# 22-3054

In the
# United States Court of Appeals
For the Second Circuit

DANIEL HALLER and LONG ISLAND SURGICAL PLLC,

*Plaintiffs-Appellants,*

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
200 INDEPENDENCE AVENUE SW, WASHINGTON, DC 20201,

*Defendants-Appellees,*

*(See inside cover for continuation of caption)*
ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK (CENTRAL ISLIP)

## CORRECTED BRIEF FOR PLAINTIFFS-APPELLANTS

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*Defendants-Appellees.*

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## INTRODUCTION

The untouchable body of rights enshrined in Amendments to the United States Constitution are guarantees, not options. Medical care is essential to our health and lives and the lives of our loved ones. Absence of adequate medical care has long been a paramount issue in the United States. With the stated goal of improving access to affordable health care, and preventing "surprise bills", as part of the Consolidated Appropriations Act of 2021, on December 27, 2020, the United States Congress enacted the "No Surprises Act" (Pub. L. 116-260) (herein "the Act" or "Law"). The Act went into effect on January 1, 2022. The key provision are 42 U.S.C. § 300gg-111(c), and§ 300gg-131 and 300gg-132.

The Act is both unconstitutional and rather than furthering the public interest, is severely harmful to the public interest.

This appeal is from those provisions of the Decision and Order of District Court Judge Ann M. Donnelly, entered August 11, 2022 (JA-48) which denied Plaintiff-Appellant's motion for a preliminary injunction to enjoin enforcement of the Act on the grounds that it violates the Unites States Constitution's Seventh Amendment guarantee of a jury trial, and the Fifth Amendment "Takings" clause. JA-44. The appeal is also based on the Court's granting of Defendant-Respondent's motion to dismiss all claims including those on appeal: Count II, that

the Act violates the Seventh Amendment, and Count IV that the Act violates the Takings Clause of the Fifth Amendment. JA-46.

The Act absolutely prohibits any medical care providers from "balance billing" any patients, whose lives they saved. Period. 42 U.S.C. § 300gg-131 and 300gg-132.

If a team of surgeons who are "out-of-network" save the life of a bullet-riddled patient in 14 hours surgery, and the insurer pays $250, the surgeons cannot "balance bill" the patient. If they complain to the insurers the insurers may elect the Act's "Independent Dispute Resolution" (herein, "IDR") procedure in which the surgeons are required to participate, and are denied access to Article III court's with a jury in stark violation of the Seventh Amendment. § 300gg-111(c)(1)(B).

Other than absolutely prohibiting billing patients, the Act effectively requires medical care providers to attend an administrative arbitration procedure, the IDR. The Act provides that either the medical provider or the insurer "May" elect arbitration. *Id.* There is no requirement of consent by both. If an insurance company elects the IDR the medical providers must attend, and are denied access to Article III courts guaranteed under the Seventh Amendment to the Constitution.

The most important feature considered by IDR entities is the QPA, a secretly formulate number the insurers generate as the median of in-network

payments they offer, based on a hodgepodge of "codes". In the Act it is the first consideration listed. 42 U.S.C. §§ 300gg-111(c)(5)(C)(i)(I) and (a)(3)(E)(i).

"Additional considerations" include the medical providers' experience, training, success rate, and other factors. *Id.* § 300gg-111(c)(5)(C)(ii). However, under no circumstances may the IDR consider the medical providers' "usual and customary rate" and what the providers' would have charged in the absence of the Act. *Id.* § 300gg-111(c)(5)(D). The IDR process itself is thus heavily weighted in favor of insurers.

It is clear the Acts seeks to impose upon medical providers "cost-shifting", rather than include insurers and the public in this process. However, the effect of this Law is having a devastating effect on medical practices.(JA-36).Surgeons, anesthesiologists, pathologists, radiologists and other staff are going out of business in droves. The result is the disappearance of available, quality health care, which is the most costly outcome to the public, and does not further the public interest, but endangers it. JA-36.

Numerous regulations (the "Rules") have been put into effect, which are far worse than the Act, requiring, inter alia, that IDR entities accept the insures' QPA as the presumptively correct number, and other onerous provisions.

In the Complaint (JA-12, at p.15) Plaintiff-Appellants also sought to set aside, under the Administrative Procedure Act, specific provisions of an interim

final rule entitled "Requirements Related to Surprise Billing; Part II," 86 Fed. Reg. 55980 (Oct. 7, 2021) (the "Rule"). On February 23, 2022, the Honorable Jeremy D. Kernodle vacated the Rule in a separate case, *Texas Medical Association v. U.S. Department of Health and Human Services*. No. 21- CV-425, 2022 WL 542879, at *14 (E.D. Tex. Feb. 23, 2022). The "Rules" have been revised and reissued, and stricken again in Texas. Therefore the question is moot at this point, and not subject to this appeal.

The District Court in this case erred in her Decision and Order which denies any Seventh Amendment challenge to the Act. JA-48. The District Court held that anytime Congress created a statute, which created a "new public right" Congress could create an administrative tribunal and foreclose recourse to Article III courts. *Id.* She flatly erroneously held without the Act's IDR entity, medical providers could never seek reimbursement from insurance companies, as they had no common law right to sue, and therefore the IDR was a brand new "new public right" permitting circumvention of Article III Courts. *Id*

However, this is plainly and conspicuously wrong as there is a long, well-established body of common law permitting medical providers to seek proper compensation from insurers with a jury in Article III Courts, as detailed in the Argument herein. With such well-established common law, the entire basis for the District Court's Decision and Order's basis for claiming there was a new "pubic

right" permitting circumvention of Article III Court collapses. The Act does indeed utterly violate the Seventh Amendment, and the Court is in clear error.

The District Court cites to a long evolving body of United States Supreme Court cases addressing Congresses ability to create "new public rights" and when they do and do not permit compulsory non-Article III administrative adjudication. *Id*. In all of the cases the bedrock principle remains that if there is an existing common law right of the parties to join issue in Article III courts, which are not dependent on the new "public right", the parties cannot be denied access to the Seventh Amendment guarantee to trial by jury. Any abrogation of that right, as in the Act, is a violation of the Seventh Amendment. The *sine qua non* of creation of "new public rights" which may be relegated to administrative tribunals, is that they do not replace common law rights enshrined in Article III Courts. Where there is a well-established body of common law in Article III Courts, stripping them away by Congressional fiat and dumping them in administrative tribunals is a violation of the Seventh Amendment.

The primary purpose of the Act, to prevent balancing billing or "surprise bills", is also violative of the Seventh Amendment and in fact does not further the public interest. 42 U.S.C. § 300gg-111, § 300gg-131-132.

As beneficent as the purpose sounds, and may be, absolute prohibition of any medical provider from suing or even billing a patient is unconstitutional, and is

also leading to the corrosion of access to quality medical care. Here, as well, there is a deep body of well-established common law which permits "balance billing" and filing suit against a patients, although physicians rarely if ever actually sue patients. However, at the very least issuing bills to patients encourages insurance companies, who unlike doctors who save lives, are driven entirely by greed and avoiding payment as much as possible, to agree to more reasonable in-network payments. JA-36.

Where the insurer will not pay for a 12-hour surgery to save a patient's life, and the insurer pays little or nothing, it is not unreasonable to simply balance bill that patient. Certainly if a party is brought to the emergency room with a bullet in his heart and a bullet in his lung, it is reasonable to infer from the circumstances that party assents to surgery to save his life and possibly foot a bill, rather than die. Particularly considered the well-established common law right to sue patients, whether in quasi contract, unjust enrichment, implied-contract and quantum meruit, the absolute denial of the right to at least balance bill that party is also violative of the Seventh Amendment.

In addition, the Congress' wholesale taking of medical provider's property interest for public use without reasonable and just compensation is violative of the Fifth amendments "Takings Clause". The Court Decision and Order denying any such right as speculative and not yet vested is erroneous. All calculations of

income or value of property in any case can be deemed "speculative" (as virtually every adversary argues), yet many cases addressing takings, which today mostly do not involve actual physical takings, find such deprivations to be not speculative but actual "takings", based on reasonable investment-backed expectations.

As a result of the Act, rather than promoting the public interest, medical practices are collapsing- which is not in the public interest. Medical practices are not able to meet their bottom lines, surgeons, anesthesiologists, pathologists, radiologists and other who are called in from home at 4:00 am are no longer willing to do so, knowing there is a high chance they will not receive any reasonable compensation. Practices are failing resulting in a scarcity of medical resources. JA-36. This is highly damaging to the public interest.

The apparent belief that life-saving medical providers are unscrupulous vultures who should be denied reasonable payment, and insurance companies, of all entities, are benighted white knights who should profit at doctors' expense, as a means of facilitating the public interest is misguided. And the bottom line is that means of doing so employed under the Act are clearly unconstitutional.

