived amount" for a particular service that a health plan may have established for cost-sharing or other internal accounting purposes as the basis for the median contracted rate calculation. 86 Fed. Reg. at 36,893. Bonus payments thus fall naturally outside the approach the Departments adopted to address non-fee-for-service payment models, pursuant to the authority delegated by the No Surprises Act to address this issue.

As the Departments explained, moreover, the approach taken for bonus or incentive payments tracks the manner in which cost-sharing amounts for in-network items and services are customarily calculated at or near the time an item or service is furnished, based on the total, maximum payment at that time and not subject to retrospective adjustment. 86 Fed. Reg. at 36, 894. The QPA itself performs a crucial function under the Act in determining a patient's cost-sharing obligations for covered services where the QPA is less than the amount billed by the provider and there is no applicable specified state law or All-Payer Model Agreement that would otherwise set a cost-sharing cap. 42 U.S.C. § 300gg-111(a)(1)(C)(iii), (a)(3)(H). In setting out a methodology for calculating that amount and establishing requirements that will govern cost sharing under the Act, the Departments thus incorporated established industry practice that has long been used in calculating patient cost-sharing amounts. *See City of Dallas v. FCC*, 118 F.3d 393, 395 (5th Cir. 1997) (looking to industry practice and holding that agency regulation interpreting statute to align with industry standards was reasonable).

At the same time, the Departments recognized that the QPA may be used not just to determine cost-sharing but as a data point in the open negotiation period between plans and providers or as a factor in any subsequent arbitration. The rule thus requires that a plan must, upon a provider's request, inform the provider whether the QPA includes contracted rates not set on a fee-for-service basis for the service at issue and whether the health plan's rates include incentive-based or retrospective payments or payment adjustments that were excluded in calculating the QPA. *See* 45 C.F.R. § 149.140(d)(2)(iv); 86 Fed. Reg. at 36,899. That information can then inform the negotiation and arbitration process that determines the amount a provider may ultimately receive from a health plan. Providing for the consideration of incentive payments in that context is consistent with the scheme Congress established, as is indeed underscored by the fact that the statute specifically directs arbitrators to consider in the IDR process "quality and outcomes measurements" of a given provider or facility among the "[a]dditional circumstances" that may be relevant at that stage. *See* 42 U.S.C. § 300gg-111(c)(5)(C)(ii).

II. The Rule Permissibly Interpreted the No Surprises Act's Statutory Deadline for Health Plans to Make an Initial Payment or Notice of Denial of Payment.

The No Surprises Act establishes a statutory requirement that a health plan shall "send to the provider[] an initial payment or notice of denial of payment" "not later than 30 calendar days after the bill for such services is transmitted by such provider." 42 U.S.C. § 300gg-112(a)(3)(A). The rule incorporates that statutory

requirement and specifies that the 30-calendar-day period begins on the date the plan or issuer receives "the information necessary to decide a claim for payment for the services." 45 C.F.R. § 149.130(b)(4)(i). The district court invalidated this sensible requirement, concluding that the plan's 30-day deadline is triggered whenever the provider submits a claim, even if the provider omits information necessary to the plan's determination of whether to accept or reject the claim.

In explaining this provision, the Departments noted that, in order to comply with the statutory requirement to send an initial payment or notice of denial of payment, health plans must "first determine[] that the billed items and services are covered under the plan or coverage." 86 Fed. Reg. at 36,900. A plan's determination of whether a furnished service is in fact a covered benefit under the terms of the plan or coverage is essential in determining whether the Act's protections apply. *See, e.g.*, 42 U.S.C. § 300gg-112(a) (specifying that the Act's provisions relating to air ambulance providers apply "if such services would be covered if provided by a participating provider"). The Departments thus explained that the statutory 30-day period begins "after a nonparticipating provider or facility submits a bill related to the items and services that fall within the scope of the new surprise billing protections," and they indicated that they understood that period to begin "on the date the plan or issuer receives the information necessary to decide a claim for payment for such services." 86 Fed. Reg. at 36,900. It would make little sense to consider a submission that does not in fact have sufficient information on which an insurer could make a

payment determination to constitute a "bill" under these circumstances, particularly when the result is that a plan in this situation may have no choice but to deny a claim, leading to confusion as to whether the service in question is covered and therefore subject to the Act's protections against surprise billing. The rule's definition thus reasonably supplies meaning to the otherwise undefined statutory term "bill for such services."

