UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

AMERICAN SOCIETY OF ANESTHESIOLOGISTS
1061 American Lane,
Schaumburg, IL 60173,

and

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
4950 W. Royal Lane
Irving, TX 75063,

and

AMERICAN COLLEGE OF RADIOLOGY
1891 Preston White Dr.
Reston, VA 20191,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 Independence Avenue, S.W.
Washington, DC 20201,

and

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201,

and

UNITED STATES DEPARTMENT OF LABOR
200 Constitution Avenue, N.W.
Washington, DC 20210,

and

Case No. 1:21-cv-06823

MARTIN J. WALSH, in his official capacity as Secretary of the United States Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210,

and

UNITED STATES DEPARTMENT OF THE TREASURY
1500 Pennsylvania Avenue, N.W.
Washington, DC 20220,

and

JANET YELLEN, in her official capacity as Secretary of the United States Department of the Treasury
1500 Pennsylvania Avenue., N.W.
Washington, DC 20220,

and

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
1900 E Street, N.W.
Washington, DC 20415,

and

KIRAN AHUJA, in her official capacity as Director of the United States Office of Personnel Management
1900 E Street, N.W.
Washington, DC 20415,

Defendants.

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Plaintiffs, the American Society of Anesthesiologists ("ASA"), the American College of Emergency Physicians ("ACEP"), and the American College of Radiology ("ACR"), bring this action against Defendants, the United States Department of Health and Human Services

("HHS"), the United States Department of Labor ("DOL"), the United States Department of the Treasury ("DOT"), the United States Office of Personnel Management ("OPM"), and the current heads of those agencies in their official capacities (collectively, the "Departments"), and state as follows:

INTRODUCTION

1. This is a civil action brought to obtain declaratory and injunctive relief to halt the implementation of specific provisions of an interim final rule ("IFR") jointly published by the Departments to implement the No Surprises Act, Pub. L. No. 116-260, 134 Stat. 1182 (2020).[1] Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021) [hereinafter "October IFR"]. The No Surprises Act addresses two interrelated problems with the private health insurance market: 1) insurers demand unreasonably low reimbursement rates as a condition of physicians participating in their networks, thus forcing many physicians to stay out of network to remain economically viable; and 2) patients who unknowingly receive certain care from out-of-network providers are responsible for amounts not paid by their insurance companies, which is known as "surprise billing." Plaintiffs support Congress's reforms, which, if properly implemented, will ensure fair reimbursement for physicians and reasonable cost sharing by patients. Unfortunately, the Departments have turned these reforms upside down and transformed an act intended to protect patients and their doctors into a giveaway to private insurers that will harm patients and providers. Certain provisions of the Departments' October IFR must be reversed because they are contrary to the No Surprises Act and violate rulemaking

[1] The No Surprises Act amended provisions of the Public Health Service Act, the Employee Retirement Income Security Act, the Internal Revenue Code, and the Federal Employees Health Benefits Act. The Federal Employees Health Benefits Act, as amended by the No Surprises Act, cross references the requirements described in 42 U.S.C. § 300gg-111, 29 U.S.C. § 1185e, and 26 U.S.C. § 9816 (as applicable). 5 U.S.C. § 8902(p).

requirements of the Administrative Procedure Act ("APA"), 5 U.S.C. § 553(b)-(d).

2. These provisions of the October IFR are unlawful because they tie the hands of a statutorily mandated independent arbitrator—referred to as an independent dispute resolution ("IDR") entity—that determines the appropriate reimbursement amount for certain health care items and services furnished by a provider or facility that is not within the network of the insurer. October IFR, 86 Fed. Reg. at 56,104, 56,116, 56,128. The October IFR's provisions dictating the IDR entity's determination of the appropriate out-of-network rate for such items and services are invalid because they eliminate the IDR entity's statutory authority to weigh multiple factors impacting the rate of payment and instead require the IDR entity to give "presumptive weight" to only one factor, the qualifying payment amount ("QPA"), which is skewed in favor of insurers.

3. The No Surprises Act establishes protections for participants, beneficiaries, and enrollees (collectively, "patients") in group health plans and group and individual health insurance coverage (collectively, "insurers") from surprise billing when patients receive (1) emergency services provided by an out-of-network provider or out-of-network emergency facility, or (2) non-emergency services from an out-of-network provider with respect to a visit at an in-network health care facility. The No Surprises Act addresses surprise billing that occurs when a patient unknowingly receives items or services from an out-of-network provider at an in-network healthcare facility or emergency care provided out-of-network, and the patient is billed for amounts not covered by the patient's insurance.

4. The No Surprises Act creates a framework for determining fair payment for the provision of certain out-of-network items and services. 42 U.S.C. § 300gg-111(c); 29 U.S.C. § 1185e(c); 26 U.S.C. § 9816(c). Congress established an IDR process requiring the IDR entity to take a balanced approach to setting the amount of payment for the applicable out-of-network

items or services. 42 U.S.C. § 300gg-111(c)(5); 29 U.S.C. § 1185e(c)(5); 26 U.S.C. § 9816(c)(5). Congress unambiguously delineated a list of factors that the IDR entity "shall consider" when identifying the appropriate reimbursement amount. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). To ensure a balanced and independent process, Congress did not give any one specific factor presumptive weight. Nor did Congress authorize the Departments to determine how the IDR entity should weigh each factor.

5. Despite this clear directive, the Departments promulgated the October IFR, which unlawfully abrogates the discretion granted by Congress to IDR entities by dictating how the IDR entity should balance the statutory factors. Instead of requiring the consideration of all information that Congress deemed relevant to payment, the Departments improperly gave presumptive weight to one factor—the QPA—over all other factors unless the party can satisfy additional requirements that are not stated in the No Surprises Act. October IFR, 86 Fed. Reg. at 56,104, 56,116, 56,128.

6. The October IFR requires IDR entities to "presume that the QPA is an appropriate payment amount" unless a party provides "credible information" concerning the factors enumerated in the statute "clearly demonstrating" that the QPA is "materially different from the appropriate out-of-network rate," or unless the payment offers submitted by the provider/facility and the insurer are equally distant from the QPA but in opposing directions. *Id*. at 55,995. Under the No Surprises Act, the QPA is the insurer's median in-network rate within a particular geographic area. 42 U.S.C. § 300gg-111(a)(3)(E)(i); 29 U.S.C. § 1185e(a)(3)(E)(i); 26 U.S.C. § 9816(a)(3)(E)(i). Thus, the October IFR effectively imposes the insurer's in-network rate—the QPA—on out-of-network providers/facilities.

7. Except in the rare circumstance that the offers are equally distant from the QPA

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