## JURISDICTIONAL STATEMENT

The District Court had subject matter jurisdiction over this civil action arising under the Constitution and a United States statute, pursuant to 28 USC §1331. The District Court denied Plaintiff-Appellants motion for a preliminary

injunction, and granted Defendant-Respondents' cross-motion to dismiss all claims with prejudice except for the relief for violation of Due Process which was dismissed without prejudice. AJ-48. This Court has jurisdiction over this appeal under 28 U.S.C. §§ 1291 as the district court's August 10, 2022 order, as entered on August 11, 2022, is a judgment dismissing the case. Plaintiffs-Appellants filed a timely notice of appeal on 11-30-22 (JA-27) upon the EDNY granting an extension to that date based on Rule 4(a)(5). Due to further severe illness for which doctors saved counsel's life, and recovered his health, this Court granted a 30-day extension to file this brief to 4-26-23, and it is thus timely.

## STATEMENT OF ISSUES PRESENTED FOR REVIEW

Whether Congress' creation of a statute which includes "rights" which are not new "public right", but rights well-established in the common law and adjudicated in Article III courts, allows congress to relegate resolution to administrative tribunal, and whether doing so violates the Seventh Amendment right to trial by Jury in an Article III Court.

Whether the District Court erred in her Decision and Order holding that out-of-network medical providers possessed no common law right to seek payment from insurers in an Article III Court, and holding that Congress' enactment of the "No Surprises Act" created a "new public right", permitting relegation of such

disputes to an administrative board, notwithstanding the Seventh Amendment guarantee to a jury trial in an Article III court.

Whether the District Court erred in her Decision and Order permitting Congress to absolutely bar a physician from ever billing, or "balancing billing", a patient whose life that medical provider saved, when the insurance company refuses to pay for the life-saving services adequately or at all, and erred in finding such prohibition no offense to the providers' well-established common law right to seek such reimbursement in an Article III Court as guaranteed under the Seventh Amendment.

Whether the District Court erred in her Decision and Order in sanctioning the absolute prohibition of ever "balance billing" patients, even where an insurer issues checks for reimbursement for medical services directly to patients who often cash them and keep the funds.

Whether the District Court erred in her Decision and Order finding that the Act commits no taking of private property for public use without just compensation.

Whether the District Court erred in her Decision and Order by refusing to issue a preliminary injunction.

Whether the District Court erred in her Decision and Order granting dismissal of all of the Plaintiff-Appellants' claims.

## STATEMENT OF THE CASE

The Decision and Order appealed from was rendered by United States District Court Judge Ann M. Donnelly, on August 10, 2022, Case 2:21-cv-07208-AMD-AYS. JA- 48. Plaintiff-Appellant appeals from her Decision and Order denying the motion for a preliminary injunction, enjoining enforcement of the Act, based on violation of the Seventh Amendment guarantee to a jury trial, and Fifth Amendment "Takings Clause". *Id.* The denial of a preliminary injunction based on the Act's violation of the Due Process under the Fifth and Fourteen Amendment, is not appealed.

Plaintiff-Appellants also appeal from the Decision and Order's granting Defendant-Respondent's motion to dismiss all claims. No appeal is taken from the dismissal of the Due Process claims or the "Rules", which are moot, as the Rules in effect at the time of the Decision and Order have been stricken, promulgated again and stricken again, are now being re-written, again

## SUMMARY OF ARGUMENT

Those rights enshrined in Amendments to the United States Constitution are guarantees, not options. Absence of adequate medical care has long been an existential issue in the United States. With the stated goal of improving access to affordable health care, as part of the Consolidated Appropriations Act of 2021, on December 27, 2020, the united States Congress enacted the "No Surprises Act" (Pub. L. 116-260). The Act went into effect on January 1, 2022. The Act is both unconstitutional and rather than furthering the public interest, is severely harmful to the public interest.

The Act has two primary features. First it absolutely prohibits out-of-network medical providers from billing, or "balance billing", any patient for any monies his or her insurance company refuses to pay (other than cost-sharing requirements). Hence the term "No Surprises Act". 42 U.S.C. § 300gg-111, § 300gg-131-132.

Second, insurance companies generally have a network of preferred medical care providers with whom they have a contracted reimbursement rate for services they cover, also known as "in-network" providers. Those medical providers who are not part of any given insurer's "network" are "out-of-network". The No Surprises Act sets up an "Independent Resolution Board" ("IDR") which purports

to fairly and equitably "resolve" any reimbursement disputes between out-of-network medical providers and insurers.

Participation in this process is effectively mandatory. The Act provides that either party "may" choose to participate in IDR, at which point the other party must participate. Therefore under the Act if an insurer selects recourse to IDR, a physician is bound to participate, and bound by the arbitrator's decision, without recourse to Article III Courts. § 300gg-111(c)(1)(B).

This is in stark violation of the Seventh Amendment to the United States Constitution, which guarantees the right to trial. The Act's providing that one party can at his or her whim deny the other party's guaranteed Seventh Amendment rights is a violation of the Seventh Amendment guaranteed right to a jury.

Under the Act, the first consideration by the IDR entity is the insurer's secretly generated "Qualifying Payment Amount" ("QPA"). 42 U.S.C. §§ 300gg-111(c)(5)(C)(i)(I) and (a)(3)(E)(i). Despite language in the statute, the insurers have historically included coding for anything from a visit to a family practitioner to a visit to the emergency room to remove bullets from a person's heart and lungs to generate the median rate paid. Secondarily, other considerations which may be considered during the IDR include the medical providers experience, training, historical outcomes of services, and related considerations. However, the Act specifically prohibits from consideration, the medical providers' "usual and

customary rate" and what the providers' would have charged, in the absence of the Act.

The scheme of this Act is unconstitutional. First it flagrantly violates the Seventh Amendment

The clear intent to weight the scales in favor of the insurance companies and to engage in cost-shifting to medical providers is a senseless, destructive strategy, and the means are unconstitutional. This cost-shifting to the very people who save our lives is reflected right in the District Court's Decision and Order which notes:

> Congress considered and rejected other bills intended to address surprise medical billing…which would have instructed IDR entities to consider "commercially reasonable rates for comparable services or items in the same geographic area" and the "usual and customary cost of the item or service involved."
>
> Decision and Order, p.5, FN 2 citing "Protecting People from Surprise Medical Bills Act, H.R. 3502, 116th Cong. § 2(c) (2019).

Thus the insurers purported median rates for similar services are to be considered at the outset, but medical providers "commercially reasonable rates for comparable services or items in the same geographic area" and the "usual and customary cost of the item or service involved" are prohibited from consideration.

Addressing the Seventh Amendment challenge, the District Court held that anytime Congress created a statute, which created a "new public right" Congress could create an administrative tribunal and foreclose recourse to Article III courts.

She held that medical providers have no common law right to sue insurers. The Court held that it was the IDR which gave medical providers a "new public right" to seek compensation from insurance companies and thus, the NSA has the absolute prerogative to limit recourse to the IDR administrative tribunal, without Article III Courts.

The Court's Decision and Order is demonstratabley wrong. Medical providers have a well-established common law right to seek proper compensation from insurers with a jury in Article III Courts. The entire basis for the District Court's Decision and Order's basis for claiming there was a new "pubic right" permitting circumvention of Article III Court collapses. The NSA utterly violates the Seventh Amendment, and the Court is in clear error.

The District Court cites to the history of Supreme Court cases developing Congresses right to use administrative tribunals when new "new public rights" are created. However, every case affirms where common law rights are in place, Congress cannot abrogate the Seventh Amendment guarantee to trial by jury.

The primary purpose of the Act, to prevent balancing billing or "surprise bills" is also violative of the Seventh Amendment and does not further the public interest. As beneficent as the purpose sounds, and may be, absolute prohibition of any medical provider from suing or even billing a patient is unconstitutional, and is also leading to the corrosion of access to quality medical care. Here, as well, there

is a deep body of well-established common law which permits "balance billing" and filing suit against a patients, although physicians rarely if ever actually sue patients. However, at the very least issuing bills, encourages insurance companies, who unlike doctors who save lives, are driven entirely by greed and avoiding payment as much as possible, to agree to more reasonable in-network payments.

Where the insurer will not pay for a 12-hour surgery to save a patient's life, and the insurer pays little or nothing, it is not unreasonable to simply balance bill that patient. Certainly if a party is brought to the emergency room with a bullet in his heart and a bullet in his lung, it is reasonable to infer from the circumstances that party assents to surgery to save his life and possibly foot a bill, rather than die. Particularly considered the well-established common law right to sue patients, whether in quasi contract, unjust enrichment, implied contract and quantum meruit, the absolute denial of the right to at least balance bill that party is also violative of the Seventh Amendment.