The Departments' understanding of this term also aligns the requirement with general industry practice, pursuant to which plans are generally not required under many existing state laws to timely pay a claim until a provider includes sufficient information in a bill to render it a "clean claim," 86 Fed. Reg. at 36,900, defined as "a claim that has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment," *see Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties* 33 (Apr. 2022) (ROA.11586). Here too, when attempting to ascertain "what meaning Congress intended to invoke when using a phrase," the Departments reasonably considered industry practice as a "prime source[] for the court to determine congressional intent." *City of Dallas*, 118 F.3d at 395. To the extent that a "bill" might have different meanings in different contexts, the Departments' interpretation thus appropriately takes into account the medical billing context in which this requirement is imposed.

The district court concluded that the No Surprises Act foreclosed the Departments' interpretation because in its view, the statutory term "bill" is not

susceptible to a technical meaning but rather should be given what the district court viewed as its ordinary meaning as "an itemized list or statement of fees or charges" or "[a]n itemized account of the separate cost of goods sold, services performed, or work done: invoice." ROA.13224-24 (alteration omitted) (quoting *Bill*, Am. Heritage Dictionary 180 (5th ed. 2011); *Bill*, Merriam-Webster's Collegiate Dictionary 113 (10th ed. 2001)). But the Court should be reluctant to needlessly adopt a construction of the statute that would yield the bizarre result that a plan may have to make a final determination as to whether a claim will be accepted before the provider submits the information necessary to that analysis.

Moreover, the concept of billing in this context is informed by longstanding industry practice and implicates the principle that "when a statute is 'addressed to specialists, [it] must be read by judges with the minds of the specialists.'" *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 597 U.S. 424, 434 (2022) (alteration in original) (quoting Felix Frankfurter, *Some Reflections on the Reading of Statutes*, 47 Colum. L. Rev. 527, 536 (1947)). Under the district court's preferred definition, there is no indication whether a provider's submission needs to indicate exactly what items or services were provided, whether the services were provided to a beneficiary of the plan, whether the physician who provided those services was out-of-network, or when or where the items or services were provided—all critical information in light of the term's use in the context of a requirement that health plans make both a determination that an item or service is covered by the plan and thus subject to the

Act's protections and a payment determination within a specified period. It was entirely appropriate for the Departments to take those considerations and the industry practice more broadly into account to give the term a commonsensical meaning in this context.

The district court attributed unwarranted significance to the fact that Congress did not use the specific term "clean claim," a term Congress has used in other statutes regarding prompt payment requirements, in place of the term "bill for . . . services." ROA.13224. The district court believed that if Congress had intended for only sufficient bills to trigger the deadline, it would have used that term of art rather than the more generic term "bill." However, even if the term "clean claim" would have been clearer, the absence of a specific term of art in the statute does not preclude the Departments from adopting a regulatory definition that is consistent with the plain language of the statute and which allows the system to operate sensibly. *Cf. Caraco Pharm. Labs., Ltd. v. Novo Nordisk A/S*, 566 U.S. 399, 416 (2012) ("[T]he mere possibility of clearer phrasing cannot defeat the most natural reading of a statute[.]"). In any case, the district court was wrong to say that the Departments have simply defined a "bill" in this context as requiring everything necessary for a "clean claim" under other federal laws. Congress generally has defined a "clean claim" as "a claim that has no defect or impropriety (including a lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment." *See* 10 U.S.C. § 1095c(a)(1), (3); 42 U.S.C. § 1395h(c)(2)(A)(i), (B)(i);

id. § 1395u(c)(2)(A)(i), (B)(i); *id.* § 1395w-112(b)(4)(A)(i)-(ii).[12] While that tracks the definition of the term as used in the industry practice the Departments looked to in interpreting "bill for such services" here, the regulatory definition adopted by the Departments is not identical to the statutory definitions of "clean claim" that Congress has previously provided when using that specific term. Rather than requiring that a claim have "no defect" or "particular circumstance requiring special treatment that prevents timely payment," the rule simply requires that a bill include the information necessary to make a payment determination. That definition is fully consistent with the particular language that Congress used in the No Surprises Act and the context in which that language was used.

