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ONE HUNDRED EIGHTEENTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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November 27, 2023

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

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Julie Su
Acting Secretary
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

Dear Secretary Becerra, Secretary Yellen, and Secretary Chu:

I write to express my strong support for the Biden Administration's decision to exercise enforcement discretion regarding the District Court's decision in *Texas Medical Association et al. v. United States Department of Health and Human Services et al.* (TMA III), regarding the calculation of Qualifying Payment Amount (QPA), as well as the Administration's decision to appeal the court's decision in TMA III.[1] Allowing the court's decision to remain unchallenged would directly raise consumers' out of pocket costs and undermine the No Surprises Act's important consumer protections. I applaud the decision to protect consumers through the exercise of enforcement discretion in the interim, with the expectation that the Administration will prevail on appeal on its QPA methodology.

The No Surprises Act was the culmination of a multi-year bipartisan bicameral effort to protect patients from the unfair practice of surprise medical billing and lower health care costs for American families. Before passage of the No Surprises Act, families were burdened with

[1] Internal Revenue Service, Department of the Treasury, Employee Benefits Security Administration, Department of Labor, Department of Health and Human Services, Department of the Treasury, and the Office of Personnel Management, *FAQS About Consolidated Appropriations Act, 2021 Implementation Part 62* (Oct. 6, 2023).

medical debt from unavoidable out-of-network emergency procedures or surprise charges from an out-of-network provider they did not choose during a scheduled service at an in-network facility. For too long, patients were caught in the middle of billing disputes between providers and health plans. The No Surprises Act protects patients from these billing disputes and exorbitant surprise bills for out-of-network health care. The law limits what patients pay in surprise billing situations to their in-network cost-sharing and establishes a federal independent dispute resolution (IDR) process to fairly resolve payment disputes between health plans and providers.

The No Surprises Act has already protected millions of patients from crippling medical bills. Since the law has gone into effect, one million Americans per month have been subject to the protections of the law and from unfair, undeserved balance bills.[2] To date, tens of millions of consumers have been protected from surprise medical bills, saving patients and their families thousands of dollars in out-of-pocket costs that average up to $2,600.[3] At the time of passage, the Congressional Budget Office (CBO) also estimated that it would reduce health care costs and reduce the federal deficit by approximately $17 billion over 10 years.[4]

However, since passage of the law, private equity-backed corporate entities and provider organizations have filed over 20 lawsuits in an attempt to undermine the law and its important consumer protections.[5] The endless legal challenges, many of which have found a receptive audience in U.S. District Judge Jeremy D. Kernodle in the Eastern District of Texas, are seeking to judicially rewrite the law. Unfortunately, they have been successful in this endeavor, as the court continues to hand down ever more detailed and minute policy announcements that are generally the types of decisions left to an agency implementing a law.

Ironically, these lawsuits are threatening to stymie the entire IDR process— the process providers advocated for in Congress—as the agency continues to halt and restart arbitration proceedings in order to accommodate the court's myriad policy preferences. From April 2022 to June 2023, the Departments have reported nearly 489,000 disputes, 300,000 of which remain unresolved as of June 2023.[6] As a result of a District Court decision by Judge Kernodle, the

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[2] America's Health Insurance Plans, *New Study: No Surprises Act Protects 9 Million Americans from Surprise Medical Bills* (Nov. 17, 2022) (press release).

[3] Letter from 13 Organizations to President Joseph Biden (Oct. 3, 2023); The White House, *Fact Sheet: President Biden Announces New Actions to Lower Health Care Costs and Protect Consumers from Scam Insurance Plans and Junk Fees as Part of "Bidenomics" Push* (Jul. 7, 2023).

[4] Congressional Budget Office, *Estimate for Divisions O through FF, H.R. 133, Consolidated Appropriations Act, 2021, Public Law 116-260, Enacted on December 27, 2020* (Jan. 14, 2021) (www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf).`

[5] Affordable Care Act Litigation, *No Surprises Act* (https://affordablecareactlitigation.com/no-surprises-act/) (access Oct. 26, 2023).

[6] Internal Revenue Service, Department of the Treasury, Employee Benefits Security Administration, Department of Labor, Department of Health and Human Services, Department of the Treasury, and the Office of Personnel Management, *Federal Independent Dispute Resolution Operations* (Oct. 30, 2023) (Proposed Rule)

Departments had to delay the initial launch of the IDR process. Since then, the Departments have delayed or temporarily paused the IDR process on three different occasions due to the various court decisions, further increasing the backlog of disputes that remain unresolved.[7]

In light of several previous court decisions, the Departments have revised regulations or opted not to appeal some of the court's decisions.