The Act also constitutes a violation of the United States Fifth Amendment prohibiting the taking of private property without just compensation. The District Court erred in denying Plaintiff-Appellant's motion to obtain a preliminary injunction, based on Count IV, the Taking of private property without just compensation. Plaintiffs-Appellants, like so many other medical providers have suffered a 50% decrease in gross revenue in the past year. Cases at the IDR are not

moving forward, the harm is irreparable. Moreover any Constitutional violation, Act creates, amounts to irreparable harm as a matter of law. Based on the merits of the Takings claim, Plaintiff-Appellants are likely to succeed on the merits. Finally, again given the collapse of medical practices and availability of quality medical care, the public interest is existentially harmed by the Act. Thus the public's interest weighs in favor of injunction. Therefore the preliminary injunction should have been granted.

The District Court's dismissal of Count IV for the Takings violation was erroneous. The United States Court of Appeals reviews a dismissal of a complaint pursuant to Rule 12(b)(6) *de novo*. "The court accepts all well-pleaded allegations in the complaint as true, drawing all reasonable inferences in the plaintiff's favor."

In addition, the Congress' wholesale taking of medical provider's property interest for public use without reasonable and just compensation is violative of the Fifth amendments "Takings Clause". The Court Decision and Order denying any such right as speculative and not yet vested is erroneous. All calculations of income or value of property in any case can be deemed "speculative" (as virtually every adversary argues), yet many cases addressing takings, which today mostly do not involve actual physical takings, find such deprivations to be not speculative but actual "takings", based on reasonable investment-backed expectations.

As a result of the Act, rather than promoting the public interest, medical practices are collapsing- which is not in the public interest. Medical practices are not able to meet their bottom lines, surgeons, anesthesiologists, pathologists, radiologists and other who are called in from home at 4:00 am are no longer inclined to do so, knowing there is a high chance they will not receive any reasonable compensation. Practices are failing resulting in a scarcity of medical resources. This is highly damaging to the public interest.

The apparent belief that life-saving medical providers are unscrupulous vultures who should be denied reasonable payment, and insurance companies, of all people, are benighted entities who should profit at doctors' expense, as a means of facilitating the public interest is misguided. And the bottom lines is that means of doing so employed under the Act are clearly unconstitutional.

## STATEMENT OF FACTS

### 1. The Plaintiffs

Plaintiff Dr. Haller earned his medical degree from the Technion – Israel Institute of Technology, Faculty of Medicine, completed his residency in general surgery at Maimonides Medical Center, and his fellowship in surgical critical care at North Shore-Long Island Jewish Health System. JA-36. Dr. Haller is board-certified in both surgery and surgical critical care by the American Board of

Surgery. *Id*. He is President and 100% owner of Plaintiff Long Island Surgical PLLC ("Long Island Surgical"), a general and acute care surgical private practice in Rockville Centre, New York employing six physicians who have over forty combined years of clinical experience. *Id*. at ¶¶ 1, 5. Notably, during the first wave of COVID-19 in March of 2020 Long Island Surgical managed two intensive care units in two different hospitals, treating over 40 patients a day. *Id*at ¶4.

Dr. Haller and the other surgeons of Long Island Surgical perform approximately 2,700 emergency consultations and surgical procedures each year on patients admitted to hospitals through their emergency departments. (JA-36). Approximately 78 percent of the patients that Dr. Haller and Long Island Surgical treat each year are covered by health plans with whom Dr. Haller and Long Island Surgical have no contractual relationship. *Id* at ¶ 7. With respect to those patients, Dr. Haller and Long Island Surgical are nonparticipating, or out-of-network, providers within the meaning of the Act whose fees will be determined by the Act and the procedures established under the Act and its implementing regulations.

**2. The Act**

As part of the Consolidated Appropriations Act of 2021, on December 27, 2020, Congress enacted the "No Surprises Act" (herein "the Act"). The Act went into effect on January 1, 2022. Health insurance companies generally have a network of preferred medical care providers with whom they have a contracted

reimbursement rate for services they cover, also known as "in-network" providers. Those medical providers who are not part of any given insurer's "network" are "out-of-network".

Insurers standard "in-network" reimbursement rates do not account for the experience, success rates, skills, and other distinctive features of any given medical providers.

When an insured patient receives care from an out-of-network providers, their individual plan or issuer may refuse to pay for the service or may pay an amount that is lower than the provider's billed charges, and may have greater cost-sharing requirements than would have been charged had the services been furnished by an in-network provider.

Prior to the No Surprises Act, the and out-of-network provider could generally balance bill patients for the difference between the provider's billed charges and the sum of the amount paid by the plan or issuer and the cost sharing paid by the individual. *Id.*

For patients who receive emergency medical services from out-of-network providers, or non-emergency services from out-of-network providers in in-network facilities and for which patients do not consent, the Act limits patients' cost sharing requirements to the "requirement that would apply if such

services were provided by an in-network provider or a participating emergency facility. 42 U.S.C. § 300gg-111 ("Preventing surprise medical bills").

**3. <u>Prohibition of "Balance Billing" Patients</u>**

The Act provides that out of network providers "shall not bill, and shall not hold [the patient] liable for any amount beyond what the patient's health plan pays the physician" ("no "balancing billing") . 42 U.S.C. §§ 300gg-131(a); 300gg-132(a). The Act prohibits "balancing billing" patients for potentially life-saving medical care by a medical care provider, for which the insurance company refuses to pay. That is the core stated goal of the Act, hence the title "No surprises Act".

The act forbids any "balance billing" or filing of a claim against a patient, even if, as is often the case, the insurance company makes payment, not to the medical provider, but directly to the patients, who often keeps it for themselves. The Act thus leaves the out-of-network medical provider with absolutely no recourse to obtain compensation for a 12-hour surgery to save a life.

**4. Independent Dispute Resolution**

However, there is another key feature the of the Act, unrelated to the "no surprise" billing of patients. The Act establishes a procedure for arbitration of disputes between insurers and out-of- network providers over the payment amount for emergency and non-emergency services.

Under the Act, submission to the IDR is effectively mandatory. Within 30-days after the insurer makes a payment or declines payment, either the insurer or the provide **"may"** initiate a 30-day period of negotiation, in which both parties must participate *Id.* § 300gg-(c)(1)(A). Within 4 days of the 30-day period either the insurer or the provider **"may"** then initiate the IDR process, to which both parties are bound. §300gg-(c)(1)(B).

Under the Act, anytime one party or the other elects to use the IDR process, the other party is bound to participate and is deprived of his or her right to utilize an Article III Court and trial by jury, which are guaranteed under the Seventh Amendment to the United States Constitution. The Seventh Amendment is not subject to revocation anytime an adversary "May" chose to do so; it is a "guarantee".

The independent dispute resolution process established by the Act is a "baseball- style" arbitration in which the provider and health plan each submit their final offers concerning payment. Once an arbitrator is selected, the provider and

the health plan have 10 days to submit (1) an offer for a payment amount, (2) any information requested by the arbitrator, and (3) any additional information the party wishes the arbitrator to consider, including information relating to statutory factors the arbitrator must consider. The arbitrator is restricted to selecting the exact amount of one or the other's offer. 42 U.S.C. § 300gg-111(c)(5)(B), (C)(ii), 111(c)(2), (5).

Under the Act, when evaluating the proposals, the IDR entity must first consider the QPA. The QPA is unliterally decided by the insurer, calculated secretly. 42 U.S.C. §§ 300gg-111(c)(5)(C)(i)(I) and (a)(3)(E)(i).

The first consideration enumerated under the Act, the "QPA", is defined as the "median of the contracted rates recognized by the insurer as of January 31, 2019 in the same insurance market 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," increased by inflation over the base year. *id.* §§ 300gg-111(a)(3)(E)(i), (c)(5)(C)(i)(I). Only the insurer determines this amount. This "QPA" section is labeled considerations "in general" under the Act, as the first consideration. *Id*

Only secondarily, the IDR evaluator may consider "additional considerations". Under the Act they include: The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such

item or service , the market share held by out-of-network provider, or that of the insurer in the geographic region in which the item or service was provided, the acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual, the teaching status of the provider(s), and any demonstrations of good faith efforts made by the out-of-network provider, and good faith efforts of the plan or issuer to enter into network agreements. *Id.* §42 U.S.C. § 300gg-111(c)(5)(C)(i), (ii).

In addition to determining what the arbitrator may consider, the Act also identifies factors that the arbitrator cannot consider: including the medical providers' (i) usual and customary charges; (ii) the amount the provider would have billed for the item or service if the Act's billing provisions did not apply; and (iii) the amount a public payer (like Medicare) would have paid. *Id.* § 300gg-111(c)(5)(D).

The Act provides that the determination made in the "independent dispute resolution process" is binding upon the parties and is not subject to any judicial review except in cases of fraud, bias, misconduct where the arbitrator exceeded his or her authority. 42 U.S.C. § 300gg- 111(c)(5)(E)(i)(II). There is no provision for Article III trial *de novo*, or review of anything else.