Finally, the district court concluded that the Departments' interpretation "turns a firm 30-day deadline essential to an efficient process into an indefinite delay at the mercy of the insurer." ROA.13223. But under the Departments' interpretation, a health plan could not, as the air ambulance plaintiffs posited in challenging this provision, withhold initial payment or notice of denial of payment based on a lack of information outside of the provider's control, when the information provided by the provider is sufficient to decide a claim for payment under the terms of the plan or

[12] 38 U.S.C. § 1703D also uses the term "clean claim" in connection with a prompt payment requirement but defines the term somewhat distinctly as a claim that "contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional information from the entity or provider that furnished the care or service." *See id.* § 1703D(a)(1), (i)(2)-(3).

coverage. And to the extent that health plans might nonetheless delay payment on such a basis, the Departments emphasized in subsequent guidance that providers may contact the No Surprises Help Desk or submit a complaint if they have concerns regarding a plan's failure to comply with the requirement to send an initial payment or notice of denial of payment and that the Departments will generally enforce the relevant provisions of the No Surprises Act, in coordination with states where applicable. Aug. FAQs 20 (ROA.417).

III. At a Minimum, the Provisions Plaintiffs Challenged Should Not Have Been Vacated, Let Alone as to Non-Parties.

Even were the district court's merits decision correct, the court also erred in ordering universal vacatur of the challenged provisions of the rule. ROA.13234-37. While this Court's precedents identify vacatur as an available remedy for a successful APA challenge to a regulation, *see, e.g.*, *Franciscan All., Inc. v. Becerra*, 47 F.4th 368, 374-75 (5th Cir. 2022), the APA itself does not reference vacatur, instead remitting plaintiffs to traditional equitable remedies like injunctions, 5 U.S.C. § 703, and there is little indication that Congress intended to create a new and radically different remedy in providing that courts reviewing agency action should "set aside" agency "action, findings, and conclusions," *id.* § 706(2). *See United States v. Texas*, 599 U.S. 670, 693-703 (2023) (Gorsuch, J., joined by Thomas and Barrett, JJ., concurring in the judgment) (detailing "serious" arguments that "warrant careful consideration" as to whether the APA "empowers courts to vacate agency action").

In any event, this Court has treated universal vacatur of agency action as a discretionary equitable remedy—not a remedy that is automatic or compelled. *See, e.g.*, *Cargill v. Garland*, 57 F.4th 447, 472 (5th Cir. 2023) (en banc) (plurality op.) (concluding without contradiction from any other member of the Court that the district court could consider on remand "a more limited remedy" than universal vacatur of the final rule and instructing the district court to "determine what remedy—injunctive, declarative, or otherwise—is appropriate to effectuate [the] judgment"); *see also id.* (recognizing that a "plaintiff's remedy must be tailored to redress the plaintiff's particular injury" (quoting *Gill v. Whitford*, 138 S. Ct. 1916, 1934 (2018))); *Central S. W. Servs., Inc. v. EPA*, 220 F.3d 683, 692 (5th Cir. 2000) (declining to enter vacatur in favor of remand).

In this case, any remedy should have been limited to remand to the Departments without vacating the challenged provisions. As discussed above, QPAs play an important role across a number of contexts under the No Surprises Act. Vacatur of various aspects of the methodology used to calculate these QPAs consequently occasions serious disruption across the framework established by the Act and led to a significant pause in the operation of the No Surprises Act's arbitration process. While the district court noted that the Departments could use enforcement discretion to permit continued use of previously calculated QPAs while new QPAs are being calculated, ROA.13236, vacatur of various provisions specifying the manner in which QPAs are to be calculated nonetheless introduces significant

disruption and uncertainty into those processes. Requiring health plans, moreover, to engage in multiple rounds of calculations of the QPAs occasions significant costs. *See* 86 Fed. Reg. at 36,927-28 (estimating costs associated with calculating QPAs). Those costs could ultimately be passed along to insured consumers in the form of higher premiums, frustrating Congress's goal of protecting patients and lowering health care costs. *See* H.R. Rep. No. 116-615, pt. 1, at 55, 57 n.48 (ROA.936, 938) (noting that health plans "typically pass on to consumers" increased health care costs). These equitable interests counsel heavily in favor of remand without vacatur. *Central & S. W. Servs.*, 220 F.3d at 692.