Court Decision in TMA I and the Departments' Response:

In *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, (TMA I), the provider organizations challenged IDR guardrails that provided a rebuttable presumption to arbitrators that the QPA was "reasonable." The provider organizations challenged the provisions of the rule that directed the IDR entities to select the QPA as the appropriate payment amount unless there is credible information that demonstrates that the QPA is materially different from the appropriate out-of-network rate.[8] The District Court subsequently ruled in their favor, vacating certain provisions governing the IDR process.

The No Surprises Act requires the consideration of the QPA in the IDR entity's determination and explicitly excludes consideration of other rates, such as usual and customary charges and public payor rates, reflecting Congress' determination that the QPA is the most reasonable rate among those rates. The statute clearly specifies in detail how health plans must calculate the QPA, underscoring Congress' intent for the QPA to serve as a predominant data point for the IDR entity to consider.

As I outlined in a previous letter[9] and subsequent amicus brief,[10] it is my belief that the Departments' rule implementing IDR guardrails[11] was consistent with congressional intent. However, the District Court vacated provisions of the interim final rule related to the rebuttal presumption. As a result of the TMA I decision, the Departments began the process of updating the IDR guidance to make it consistent with the TMA I decision, choosing not to appeal the court's decision.

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[7] Centers for Medicare and Medicaid Services, *No Surprises Act: Overview of Rules & Fact Sheets* (Oct. 18, 2023); Centers for Medicare and Medicaid Services, *No Surprises Act: Payment Disputes Between Providers and Health* Plans (Oct. 18. 2023).

[8] *Texas Medical Association and Adam Corley v. United States Department of Health and Human Services, et al.,* Case No. 6:21-cv-425 (E.D. Tex.).

[9] Letter from Rep. Frank Pallone, Jr., Chairman, Committee on Energy and Commerce, and Sen. Patty Murray, Chair, Health, Education, Labor, and Pensions Committee, to Secretary Becerra, Secretary Yellen, and Secretary Walsh (Oct. 20. 2021).

[10] *See* note 7.

[11] Office of Personnel Management, Internal Revenue Service, Department of the Treasury, Employee Benefits Security Administration, Department of Labor and Department of Health and Human Services, *Requirements Related to Surprise Billing*; Part I 86 Fed. Reg. 36872 (Jul. 13, 2021) (Rule).

After TMA I, the Departments revised the interim final rules released in July 2021 and October 2021,[12] and a subsequent August 2022 rule removed language invalidated by the District Court. Specifically, the Departments removed the provisions vacated by the District Court, including the requirement that IDR entities select the offer closest to the QPA, unless there is credible information to demonstrate otherwise.[13] The new final rules specified that IDR entities select the offer that best represents the value of the service after considering the QPA and all permissible information submitted by the parties.

Court Decision in TMA II and the Departments' Response:

In *Texas Medical Association et al. v. U.S. Department of Health and Human Services et al.* (TMA II), the District Court again ruled in favor of providers, vacating provisions of the August 2022 rule issued by the Departments.[14] Specifically, the District Court inserted new meaning into the law by ruling that the IDR process must consider all specified information and further ruling that nothing in the law instructs the IDR entities to prioritize QPA above other factors.

As described earlier in this letter, the law specifically requires the consideration of the QPA in the IDR entity's determination and explicitly excludes consideration of other rates, reflecting Congress' determination that the QPA is the most reasonable rate among those rates. The law clearly specifies that the IDR entity "shall consider" the QPA when deciding between the two offers submitted by the parties. The law designates the QPA as the only factor that must be submitted and considered without qualification in every dispute under consideration by the IDR entity, and clearly specifies in detail how health plans must calculate, and how the departments will independently audit the QPA, underscoring Congress' intent for the QPA to serve as a predominant data point for the IDR entity to consider.

However, as a result of the District Court's decision, the Departments had to temporarily suspend the IDR process and issue new guidance.[15] In July 2023, the Department of Justice filed an appellate brief to appeal the TMA II decision.[16]

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[12] *See* note 8; Additionally, see *LifeNet, Inc.* v. *United States Department of Health and Human Services, et al.,* Case No. 6:22-cv-162-JDK (E.D. Tex.).

[13] Internal Revenue Service, Employee Benefits Security Administration, Department of Health and Human Services, *Requirements Related to Surprise Billing* 87 Fed. Reg. 52618 (Aug. 26, 2022) (Rule).

[14] *Texas Medical Association, et al., v. U.S. Department of Health and Human Services, et al.*, Case No. 6:22-cv-372-JDK (E.D. Tex.).

[15] Centers for Medicare and Medicaid Services, *No Surprises Act: Payment Disputes Between Providers and Health* Plans (Oct. 18. 2023); Department of Labor, Department of Health and Human Services, and Department of the Treasury, *Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties* (Mar. 2023).

[16] Brief for Appellants, *Texas Medical Association, et al., v. United States Department of Health and Human Services, et al.*, Case No. 23-40217, Document 35-1. (Jul. 12, 2023).