The Act itself is thus weighted heavily in favor or the insurance companies. The first and primary consideration by the IDR entity is the QPA, determined

solely by the insurance provider. 42 U.S.C. §§ 300gg-111(c)(5)(C)(i)(I) and (a)(3)(E)(i). This calculation is based on insurance companies' secret methodology for determining the "QPA", which purports to be based on the insurance company's negotiations with in-network providers, bundled together and averaged, without consideration of whether the coding is for a family practitioner or a heart surgeon. Thus the QPA under the Act, guarantees emergency surgeons and other medical providers rendering more complex medical services will be underpaid.

The Seventh Amendment guarantees the right to a jury in "suits at common law, where the value in controversy shall exceed twenty dollars." U.S. Const. Amend. VII. "The Framers regarded the checks and balances that they had built into the tripartite Federal Government as a self-executing safeguard against the encroachment or aggrandizement of one branch at the expense of the other." *Northern Pipeline Construction Co. v. Marathon Pipe Line Co.*, 458 U.S. 50, 58 (1982), citing The Federalist No. 47, p. 300 (H. Lodge ed. 1888) (J. Madison).

# ARGUMENT

I

## The District Court Judge Erred in Finding the Act Does Not Violate the Plaintiff- Appellants' Seventh Amendment Rights

### 1. The District Court Erred in Holding that that the "No Surprises Act" Does not Violate Medical Providers' Seventh Amendment to the United States Constitution, by Holding There is NO Common Law Right for them to Sue Insurers

Plaintiff-Appellants, emergency physicians who provide life-saving care to patients, and other medical providers, have a well-established common law right to file claims in Article III Court's against insurers for payment of services provided to their enrollees A robust body of caselaw in New York firmly establishes this common law.

The District Court's analysis of the Seventh Amendment claim begins by underscoring that "private rights" are protected by the Seventh Amendment but "public rights" are not. JA-48 at 9 citing *Atlas Roofing Co. v. Occupational Safety & Health Rev. Comm'n*, 430 U.S. 442, 455 (1977).The gravamen of the District Court's Order is that Petitioners-Appellants could not show a likelihood of success on the merits or irreparable harm, because, the Court holds, there is no common law right of providers to sue insurers, and only the Act provided such a new right, thus creating a brand "new public right" allowing circumvention of Article III Courts. JA-48. The Court holds since there is no common law right, the Seventh

Amendment is not violated. *Id.* The Court granted the defendants' motion to dismiss on the same essential grounds. *Id.* The District Court recognizes that the *sine qua non* of creating new "public rights" is that there is no common law enshrining such rights in Article III Court. By her own terms, the District Court's decision is fatally flawed.

Indeed, there is an abundance of common law demonstrating that providers do indeed have a common law right to sue insurers in Article III Courts, for compensation for services to out-of-network patients. There is thus no "new public right", concerning suits by medical providers against insurers and the District Court's entire "new public right" analysis collapses.

The District Court below held:

> When Congress enacted the No Surprises Act, it permitted health care providers to recover payment directly from insurers for out-of-network services, which is a new public right. Out-of-network providers' claims against insurers do not arise under state common law, but instead depend upon the will of [C]ongress,

JA-48 at 12 (emphasis added)(citations omitted.

The District Court further held: "Indeed, a provider's right to recover payment directly from an insurer is completely dependent upon the adjudication of a claim created by the Act." *Id* at 13 (internal citations omitted). Again this claimed lack of common law is flat out false.

The District Court held: "The Act does not compel providers to arbitrate state common law claims to which they had a right to a jury trial." *Id* at 11. "The plaintiff previously [prior to enactment of the No Surprises Act] had no cause of action". *Id* at 12. The District Court's analysis is demonstratabley false.

In fact, there is a well-established body of common law providing the right of a medical provider to sue an insurer under unjust enrichment and quasi contract principles. See *N.Y.C. Health & Hosps. Corp. v. Wellcare of N.Y., Inc.,* 937 N.Y.S. 2d 540 (Sup. Ct. NY Cty. 2011)(Anil Singh, J.S.C, now on the Appellate Division, First Department). The Court held:

> where, as here, a hospital is required by law to treat patients in an emergency room, an insurance company is unjustly enriched if it fails to pay the hospital in full for the costs incurred in rendering the necessary treatment to the insurer's enrollees.

*Id* at 527.

The *Wellcare* court noted that defendants claimed the treatment was not made directly at defendant insurer's behest. However, the Court noted, the medical services provided were performed in the emergency room where providers must provide care. *Id.* The Court further stated: "[a] claim for unjust enrichment does not require that the party enriched take an active role in obtaining the benefit." *Id* at 258, citing, 22A NY Jur 2d Contracts § 523. *Wellcare* demonstrated that prior to the Act, common law in New York permitted providers to sue insurance companies directly, in Article III courts. This completely undercuts the District Court's claim

that there was a “new public right”, for the first time ever permitting medical providers to pursue insurers for payment of services, and thus permitting Congress to creates its own “arbitration board”.

It is critical to note, first, under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 USC § 1395dd, any hospital that accepts payment from Medicare must treat patients who seek emergency services without inquiry into any patient's insurance coverage or ability to pay until the patient's condition has been stabilized. Every hospital in New York accepts payments from Medicare and is hence subject to EMTALA.

Second, it is a crime, for any provider to refuse emergency treatment to any patient who arrives at the hospital. Under New York law, "[a]ny licensed medical practitioner who refuses to treat a person arriving at a general hospital to receive emergency medical treatment. . . shall be guilty of a misdemeanor and subject to a term of imprisonment not to exceed one year and a fine not to exceed one thousand dollars." N.Y. Pub. Health Law § 2805-b(2)(b).

Hence all medical providers at any hospital must treat any patient regardless of insurance status and whether they are in or out-of-network. A patient appearing in the emergency room may be conscious and explicitly request treatment, but often will come in unconscious and cannot specify any preferences. Medical providers have no choice.

It certainly has long been hold that it is against equity and good conscience for a medical provider to provide 12 hours of surgery to save a life, and get paid nothing.

In *Josephson v. Oxford Health Insurance, Inc.*, 2012 NY Slip Op 32112 (Sup Ct., Nassau Cty., 2012), the New York Supreme Court held, regardless of any statutes: "to prevent injustice, an out-of-network provider who has not been paid at reasonable and customary rates may maintain an action for unjust enrichment" against the insurer. *Id.*

In the same case, *Josephson v. Oxford Health Ins., Inc.* 2014 NY Slip Op 34001 (Sup Ct., Nassau Cty., 2014), the Court later denied defendant insurerer's motion for summary judgment against the medical care providers, similarly holding, "defendants' motion for summary judgment dismissing plaintiffs' claim for unjust enrichment is denied." *Id.*

In *Beth Israel Med. Ctr. v. Horizon Blue Cross & Blue Shield of N.J., Inc.,* 448 F.3d 573, 586 (2d Cir. 2006), this Court analyzed the out of network provider versus insurer common law claim. The Court held "To prevail on a claim for unjust enrichment in New York, a plaintiff must establish (1) that the defendant benefitted; (2) at the plaintiff's expense; and (3) that equity and good conscience require restitution. "

In *Beth Israel Med. Ctr.,* this Court held "'The theory of unjust enrichment lies as a quasi-contract claim. It is an obligation the law creates *in the absence of any agreement.'" Id* at 587(emphasis in original). This Court further held:

> A 'quasi contract'" is not really a contract at all, but rather a legal obligation imposed in order to prevent a party's unjust enrichment. . . Briefly stated, a quasi-contractual obligation is one imposed by law ***where there has been no agreement or expression of assent, by word or act, on the part of either party involved. . . .***

*Id* at 587 (emphasis in original), quoting *Clark-Fitzpatrick, Inc. v. Long Island R.R. Co.,* 70 N.Y.2d 382, 388-89 (1987).

Pursuant to this Court, there need be no word or act by either a plaintiff or defendant to invoke application of unjust enrichment. This Court recognizes this based on New York state common law principles enshrined in Clark-Fitzpatrick. This Court in *Beth Israel* only denied the unjust enrichment claim as there was already an express contract between the parties, which displaces claims of unjust enrichment. However, this Court clearly recognized the principles of unjust enrichment in the context of out-of-network providers versus insurers.

New York Federal Courts recognize the common law right of providers to file suit against insurers for unjust enrichment[1] in Article III Courts. In *Emergency*

[1] In support of the argument that the NSA abrogated the Seventh Amendment, at the District level, Plaintiffs did not focus on unjust enrichment claims. However, "once a federal claim is properly presented a party can make any argument in support of that claim; parties are not limited to the precise arguments they made below." *Yee v. City of Escondido,* 503 U.S. 519, 534 (1992). See also *Bartley v.*

*Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 2021 WL 4437166, (S.D.N.Y. Sept. 28, 2021)(Allison J. Nathan, United States District Judge) the court recognized EMTALA, N.Y. Pub. Health Law § 2805-b(2)(b), making it a crime for an emergency room to deny treatment to any patient; and N.Y. Fin. Serv. Law § 605(a)- as a benchmark for why health insurance companies must paya reasonable amount for the services of out-of- network emergency medical providers.