At a minimum, any immediately effective relief should have been limited to the specific plaintiffs who are parties to this lawsuit. Ordinarily, principles of Article III standing and equity require that a court tailor remedies to address the plaintiff's injury. *See, e.g.*, *Gill*, 138 S. Ct. at 1933; *Madsen v. Women's Health Ctr., Inc.*, 512 U.S. 753, 765 (1994). Courts should thus "ask[] whether party-specific relief can adequately protect the plaintiff's interests" before entering broader relief. *Texas*, 599 U.S. at 703 (Gorsuch, J., joined by Thomas and Barrett, JJ., concurring in the judgment). And universal vacatur is particularly inequitable here, where a large industry group unsuccessfully challenged one of the same provisions invalidated by the district court here, yet all of its members have been awarded the same remedy as a prevailing plaintiff—effectively nullifying the judgment of another district court. *See supra* p. 32.

Equitable relief as to the challenged portions of the final rule only with respect to the plaintiffs to this suit would remedy the injuries they claim.

CONCLUSION

For the foregoing reasons, the judgment of the district court should be reversed.

Respectfully submitted,

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January 2024

CERTIFICATE OF SERVICE

I hereby certify that on January 12, 2024, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. Service will be accomplished by the appellate CM/ECF system.

s/ Leif Overvold
Leif Overvold

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 28.1(e)(2)(A) because it contains 12,897 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Word for Microsoft 365 in Garamond 14-point font, a proportionally spaced typeface.

s/ Leif Overvold
Leif Overvold

No. 23-40605

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Texas Medical Association; Tyler Regional Hospital, L.L.C.; Dr. Adam Corley,
Plaintiffs-Appellees/Cross-Appellants,

v.

United States Department of Health and Human Services; Office of Personnel Management; United States Department of Labor; United States Department of Treasury; Xavier Becerra, Secretary, U.S. Department of Health and Human Services, in his official capacity; Kiran Ahuja, in her official capacity as the Director of the Office of Personnel Management; Janet Yellen, Secretary, U.S. Department of Treasury, in her official capacity; Julie A. Su, Acting Secretary, U.S. Department of Labor, in her official capacity;
Defendants-Appellants/Cross-Appellees.

LifeNet, Incorporated; Air Methods Corporation; Rocky Mountain Holdings, L.L.C.; East Texas Air One, L.L.C.
Plaintiffs-Appellees/Cross-Appellants,

v.

United States Department of Health and Human Services; Office of Personnel Management; United States Department of Labor; United States Department of Treasury; Xavier Becerra, Secretary, U.S. Department of Health and Human Services, in his official capacity; Kiran Ahuja, in her official capacity as the Director of the Office of Personnel Management; Janet Yellen, Secretary, U.S. Department of Treasury, in her official capacity; Julie A. Su, Acting Secretary, U.S. Department of Labor, in her official capacity;
Defendants-Appellants/Cross-Appellees.

On Appeal from the United States District Court
for the Eastern District of Texas

ADDENDUM TO BRIEF FOR APPELLANTS

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42 U.S.C. § 300gg-111 (excerpts)

§ 300gg-111. Preventing surprise medical bills

(a) Coverage of emergency services

(1) In general

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating provider or a nonparticipating emergency facility—

(i) such services will be provided without imposing any requirement under the plan or coverage for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

(ii) the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

(iv) the group health plan or health insurance issuer, respectively—

(I) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or

facility, as applicable, an initial payment or notice of denial of payment; and

(II) pays a total plan or coverage payment directly to such provider or facility, respectively (in accordance, if applicable, with the timing requirement described in subsection (c)(6)) that is, with application of any initial payment under subclause (I), equal to the amount by which the out-of-network rate (as defined in paragraph (3)(K)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

(v) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 300gg-3 of this title, including as incorporated pursuant to section 1185d of title 29 and section 9815 of title 26, and other than applicable cost-sharing).

* * *

(B) Rulemaking

Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking—

(i) the methodology the group health plan or health insurance issuer offering group or individual health insurance coverage shall use to determine the qualifying payment amount, differentiating by individual market, large group market, and small group market;

(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved

areas, including health professional shortage areas, as defined in section 254e of this title; and

(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i) by group health plans and health insurance issuers offering group or individual health insurance coverage.

Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology 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. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate, taking into account the findings of the report submitted under section 109(a) of the No Surprises Act.