Court Decision in TMA IV and the Departments' Response:

In *Texas Medical Association v. United States Department of Health and Human Services et al.* (TMA IV), the District Court again ruled in favor of the provider organizations vacating the administrative fee established by a previous guidance and parts of the final rule.[17] The District Court ruled that the increase to the administrative fee to participate in the IDR process violated the Administrative Procedures Act.[18] The law allowed batching of multiple items and services to be considered jointly as part of a single determination, and gave the Departments the authority to outline rules in regard to batching. However, the District Court vacated parts of the rule that limited batching to claims that are billed under the same service code or procedural code.[19]

As a result of the District Court's decision, the Departments temporarily suspended all IDR process operations, further increasing the backlog of disputes that remain unresolved.[20]

Court Decision in TMA III and the Departments' Response:

On August 24, 2023, the District Court once again vacated certain provisions of the July 2021 interim final rule and guidance documents issued by the Departments, striking down important pieces of the rule including certain portions of the rule regarding the calculation of the QPA.[21] In *Texas Medical Association v. United States Department of Health and Human Services et al.* (TMA III), the District Court is unilaterally rewriting the QPA methodology. The District Court vacated a number of provisions related to the QPA methodology, including the inclusion of contracted rates for items and services "regardless of the number of claims paid at that contracted rate;" the use of contracted rates of all self-insured group health plans administered by the same entity; rules governing calculation of the QPA for providers "in the same or similar specialty;" the exclusion of bonus, incentive, and risk-sharing payments; and the exclusion of single case agreements.

The District Court blatantly ignored how rates are negotiated in the private insurance market, which are generally negotiated prospectively. It also ruled that insurers cannot exclude incentive-based and retrospective payments in the QPA calculations, and ruled that allowing third-party administrators to determine the QPA for all self-insured group health plans was not in accordance with the law. In its ruling, the District Court is clearly making detailed and minute policy decisions that should be left to the Departments implementing the law.

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[17] Centers for Medicare and Medicaid Services, *No Surprises Act: Payment Disputes Between Providers and Health* Plans (Oct. 18. 2023).

[18] *Texas Medical Association, et al., v. U.S. Department of Health and Human Services, et al.*, Case No. 6:23-cv-59-JDK (E.D. Tex.).

[19] *Id.*

[20] *See* note 15.

[21] Zachary Baron, *Latest Twists and Turns in No Surprises Act Litigation: What it Means for Consumers and Ongoing Implementation*, O'Neill Institute, Georgetown Law (Aug. 31, 2023).

The Departments' current interpretation of the role of the QPA and the QPA methodology appropriately implements Congressional intent to ensure that the law lowers health care costs for consumers and does not have an inflationary effect on health care costs. Analyses conducted by the CBO reflect the consensus at the time of passage that the QPA is central to the IDR process. CBO projected that the No Surprises Act would reduce private health plan premiums by 0.5 percent to 1 percent on average and reduce the federal deficit by approximately $17 billion over 10 years.[22] In its analyses of the different surprise billing legislation, CBO concluded that the consideration of the QPA in the IDR process would have an anchoring effect, whereby payment rates for providers in facilities where surprise bills are likely would reduce health care costs. This estimate was provided based on the assumption and the understanding by CBO that the QPA is central to the IDR determination, above all other factors.

I strongly support the Departments' decision to exercise enforcement discretion in the wake of the TMA III ruling. The District Court's decision in TMA III will require the review and recalculation of millions of existing QPAs and a substantial number of new QPAs. This would be costly, require significant resources, and further increase the backlog of disputes that remain unresolved. The Departments have announced that they will exercise enforcement discretion for any plan, issuer, or party to a payment dispute in the IDR process that uses a QPA calculated in accordance with the methodology under the July 2021 interim final rule and guidance in effect prior to the TMA III decision for items and services furnished before May 1, 2024.[23]

If the Departments did not take this action, new QPAs would have to be calculated that would be higher, resulting in higher out-of-pocket costs for consumers and raising costs for millions of American families. Additionally, forcing every union, employer or insurer in the country to immediately recalculate millions of QPAs would be a costly and potentially unnecessary exercise that could lead to higher premiums. I believe the Departments' decision to exercise enforcement discretion will protect consumers from high out-of-pocket costs. A coalition of 13 organizations have also written with strong concerns that the District Court's decision could have "massive implications for patient cost-sharing protections and directly raise costs for families protected under the NSA."[24] I share the coalition's concerns that weakening the guardrails of the arbitration process could result in increased out-of-pocket costs and higher premiums for consumers.

I applaud the Departments for the ongoing work of implementing this important law, particularly in the face of seemingly endless legal challenges. I also strongly support the Departments' decision to appeal the TMA III decision. Thank you for your continued work and commitment to protecting millions of patients from crippling medical bills.

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[22] *See* note 4.

[23] *See* note 1.

[24] *See* note 3.

Sincerely,

Frank Pallone, Jr.
Ranking Member