The Southern District decision went on to quote the seminal rule in the Second Circuit in *Beth Israel Med. Ctr. v. Horizon Blue Cross & Blue Shield of N.J., Inc.,* 448 F.3d 573, 586 (2d Cir. 2006): "To prevail on a claim for unjust enrichment in New York, a plaintiff must establish (1) that the defendant benefitted; (2) at the plaintiff's expense; and (3) that equity and good conscience require restitution." The Court also cited the law enshrined in Clark-Fitzpatrick that: "The theory of unjust enrichment lies as a quasi-contract claim. It is an obligation the law creates *in the absence of any agreement.*" *Id.*

The Southern District in *Emergency Physician Servs. of N.Y.* then ruled "where, as here, a hospital is required by law to treat patients in an emergency

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*Kim's Enterprise Of Orlando, Inc* (11th Circuit, 2014)("Having preserved that broader claim in the district court, [appellant] is not precluded from raising new arguments in support of that claim on appeal").

room, an insurance company is unjustly enriched if it fails to pay the hospital in full for the costs incurred in rendering the necessary treatment to the insurer's enrollees." *Id* at **11, citing Wellcare,* 937 N.Y.S.2d at 545.

Thus there is a well-established body of common law providing for out-of-network providers to file claims in Article III Courts against recalcitrant insurers.

The District Court's holding that the Act's IDR process providing for a forum for medical care providers to seek compensation from insurers is a "public right", because there was no common law right of medical providers to sue insurers in Article III Courts, and therefore no violation of the Seventh Amendment, is completely incorrect.

The sole case the District Court cited to support its conclusion that there is no common law right of a medical provider to pursue claim against an insurer in an Article III Court is *Buffalo Emergency Assocs., LLP v. Aetna Health, Inc.*, 167 A.D.3d 461, 462 (1st Dep't 2018). [2]The District Court's analysis of Buffalo is that

[2] The District Court also noted that counsel for Plaintiffs below conceded that that a medical provider cannot sue an insurer. Such statements were made in error and are contrary to law . Plaintiffs-Appellants and the Court are not bound by such errors. See *Hankins v. Lyght,* 441 F. 3d 96 (2d Cir.2006)("Appellees' position that the RFRA does not apply to suits between private parties is not determinative of our analysis, given that they have vigorously pursued and preserved the substance of the issue. We are required to interpret federal statutes as they are written — in this case the ADEA as amended by the RFRA — and we are not bound by parties' stipulations of law." *Id* at 104-105 (emphasis added). See also *Becker v. Poling Transp. Corp.,* 356 F. 3d 381 (2nd Circuit 2004)("whether Metro's liability to

it "dismiss[ed] providers' suit against an insurer because 'the New York Emergency Services and Surprise Bills Act . . . does not provide for a private right of action to enforce its provisions'"". JA-48. This de minimus purported authority offers no support.

The District Court only refers to *Buffalo* for the proposition that when a provider is perceived to rely on the New York's No Surprises Act, which provides no private cause of action to enforce *it*. However *Buffalo* says nothing prohibiting common law claims in general.

Recently, on April 4, 3023, in *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp. Inc.,*20-cv-9183 (JGK) (SDNY, April 4, 2023)(John G. Koeltl, United States District Judge)(Herein "Emergency Physician Servs. of N.Y. II") in his decision denying defendants' motion for summary judgment, a new Justice revisited and more strongly affirmed the common law right of providers serving out-of-network patients to file suit against insurers in Article III courts.

The Southern District of New York in Emergency Physician Servs. of N.Y. II") addressing *Buffalo* held:

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appellees is vicarious or direct based on the answer to Question 4 is a matter of law, and we are not bound by stipulations of law". *Id* at 390).

> This analysis of the plaintiffs' perceived attempt to assert claims under the [NY Emergency Services Act] which comprises a single sentence in the First Department's brief opinion, nowhere implies that that Act operates as a … bar on otherwise viable common- law claims seeking reimbursements for the reasonable value of emergency medical services.

*Id* at 20 (emphasis added).

Based only on *Buffalo*, the District Court in the instant case extrapolated improperly:

> Thus, the Act does not compel providers to arbitrate state common law claims to which they had a right to a jury trial. Instead, as the defendants point out, "[i]n cases where the federal law applies, it is the No Surprises Act itself that creates [an out-of-network] health care provider's right to recover payments directly from a health plan or insurer.

JA-48 at 11

The District Court's decision is deeply flawed as it is based on the fallacious repeated proposition that a medical provider has no common law claim directly against an insurer. This is demonstrably false.

In *Emergency Physician Servs. of N.Y. II* the Southern District Court squarely addressed *Buffalo Emergency Assocs., LLP v. Aetna Health, Inc.*, 167 A.D.3d 461, 462 (1st Dep't 2018), upon which the District Court in this case relies.

*Emergency Physician Servs. of N.Y. II* noted that the brief decision in Buffalo Emergency Assocs., LLP, affirmed the lower court's dismissal of plaintiff providers action, on two bases. First the Court held that New York's Emergency

Medical Services and Surprise Bills Act (the "NY Emergency Services Act" ), did not provide for a "private right of action" and plaintiffs' copious reference to the NY Emergency Services Act, was an improper effort to "circumvent the legislative preclusion of private lawsuits" for violation of the NY Emergency Services Act. *Buffalo* at 463. Second, the *Buffalo* case held that plaintiff had failed to show an "equitable obligation running from the defendants to plaintiffs." *Id.*

The New York Southern District's recent decision in *Emergency Physician Servs. of N.Y. II* overwhelmingly and authoritatively demonstrates that the District Court's citation, in the instant case, to Buffalo in no way supports the notion that there is no common law right of providers of services to out-of-network patients to sue insurers. It only serves to underscore that such a common law right exists in New York.

*Emergency Physician Servs. of N.Y. II* held;

> Thus, neither [the Supreme Court nor the Appellate Division in the Buffalo cases] suggested that the Emergency Services Act …precludes common-law unjust enrichment claims seeking the reasonable value of emergency medical services, and they did not hold that such claims could never be viable under New York law.

*Id* ta 21.

According to the New York Court of Appeals, "[m]ere overlap between the common law and the [statute in question] is not enough to extinguish common-law remedies." *Assured Guaranty. v. JP Morgan*, 18 N.Y.3d 341, 353 (2011)

Thus that a provider has a common law right to pursue an insurer in an Article III Court for unjust enrichment, and a statute such as the New York Emergency Services Act makes reference to "reasonable value" does not mean the state statute supersedes and extinguishes the providers common law rights.

The second basis for the Buffalo Court's decision: that plaintiffs in that particular case did not sufficiently demonstrate an "equitable obligation running from the defendant to plaintiff" was limited to that case. The Court in *Emergency Physician Servs. of N.Y. II* held

> Indeed the question of whether emergency care providers generally, and the plaintiffs in particular, could ever bring viable unjust enrichment claims for the reasonable value of emergency medical services was not before the [Buffalo] Court
>
> Emergency Physician Servs. of N.Y. II at 21 (emphasis in original), Citing *Buffalo* at 877 (emphasis added)

The District Court in *Emergency Physician Servs. of N.Y. II* concluded:

> In short, the Buffalo Emergency Cases do not support the defendants' position that New York law … preclude[s] or bar[s] emergency medicine providers from us[ing] common law unjust enrichment claims to seek reimbursements from insurers for the "reasonable value" of emergency medical services . . . rendered to members of [the insurer's] employer-sponsored health benefit plans.
>
> *Id* at 31 (internal citations omitted).

The aforementioned cases thoroughly demonstrate the error in the District Court's holding, in the instant case that:

> When Congress enacted the No Surprises Act, it permitted health care providers to recover payment directly from insurers for out-of-network services, which is a new public right. Out-of-network providers' claims against insurers do not arise under state common law, but instead depend "upon the will of [C]ongress…. Indeed, a provider's right to recover payment directly from an insurer is "completely dependent upon" the adjudication of a claim created by the Act.

JA-48 at 12 (emphasis added).

The District Court's decision conclusory statement that the out-of-network providers right to pursue insurers for compensation does not arise under start common law is flatly wrong as demonstrated in *N.Y.C. Health & Hosps. Corp. v. Wellcare of N.Y., Inc.,* 937 N.Y.S. 2d 540 (Sup. Ct. NY Cty. 2011), *Josephson v. Oxford Health Insurance, Inc.*, 2012 NY Slip Op 32112 (Sup Ct., Nassau Cty., 2012); *Josephson v. Oxford Health Ins., Inc.* 2014 NY Slip Op 34001 (Sup Ct., Nassau Cty., 2014)*Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 2021 WL 4437166, (S.D.N.Y. Sept. 28, 2021); *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp. Inc.*,20-cv-9183 (JGK) (S.D.N.Y., April 4, 2023).