(3) Definitions

* * *

(E) Qualifying payment amount

(i) In general

The term "qualifying payment amount" means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering group or individual health insurance coverage—

(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market (specified in subclause (I), (II), (III), or (IV) of clause (iv)) as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, 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, consistent with the methodology established by the Secretary under paragraph (2)(B),

increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

(II) for an item or service furnished during 2023 or a subsequent year, the qualifying payment amount determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(ii) New plans and coverage

The term "qualifying payment amount" means, with respect to a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

(I) for the first year in which such group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan or coverage and furnished during such first year; and

(II) for each subsequent year such group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in such region, the qualifying payment amount determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(iii) Insufficient information; newly covered items and services

In the case of a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (v)(III)), in the first coverage year (as defined in clause (v)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case

with respect to which clause (ii) applies)) the term "qualifying payment amount"—

(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (v)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term qualifying payment amount in clause (i)(I), except that in applying such clause to such item or service, the reference to "furnished during 2022" shall be treated as a reference to furnished during such first sufficient information year, the reference to "in 2019" shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to "furnished during 2023 or a subsequent year" shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(iv) Insurance market

For purposes of clause (i)(I), a health insurance market specified in this clause is one of the following:

(I) The individual market.

(II) The large group market (other than plans described in subclause (IV)).

(III) The small group market (other than plans described in subclause (IV)).

(IV) In the case of a self-insured group health plan, other self-insured group health plans.

(v) Definitions

For purposes of this subparagraph:

(I) First coverage year

The term "first coverage year" means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance issuer and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

(II) First sufficient information year

The term "first sufficient information year" means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance issuer—

(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which the sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

(III) Newly covered item or service

The term "newly covered item or service" means, with respect to a group health plan or group or individual health insurance issuer offering health insurance coverage, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

* * *

(H) Recognized amount

The term "recognized amount" means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer—

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount that is the qualifying payment amount (as defined in subparagraph (E)) for such year and determined in accordance with rulemaking described in paragraph (2)(B)) for such item or service; or

(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act [42 U.S.C. 1315a], the amount that the State approves under such system for such item or service so furnished.

***

(K) Out-of-network rate

The term "out-of-network rate" means, with respect to an item or service furnished in a State during a year to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer receiving such item or service from a nonparticipating provider or nonparticipating emergency facility—

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case such State does not have in effect such a law with respect to such item or service, plan, and provider or facility—

(I) subject to subclause (II), if the provider or facility (as applicable) and such plan or coverage agree on an amount of payment (including if such agreed on amount is the initial payment sent by the plan under subsection (a)(1)(C)(iv)(I), subsection (b)(1)(C), or section 300gg-112(a)(3)(A) of this title, as applicable, or is agreed on through open negotiations under subsection (c)(1)) with respect to such item or service, such agreed on amount; or

(II) if such provider or facility (as applicable) and such plan or coverage enter the independent dispute resolution process under subsection (c) and do not so agree before the date on which a certified IDR entity (as defined in paragraph (4) of such subsection) makes a determination with respect to such item or service under such subsection, the amount of such determination; or

(iii) in the case such State has an All-Payer Model Agreement under section 1115A of the Social Security Act [42 U.S.C. 1315a], the amount that the State approves under such system for such item or service so furnished.

(L) Cost-sharing

The term "cost-sharing" includes copayments, coinsurance, and deductibles.

(b) Coverage of non-emergency services performed by nonparticipating providers at certain participating facilities

(1) In general

In the case of items or services (other than emergency services to which subsection (a) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering group or individual health insurance coverage furnished to a participant, beneficiary, or enrollee of such plan or coverage by a nonparticipating provider (as defined in subsection (a)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and

consent criteria of section 300gg-132(d) of this title) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively—

(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing requirement for such items and services so furnished that is greater than the cost-sharing requirement that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (a)(3)(G)(ii));

(B) shall calculate such cost-sharing requirement as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (a)(3)(H)) for such items and services, plan or coverage, and year;

(C) not later than 30 calendar days after the bill for such services is transmitted by such provider, shall send to the provider an initial payment or notice of denial of payment;

(D) shall pay a total plan or coverage payment directly, in accordance, if applicable, with the timing requirement described in subsection (c)(6), to such provider furnishing such items and services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (C), equal to the amount by which the out-of-network rate (as defined in subsection (a)(3)(K)) for such items and services involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)) and year; and

(E) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant, beneficiary, or enrollee (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

***

(c) Determination of out-of-network rates to be paid by health plans; independent dispute resolution process

(1) Determination through open negotiation

(A) In general

With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, in a State described in subsection (a)(3)(K)(ii) with respect to such plan or coverage and provider or facility, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(1) or (b)(1), the provider or facility (as applicable) or plan or coverage may, during the 30-day period beginning on the day the provider or facility receives an initial payment or a notice of denial of payment from the plan or coverage regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such provider or facility and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider or facility, respectively, and such plan or coverage for payment (including any cost-sharing) for such item or service. For purposes of this subsection, the open negotiation period, with respect to an item or service, is the 30-day period beginning on the date of initiation of the negotiations with respect to such item or service.

(B) Accessing independent dispute resolution process in case of failed negotiations

In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

(2) Independent dispute resolution process available in case of failed open negotiations

(A) Establishment

Not later than 1 year after December 27, 2020, the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the "IDR process") under which, in the case of an item or service with respect to which a provider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a "qualified IDR item or service"), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such item or service furnished by such provider or facility.

* * *

(5) Payment determination

(A) In general

Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the certified IDR entity shall—

(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such item or service determined under this subsection for purposes of subsection (a)(1) or (b)(1), as applicable; and

(ii) notify the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination of the offer selected under clause (i).

(B) Submission of offers

Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination—

(i) shall each submit to the certified IDR entity with respect to such determination—

(I) an offer for a payment amount for such item or service furnished by such provider or facility; and

(II) such information as requested by the certified IDR entity relating to such offer; and

(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

(C) Considerations in determination

(i) In general

In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider—

(I) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

(ii) Additional circumstances

For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer of group or individual health insurance coverage the following:

(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act [42 U.S.C. 1395aaa]).

(II) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(D) Prohibition on consideration of certain factors

In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges, the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 300gg-131 or 300gg-132 of this title (as applicable) not applied, or the payment or reimbursement rate for such items and services furnished by such provider or facility payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], under the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.], under the Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.], under the TRICARE program under chapter 55 of title 10, or under chapter 17 of title 38.

(E) Effects of determination

(i) In general

A determination of a certified IDR entity under subparagraph (A)—

(I) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and

(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9.

* * *

(6) Timing of payment

The total plan or coverage payment required pursuant to subsection (a)(1) or (b)(1), with respect to a qualified IDR item or service for which a determination is made under paragraph (5)(A) or with respect to an item or service for which a payment amount is determined under open negotiations under paragraph (1), shall

be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made

* * *

42 U.S.C. § 300gg-112 (excerpts)

§ 300gg-112. Ending surprise air ambulance bills

(a) In general

In the case of a participant, beneficiary, or enrollee who is in a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who receives air ambulance services from a nonparticipating provider (as defined in section 300gg-111(a)(3)(G) of this title) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan or coverage—

(1) the cost-sharing requirement with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

(2) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

(3) the group health plan or health insurance issuer, respectively, shall—

(A) not later than 30 calendar days after the bill for such services is transmitted by such provider, send to the provider, an initial payment or notice of denial of payment; and

(B) pay a total plan or coverage payment, in accordance with, if applicable, subsection (b)(6), directly to such provider furnishing such services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (A), equal to the amount by which the out-of-network rate (as defined in section 300gg-111(a)(3)(K) of this title) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with paragraphs (1) and (2)).

(b) Determination of out-of-network rates to be paid by health plans; independent dispute resolution process

(1) Determination through open negotiation

(A) In general

With respect to air ambulance services furnished in a year by a nonparticipating provider, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(3), the provider or plan or coverage may, during the 30-day period beginning on the day the provider receives an initial payment or a notice of denial of payment from the plan or coverage regarding a claim for payment for such service, initiate open negotiations under this paragraph between such provider and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider, and such plan or coverage for payment (including any cost-sharing) for such service. For purposes of this subsection, the open negotiation period, with respect to air ambulance services, is the 30-day period beginning on the date of initiation of the negotiations with respect to such services.

(B) Accessing independent dispute resolution process in case of failed negotiations

In the case of open negotiations pursuant to subparagraph (A), with respect to air ambulance services, that do not result in a determination of an amount of payment for such services by the last day of the open negotiation period described in such subparagraph with respect to such services, the provider or group health plan or health insurance issuer offering group or individual health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

(2) Independent dispute resolution process available in case of failed open negotiations

(A) Establishment

Not later than 1 year after December 27, 2020, the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this

subsection as the "IDR process") under which, in the case of air ambulance services with respect to which a provider or group health plan or health insurance issuer offering group or individual health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a "qualified IDR air ambulance services"), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such services furnished by such provider.