**2. Relevant Supreme Court Caselaw**

There are a series of germane United States Supreme Court cases helping guide analysis of when a Congressionally created statute creates a "new public right" previously unknown, thus permitting adjudication outside of Article III

Courts, and when a statute creating an administrative adjudication usurps a common law right thus violating the Seventh Amendment guarantee.

The District Court's analysis of the Seventh Amendment claim begins by underscoring that "private rights" are protected by the Seventh Amendment but not "public rights" citing *Atlas Roofing Co. v. Occupational Safety & Health Rev. Comm'n*, 430 U.S. 442, 455 (1977). JA-48.

It is notable that *Atlas Roofing* involved a claim "unknown to the common law". *Id* at 453, citing *NLRB* v. *Jones & Laughlin Steel Corp.,* 301 U. S. 1 (1937). The Congressionally created statute "Created a new cause of action, and remedies therefor, unknown to the common law". *Id* at 461.

In *Atlas*, Congress created an entirely new regulatory statute, addressing unsafe work conditions, and assigned an administrative panel the duty to assess the same and issue penalties. However, the existing common law right of injured workers to sue for injuries sustained by unsafe work conditions remained in Article III courts, therefore simultaneously "existing state statutory and common-law remedies for actual injury and death remain unaffected". *Atlas*, 484.

*Atlas* Further held where Congress creates a statutory right but "the action involves rights and remedies recognized at common law, *it must preserve to parties their right to a jury trial.*" *Atlas,* 453 (emphasis added. In the instant case there is a well-established body of common law rights of physicians to seek

payment from insurers in Article III Courts and there is no creation of a "new public right" through the IDR, and thus government "must preserve the parties right to a jury trial". The Act's failure to protect Seventh Amendment guarantees renders it unconstitutional

*Atlas* held that only when Congress created "new public rights" it may assign resolution to administrative boards. However, "on the common law side of the federal courts, the aid of juries …is required by the Constitution itself." *Id.* In the instant case before this Court, the Act's arbitration panel indeed does "replace a right to … compensation under state law." It replaces the existing common law right of providers saving the lives of out-of-network patients to recover under the common law right of unjust enrichment. The Act's IDR panel does not create a "new public right".

The District Court also cited *Northern Pipeline Construction Co. v. Marathon Pipe Line Co.*, 458 U.S. 50 (1982). In that case, new bankruptcy regulations were enacted, to be adjudicated in administrative proceedings outside of Article III Courts. One of the claimants brought a contract breach claim which was deemed to be subject to adjudication in the administrative proceedings. The United States Supreme Court found that that it was a well-established common law right and not a "new public right" and the Act in that case violated the

Constitutional guarantee of the Seventh Amended right to a jury in an Article III Courts.

In fact, the Court in *Northern Pipeline* held:

> when Congress creates a statutory right, …it may also provide that persons seeking to vindicate that right must do so before particularized tribunals created to perform the specialized adjudicative tasks related to that right. No comparable justification exists, however, when the right being adjudicated is **not of congressional creation**.

*Id* at 83-84

The United States Supreme Court continued "Rather, such inroads suggest unwarranted encroachments upon the judicial power of the United States, which our Constitution reserves for Art. III courts." *Id* at 84. The Court continued, "indeed, the cases before us, which center upon appellant Northern's claim for damages for breach of contract and misrepresentation, involve a right created by *state* law" and therefore as not a new "public right" permitting circumvention of the Seventh Amendment. *Id*

The Court in *Norther Pipeline* indicated that the separation of powers under Constitutional tripartite framework is essential. The Court held that if Congress creates an entirely new "public right", it may assign adjudication to administrative non-Article III Courts. But:

> No justification exists, however, when the right being adjudicated is not of congressional creation. In such a situation, substantial inroads into functions that have traditionally been performed by the Judiciary cannot

> be characterized merely as incidental extensions of Congress' power to define rights that it has created. Rather, such inroads suggest unwarranted encroachments upon the judicial power of the United States, which our Constitution reserves for Art. III courts. We hold that the Bankruptcy Act of 1978 carries the possibility of such an unwarranted encroachment. Many of the rights subject to adjudication by the Act's bankruptcy courts, like the rights implicated in *Raddatz,* are not of Congress' creation. Indeed, the cases before us, which center upon appellant Northern's claim for damages for breach of contract and misrepresentation, involve a right created by *state* law, a right independent of and antecedent to the reorganization petition that conferred jurisdiction upon the Bankruptcy court
>
> *Id.*

The United States Supreme Court case of *Thomas v. Union Carbide Agricultural Products Co*., 473 US 568 (1985) involved a Congressional scheme under the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA). It was an entire new scheme creating new relationships and issues. As a precondition for registration of a pesticide, manufacturers were required to submit research data to the Environmental Protection Agency (EPA) concerning the product's health, safety, and environmental effects. As a result trade secrets were submitted and utilized by subsequent registrants. Congress enacted FIFRA to provide compensation through arbitration.

This case is best-known for announcing that "public rights" and "private rights" are not determined by whether the government is a party. A statutory scheme may be enacted in which only private parties are participants and still involved "new public rights". However, *Thomas* maintained the fundamental

cardinal principle that Congress can only force adjudication, without Article III Courts, if "new public rights" are created, and existing common law claims cannot be divested from Article III Courts. *Id* at 594.

Under *Thomas* "for purposes of compensation under FIFRA's regulatory scheme, however, it is the 'mandatory licensing provision' that creates the relationship between the data submitter and the follow-on registrant, and federal law supplies the rule of decision." *Id* at 585.

In other words the statute does not replace any existing relationships adjudicated at common law. Thomas involved the creation of entirely "new public rights".

The Court in *Thomas* emphasized that "Any right to compensation from follow-on registrants under § 3 (c)(1)(D)(ii) for EPA's use of data results from FIFRA and does not depend on or replace a right to such compensation under state law." *Id* at 594.

*Thomas* is further supportive of Plaintiffs-Appellants' position: unlike in *Thomas*, in the instant case before this Court the Act's arbitration panel indeed does "replace a right to … compensation under state law." It replaces the right of providers saving the lives of out-of-network patients to recover through the common law right of unjust enrichment. That right is guaranteed under the Seventh Amendment to the Constitution.

In *Granfinanciera, S.A. v. Nordberg,* 492 U.S. 33 (1989), the United States got right to the point, concerning the inviolability of the Seventh Amendment, when confronted with another Congressional statutory scheme:

> The question presented is whether a person who has not submitted a claim against a bankruptcy estate has a right to a jury trial when sued by the trustee in bankruptcy to recover an allegedly fraudulent monetary transfer. We hold that the Seventh Amendment entitles such a person to a trial by jury, notwithstanding Congress' designation of fraudulent conveyance actions as "core proceedings" in 28 U. S. C. § 157(b)(2)(H) (1982 ed., Supp. V).

*Id* at 36.

*Granfinanciera, S.A.* thus found the petitioners right to a jury trial on their claims was guaranteed by the Seventh amendment.

The District Court's decision's istatement that the out-of-network providers right to pursue insurers for compensation does not arise under common law is flatly wrong as demonstrated in *N.Y.C. Health & Hosps. Corp. v. Wellcare of N.Y., Inc.,* 937 N.Y.S. 2d 540 (Sup. Ct. NY Cty. 2011), *Josephson v. Oxford Health Insurance, Inc.*, 2012 NY Slip Op 32112 (Sup Ct., Nassau Cty., 2012); *Josephson v. Oxford Health Ins., Inc.* 2014 NY Slip Op 34001 (Sup Ct., Nassau Cty., 2014)*Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 2021 WL 4437166, (S.D.N.Y. Sept. 28, 2021); In *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 2021 WL 4437166, (S.D.N.Y. Sept. 28, 2021).

**3. The District Court's Decision Erred in Holding that that the "No Surprises Act" Does not Violate Medical Providers' Seventh Amendment Rights, by Forbidding "Balance Billing" or Filing Suit against a Patients which are Grounded in Common Law**

When a patient appears in the emergency room medical providers are absolutely bound to provide life-saving treatment, including in the most complex cases.

It is critical to note, again, under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 USC § 1395dd, any hospital that accepts payment from Medicare must treat patients who seek emergency services without inquiry into the patient's insurance coverage or ability to pay until the patient's condition has been stabilized. Every hospital in New York accepts payments from Medicare and is hence subject to EMTALA.

Second, it is a crime, for any provider to refuse emergency treatment to any patient who arrives at the hospital. Under New York law, "[a]ny licensed medical practitioner who refuses to treat a person arriving at a general hospital to receive emergency medical treatment. . . shall be guilty of a misdemeanor and subject to a term of imprisonment not to exceed one year and a fine not to exceed one thousand dollars." N.Y. Pub. Health Law § 2805-b(2)(b).