* * *

(5) Payment determination

(A) In general

Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR ambulance services, the certified IDR entity shall--

(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such services determined under this subsection for purposes of subsection (a)(3); and

(ii) notify the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination of the offer selected under clause (i).

(B) Submission of offers

Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR air ambulance services, the provider and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination--

(i) shall each submit to the certified IDR entity with respect to such determination--

(I) an offer for a payment amount for such services furnished by such provider; and

(II) such information as requested by the certified IDR entity relating to such offer; and

(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either

party, including information relating to any circumstance described in subparagraph (C)(ii).

(C) Considerations in determination

(i) In general

In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR air ambulance service shall consider—

(I) the qualifying payment amounts (as defined in section 300gg-111(a)(3)(E) of this title) for the applicable year for items or services that are comparable to the qualified IDR air ambulance service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR air ambulance service; and

(II) subject to clause (iii), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

(ii) Additional circumstances

For purposes of clause (i)(II), the circumstances described in this clause are, with respect to air ambulance services included in the notification submitted under paragraph (1)(B) of a nonparticipating provider, group health plan, or health insurance issuer the following:

(I) The quality and outcomes measurements of the provider that furnished such services.

(II) The acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

(III) The training, experience, and quality of the medical personnel that furnished such services.

(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

(VI) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if

applicable, contracted rates between the provider and the plan or issuer, as applicable, during the previous 4 plan years.

(iii) Prohibition on consideration of certain factors

In determining which offer is the payment amount to be applied with respect to qualified IDR air ambulance services furnished by a provider, the certified IDR entity with respect to such determination shall not consider usual and customary charges, the amount that would have been billed by such provider with respect to such services had the provisions of section 300gg-135 of this title not applied, or the payment or reimbursement rate for such services furnished by such provider payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], under the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.], under the Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.], under the TRICARE program under chapter 55 of title 10, or under chapter 17 of title 38.

(D) Effects of determination

The provisions of section 300gg-111(c)(5)(E) of this title shall apply with respect to a determination of a certified IDR entity under subparagraph (A), the notification submitted with respect to such determination, the services with respect to such notification, and the parties to such notification in the same manner as such provisions apply with respect to a determination of a certified IDR entity under section 300gg-111(c)(5)(E) of this title, the notification submitted with respect to such determination, the items and services with respect to such notification, and the parties to such notification.

* * *

(6) Timing of payment

The total plan or coverage payment required pursuant to subsection (a)(3), with respect to qualified IDR air ambulance services for which a determination is made under paragraph (5)(A) or with respect to an air ambulance service for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.

* * *

45 C.F.R. § 149.130 (excerpts)

§ 149.130. Preventing surprise medical bills for air ambulance services.

* * *

(b) Coverage requirements. A plan or issuer described in paragraph (a) of this section must provide coverage of air ambulance services in the following manner—

* * *

(2) The cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by a participating provider of air ambulance services were equal to the lesser of the qualifying payment amount (as determined in accordance with § 149.140) or the billed amount for the services.

* * *

(4) The plan or issuer must—

(i) Not later than 30 calendar days after the bill for the services is transmitted by the provider of air ambulance services, determine whether the services are covered under the plan or coverage and, if the services are covered, send to the provider an initial payment or a notice of denial of payment. For purposes of this paragraph (b)(4)(i), the 30–calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services.

* * *

45 C.F.R. § 149.140 (excerpts)

§ 149.140. Methodology for calculating qualifying payment amount.

(a) *Definitions*. For purposes of this section, the following definitions apply:

(1) *Contracted rate* means the total amount (including cost sharing) that a group health plan or health insurance issuer has contractually agreed to pay a participating provider, facility, or provider of air ambulance services for covered items and services, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager. Solely for purposes of this definition, a single case agreement, letter of agreement, or other similar arrangement between a provider, facility, or air ambulance provider and a plan or issuer, used to supplement the network of the plan or coverage for a specific participant, beneficiary, or enrollee in unique circumstances, does not constitute a contract.

* * *

(7) *Geographic region* means—

(i) For items and services other than air ambulance services—

(A) Subject to paragraphs (a)(7)(i)(B) and (C) of this section, one region for each metropolitan statistical area, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in a State, and one region consisting of all other portions of the State.