A party may come in with his or her body riddled in bullets, including a bullet in his heart and one in his lung. Instantaneously a surgeon must be ready to take action. Due to the complexity and urgent need to save the life, he or she may

call in another two surgeons, a radiologist, a pathologist and an anesthesiologist, all who race to the hospital from home. Many or all of them may be out-of-network. Yet they safe your life. The insurers may pay a fair and reasonable rate, little, or nothing.

The Act denies the right of any of these heroes to attempt to even send a bill to the patient, after he or she goes home intact and resumes their life.

There is a well-established body of common law permitting medical providers to bill patients, whether in quasi contract and unjust enrichment or implied contract by quantum meruit.. See *Long Island Jewish Medical Center v. Budhu*, 20 Misc.3d 131(A), *1, 867 N.Y.S.2d 17 (App. Term 2008) (Plaintiff medical provider rendered services to a patient, invoiced him, and he refused to pay. The Appellate Court reversed denial of plaintiff's motion for summary judgment on his claim for account stated, holding "The performance by plaintiff and acceptance of the services by defendant gave rise to an inference that an implied contract to pay for the reasonable value of such services existed"). See also *Huntington Hosp. v. Abrandt*, 4 Misc.3d 1, *3, 779 N.Y.S.2d 891, 892 (App. Term 2004)(affirming grant of summary judgment to medical provider who filed suit for payment of services, under account stated, where patient claims fees were "not fair and reasonable". The Appellate Court held: "In general, an agreement to pay for medical services may be implied, whether characterized as a contract implied-in-

fact or a contract implied-in-law. The performance and acceptance of services can give rise to an inference of an implied contract to pay for the reasonable value of such services (22A NY Jur 2d, Contracts § 591)"(internal citations omitted).

Indeed, even if a patient is unconscious, as a patient often may be, upon entering an emergency room, an implied contract still exists. See *Shapira v. United Med. Serv*., 15 NY2d 200 (1965) ("It is not necessary to such a medical relationship and its resulting mutual obligations that the undertaking to perform an operation be parsed out in words on one hand and an agreement to pay for it be parsed out in words on the other. That a fee is to be earned is overwhelmingly inferred and implied from the situation of medical examination and medical treatment. Indeed, in modern practice a patient may have little or no conscious contact with the surgeon who operates on him." *Id* at 220 (emphasis added).

See also *Becker v. State of NY*, 104 Misc. 2d 588, FN 2 (Crt of Claims 1980)(quasi-contract has been used "to recover fees for medical services rendered to unconscious persons incapable of assenting to an express contract").

In addition to New York's robust common law permitting physicians to bill or sue patients, for the value of their services, assent can reasonably be inferred from the surrounding circumstances. If a person has been shot, stabbed, had a massive heart attack, and is rushed to the ER, it can certainly be inferred that a reasonable person assents to life-saving surgery. Any patient, except a suicidal

person, would want medical attention including surgery, and would assent to such care. If the choice is your life with a $38,000 bill or dying on a gurney, it can be inferred any reasonable person would assent to the life-saving treatment.

And regardless, the surgeons and other staff at an ER are compelled under law, including criminal law, to treat the patients. Forbidding a physician from recouping compensation for saving a person's life by sending a bill to him or her, in the absence of insurance, or insurance willing to pay reasonably, is unconstitutional, in violation of the Seventh Amendment, and has a deleterious effect on the availability of medical providers to survive and serve the public.

See also *McQuire v. Hughes*, 27 NY 516, 521 (NY)(1913)("it should be taken as the rule of law, too well settled upon authority to be now questioned, that a physician, in the absence of a special contract, may recover upon an implied agreement to pay for his services *quantum meruit,* when they have been rendered at the request of the patient, or of a person who, in the eye of the law, is regarded as being under a legal obligation to provide such professional services for the patient"). In the instant case before this Court, a medical provider in an emergency room is indeed "under a legal obligations to provide…services for the patient". *Id. See* EMTALA, 42 USC § 1395dd, and N.Y. Pub. Health Law § 2805-b(2)(b).

It is unconscionable, and bad public policy to require that a medical provider must provide life-saving services, under penalty of imprisonment (N.Y. Pub.

Health Law § 2805-b(2)(b)) and yet not be permitted to bill the patient, and the Act's requirement violates the Seventh Amendment.

See also *United Healthcare Servs., Inc. v. Aspirinio*, 16 N.Y.S.3d 139, 49 Misc. 3d 985, 998 (Sup. Ct. Westchester Cty. 2015, Scheinkman, J.S.C)(plaintiff insurer sued defendants medical providers to enjoin them from balance billing patients. The Court denied the injunctive relief holding "absent presentation of an agreement with [the patient] whereby defendants agreed to limit the patient's obligation to the proceeds of insurance… there is no reason why defendants would not be free to seek the balance of their fees from the patient in question. This case raises the same issues of the Act's requirement of a cryptic "QPA":

> McLafferty also notes, United does not provide any of the underlying FAIR Health data to support its argument. In particular, McLafferty points out that, among other things, United has not set forth the codes it referenced in order to assess Asprinio's fee. If United is using codes relevant to a routine procedure, as opposed to complex surgery, United's conclusion would be invalid. McLafferty opines that, given the lack of disclosure as to the information that United used to make its decision, it is not possible to determine whether United's position is itself reasonable or unreasonable.
>
> *Id* at 991 (emphasis added).

See *Northeast Remsco Constr. v. Picone*, 2012 NY Slip Op 51229 (Sup. Ct., Nassaut Cty., 2012)("an implied-in-law contract or quasi-contract is not a contract at all but instead is an obligation that the law imposes to prevent unjust enrichment (internal citations omitted). It is a restitutionary device, the classic example of

which arises when a doctor treats an unconscious person. In that circumstance, the law imposes a quasi-contract to compensate the doctor for rendering medical treatment").

The aforementioned common law concerning invoicing and if need be suing a patient reflects a robust common law, invoking the Seventh Amendment right to a jury.

Moreover, after medical treatment, including emergency medical care by out--of-network providers, even where a patient has filled out the "assignment of benefits" form, it is not uncommon for insurance companies instead of sending payment to the provider, to send payment directly to the patient who may or may not remit the same to the provider. JA-36, at par.16. There is no rational reasonable basis for the insurance companies to do this. The clear unscrupulous tactic is to leave providers scrambling, and try to force them to accede to the insurers lower in-network rates.

Under such a common circumstance, the Act leaves the provider with absolutely no recourse. The provider is literally left with no option whatsoever. He or she cannot sue the patient for the money the insurance company sent him. *Id.* The provider cannot look to the IDR process, as the insurer has already "paid".

The Act's absolute prohibition against sending a bill to a patient is a far greater Constitutional violation than even the required IDR process which

displaces providers right to sue insurers in Article III Courts, in violation of the Seventh Amendment. The Act's absolute prohibition against invoicing a patient whose life was just saved, provides NO forum whatsoever to obtain compensation from him or her. This is a gross violation of the Seventh Amendment.

The District Court then claims the IDR is filled with people who have expert training in addressing the relevant issues. JA- 48 at 13. This no basis for violating the Seventh Amendment. If so, medical malpractice claims could be taken away from juries, and tried only by experts in medicine. Nearly any kind of common law matter could circumvent the Seventh Amendment because Congress empanels "experts" in negligence, contracts (which can be very complex), etc. The District Court's decision flirts with abolition of the entire Constitutional tripartite structure of government. Moreover, all that has been clear so far regarding the IDR is that is is cumbersome, inefficient, expensive, and driving doctors out of business.

### 4. Purported Efficiency and Expertise Cannot Override the Constitutional Guarantee of the Seventh Amendment Right to A Jury Trial in an Article III Court

The District Court places particular emphasis on the notion that Congressionally created administrative tribunals which are purportedly more efficient, lower cost, and expert in a given areas, permits encroachment of the Seventh Amendment. The Court states: "Congress devised an expert and

inexpensive method for dealing with a class of questions of fact which are particularly suited to examination and determination by an administrative agency." *Id* at 20.

Such considerations can never trump the Seventh Amendment.

The United States Supreme Court held in *Granfinanciera, S.A. v. Nordberg,* 492 U.S. 33 (1989):

> It may be that providing jury trials .. would impede swift resolution ..proceedings and increase the expense…But these considerations are insufficient to overcome the clear command of the Seventh Amendment.[T]he fact that a given law or procedure is efficient, convenient, and useful in facilitating functions of government.. will not save it.

*Id* at 63.

The United States Supreme Court held *INS v. Chadha*, 462 US 919, 944 (1983): "the fact that a given law or procedure is efficient, convenient, and useful in facilitating functions of government, standing alone, will not save it if it is contrary to the Constitution. Convenience and efficiency are not the primary objectives — or the hallmarks — of democratic government."