(B) If a plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region described in paragraph (a)(7)(i)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in the State, and one region consisting of all other portions of the State.

(C) If a plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region described in paragraph (a)(7)(i)(B) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau.

(ii) For air ambulance services—

(A) Subject to paragraph (a)(7)(ii)(B) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in the State, and one region consisting of all other portions of the State, determined based on the point of pick-up (as defined in 42 CFR 414.605).

(B) If a plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an air ambulance service provided in a geographic region described in paragraph (a)(7)(ii)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau, determined based on the point of pick-up (as defined in 42 CFR 414.605).

* * *

(16) *Qualifying payment amount* means, with respect to a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage, the amount calculated using the methodology described in paragraph (c) of this section.

* * *

(b) *Methodology for calculation of median contracted rate*—

(1) *In general.* The median contracted rate for an item or service is calculated by arranging in order from least to greatest the contracted rates of all group health plans of the plan sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) or all group or individual health insurance coverage offered by the issuer in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished and selecting the middle number. If there are an even number of contracted rates, the median contracted rate is the average of the middle two contracted rates. In determining the median contracted rate, the amount negotiated under each contract is treated as a separate amount. If a plan or issuer has a contract with a provider group or facility, the rate negotiated with that provider group or facility under the contract is treated as a single contracted rate if the same amount applies with respect to all providers of such provider group or facility under the single contract. However, if a plan or issuer has a contract with multiple providers, with separate negotiated rates with each particular provider, each unique contracted rate with an individual

provider constitutes a single contracted rate. Further, if a plan or issuer has separate contracts with individual providers, the contracted rate under each such contract constitutes a single contracted rate (even if the same amount is paid to multiple providers under separate contracts).

(2) *Calculation rules.* In calculating the median contracted rate, a plan or issuer must:

(i) Calculate the median contracted rate with respect to all plans of such sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) or all coverage offered by such issuer that are offered in the same insurance market;

(ii) Calculate the median contracted rate using the full contracted rate applicable to the service code, except that the plan or issuer must—

(A) Calculate separate median contracted rates for CPT code modifiers "26" (professional component) and "TC" (technical component);

(B) For anesthesia services, calculate a median contracted rate for the anesthesia conversion factor for each service code;

(C) For air ambulance services, calculate a median contracted rate for the air mileage service codes (A0435 and A0436); and

(D) Where contracted rates otherwise vary based on applying a modifier code, calculate a separate median contracted rate for each such service code-modifier combination;

(iii) In the case of payments made by a plan or issuer that are not on a fee-for-service basis (such as bundled or capitation payments), calculate a median contracted rate for each item or service using the underlying fee schedule rates for the relevant items or services. If the plan or issuer does not have an underlying fee schedule rate for the item or service, it must use the derived amount to calculate the median contracted rate; and

(iv) Exclude risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments.

* * *

(d) *Information to be shared about qualifying payment amount.* In cases in which the recognized amount with respect to an item or service furnished by a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services is the qualifying payment amount, the plan or issuer must provide in writing, in paper or electronic form, to the provider or facility, as applicable—

(1) With each initial payment or notice of denial of payment under § 149.110, § 149.120, or § 149.130:

(i) The qualifying payment amount for each item or service involved;

* * *

(iii) A statement to certify that, based on the determination of the plan or issuer—

(A) The qualifying payment amount applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing); and

(B) Each qualifying payment amount shared with the provider or facility was determined in compliance with this section;

(iv) A statement that if the provider or facility, as applicable, wishes to initiate a 30–day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30–day negotiation period does not result in a determination, generally, the provider or facility may initiate the independent dispute resolution process within 4 days after the end of the open negotiation period; and

(v) Contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.

(2) In a timely manner upon request of the provider or facility:

(i) Information about whether the qualifying payment amount for items and services involved included contracted rates that were not on a fee-for-service basis for those specific items and services and whether the qualifying payment amount for those items and services was determined using underlying fee schedule rates or a derived amount;

(ii) If a plan or issuer uses an eligible database under paragraph (c)(3) of this section to determine the qualifying payment amount, information to identify which database was used; and

(iii) If a related service code was used to determine the qualifying payment amount for an item or service billed under a new service code under paragraph (c)(4)(i) or (ii) of this section, information to identify the related service code; and

(iv) If applicable, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved (as applicable) that were excluded for purposes of calculating the qualifying payment amount.

* * *