The United States Supreme Court in *Stern v. Marshall,* 564 US 462 (2011):

> A statute may no more lawfully chip away at the authority of the Judicial Branch than it may eliminate it entirely. "Slight encroachments create new boundaries from which legions of power can seek new territory to capture." (internal citations omitted). Although "[i]t may be that it is the obnoxious thing in its mildest and least repulsive form," we cannot overlook the

> intrusion: "illegitimate and unconstitutional practices get their first footing in that way, namely, by silent approaches and slight deviations from legal modes of procedure." (internal citations omitted). We cannot compromise the integrity of the system of separated powers and the role of the Judiciary in that system, even with respect to challenges that may seem innocuous at first blush.

*Id* at 482

**5. The District Court Erred in Denying Plaintiffs-Appellants' Motion for a Preliminary Injunction on the Second Count for Violation of the Seventh Amendment**

To obtain a preliminary injunction, the moving party must demonstrate (1) irreparable harm absent injunctive relief; (2) either a likelihood of success on the merits, or a serious question going to the merits to make them a fair ground for trial, with a balance of hardships tipping decidedly in the plaintiff's favor; and (3) that the public's interest weighs in favor of granting an injunction."

For all of the reasons discussed the application should have been granted. It cannot be denied that Plaintiffs-Appellant demonstrated a likelihood of success on the merits. The abundance of common law permitting medical providers to sue insurance companies, and Supreme Court jurisprudence, by the District Court's own definition, collapses any holding that the Act created a wholly new "public right", permitting total circumvention of the Seventh Amendment.

The hardships balance in the Plaintiffs-Appellants' favor, being denied relief on such strong claims.

Plaintiffs-Appellants, and other medical providers, will suffer irreparable injury in the absence of a preliminary injunction. Plaintiffs-Appellants have already spent enormous sums of money filing claims with the IDR, and their claims are unresolved. JA-36. They are hemorrhaging money daily. Other medical providers are shutting down. The Constitutional violations which the Act creates is inherently irreparable injury as a matter of law. While the "public interest" is the stated interest of the Act, in fact by subjecting medical providers to such onerous "cost-shifting", imbalanced IDR proceedings, loss of any leverage to negotiate with insurance companies, loss of the ability to file any kind of suits existing in common law, medical practices are shutting down. *Id*. Out-of network edical providers cannot come in on a 24-hour basis, draining their mental and physical resources, knowing they will likely not be paid adequately or at all. This has led and is exponentially leading to a scarcity of life-saving medical providers. That causes significant existential damage to the public interest. Despite the purported goal of the Act, the public interest weighs in favor of injunctive relief.

### 6. The District Court Erred in Granting Defendants-Appellees' Motion to dismiss the Second Count for The Act's Violation of the Seventh Amendment

The United States Court of Appeals reviews a dismissal of a complaint pursuant to Rule 12(b)(6) *de novo.* "The court accepts all well-pleaded allegations in the complaint as true, drawing all reasonable inferences in the plaintiff's favor. In order to survive a motion to dismiss under Rule 12(b)(6), a complaint must allege a plausible set of facts sufficient to raise a right to relief above the speculative level." *Operating Local 649 Annuity v. Smith Barney Fund*, 595 F. 3d 86, 91 (2nd Cir. 2010). "A court must proceed on the assumption that all the allegations in the complaint are true." *Ashcroft v. Iqbal,* 556 U.S. 662, 684 (2009).

For all the aforementioned reasons, the District Court's granting of the Defendants-Appellees motion to dismiss was clear error. Accepting all well-pleaded allegations in Count II of the complaint as true, as amplified in the record since then, and drawing all reasonable inferences in the plaintiff's favor the motion to dismiss should have been denied.

## II

## The Court Erred in Finding The Act Does Not Effect a Taking

The Takings Clause of the Fifth Amendment provides that no private property "shall . . be taken for public use, without just compensation." U.S. Const. amend. V. In the federal takings context, "to succeed in establishing a constitutional violation claimants must demonstrate: (1) that they have a property interest protected by the Fifth Amendment, (2) that they were deprived of that interest by the government for public use, and (3) that they were not afforded just compensation." *Ganci v. N.Y.C. Transit Auth.*, 420 F. Supp. 2d 190, 195 (S.D.N.Y., 2005).

*Ruckelshaus v. Monstanto Co*., 467 US 986 (1984), is on point. This case Involved the Congressional scheme under the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), requiring companies to disclose their ingredients. Eventually the ingredients, which are a trade secret, would become publicly available to competitors.

An arbitration board was set up to determine appropriate compensation. The Court noted:

> After finding that the data-consideration provisions operated to effect a taking of property, the District Court found that the compulsory binding-arbitration scheme set forth in § 3(c)(1)(D)(ii) did not adequately provide compensation for the property taken. The court found the arbitration provision to be arbitrary and vague, reasoning that the statute does not give arbitrators guidance as to the factors that

> enter into the concept of just compensation, and that judicial review is foreclosed except in cases of fraud.

*Id* at 1000.

Contrary to the Decision and Order of the District Court in the instant case, the Supreme Court in *Monstanto Co*., found a taking despite it involving the future value of a trade secret, which had not yet vested, and cannot be predicted with absolute precision, i.e., it can, like all damages expected be called to a degree "speculative". No assessment of damages can be 100% guaranteed. Intelligent prudent analysis is reasonable.

Moreover the IDR in the Act in the instant case, is heavily weighted in favor of the insurers, considers their cryptic "QPA" first, yet gives no consideration to providers "usual and customary rate" and what the providers' would have charged, in the absence of the Act. It too provides no Article III review except for issues of fraud and the like by the IDR entity.

A medical provider can reasonably calculate expected income for any given year. This is not merely "speculative. The question is the "reasonable investment-backed expectations". *Id* at 1005. The reasonable calculation of future income stream. This is a property interest, just as the future expectation of the value of a trade secret. Moreover, it is being effectively taken by the inequity of the IDR in favor of insurers. It is clearly taken for "public use" as the stated purpose of the Act. And again given the heavy weighting in favor of insurers, just compensation

cannot be expected in the IDR just as it could not be expected in the arbitration board in *Monstanto Co*.

The Fifth Amendment protects even valid contract rights, and all of the projections of investment-backed expectations and uncertainties of compensation. *See Lynch v. United States*, 292 U.S. 571, 579 (1934) ("The Fifth Amendment commands that property be not taken without making just compensation. Valid contracts are property, whether the obligor be a private individual, a municipality, a State or the United States."); *Cienega Gardens v. U.S.*, 331 F.3d 1319, 1334 (Fed. Cir. 2003) (agreements between private parties "give rise to protected property interests, irrespective of whether the subject matter of the contracts is under the government's regulatory jurisdiction").

It is been long-established that the Taking Clause is not remotely restricted to physician invasions of property, as the District Court suggests. The District Court held: "While the Act prohibits out-of-network providers from balance billing patients covered by the Act, it also gives providers a right to recover the value of the services provided directly from insurers and creates a process to adjudicate that right." At 12.

First this is squarely incorrect, as it is a common practice of health insurance companies to send whatever payment they make directly to the patient and not to the medical provider; and patients often use the money for themselves. The Act,

by forbidding suing or even balance billing the patient, and providing a medical provider only the IDR, where the only outcome is finding the insurer already issued a check, leaves the medical provider no recourse at all, and effects a taking with no possibility of just compensation.

Moreover, the Act requires the IDR entity to consider, first the QPA which is entirely determined by the Insurance company, and does not permit the "usual and customary" rate of medical providers, does constitute a taking without just compensation. The insurer's methodology for determining the cryptic QPA, is known to include, for example, averaging of payments to family doctor visits and other "coded" amounts in its calculation of what to pay a heart surgeon: this creates a mass distortion to the detriment of providers *ab initio*. On its face the Act thus guarantees a taking without just compensation.

In *Cienega Gardens v. U.S.*, 331 F.3d 1319, 1334 (Fed. Cir. 2003) the court found that "[u]nquestionably, Congress acted for a public purpose (to benefit a certain group of people in need of low-cost housing), but just as clearly, the expense was placed disproportionately on a few private property owners." *Id* at 1338. The court held that Congress' objective " is the kind of expense-shifting to a few persons that amounts to a taking. This is especially clear where, as here, the alternative was for all taxpayers to shoulder the burden." *Id*. at 1338-1339.

The Act similarly compels physicians to bear the societal burden of the increasing cost of health care, without imposing any corresponding burden on insurers or patients or the general public. The Act does not compensate physicians for benefitting insurers and the taxpayer at the expense of physicians, and therefore violates the Fifth Amendment's proscription against taking private property for public use without just compensation.

The District Court erred in denying Plaintiff-Appellant's motion to obtain a preliminary injunction, based on Count IV, the Taking of private property without just compensation. Plaintiffs-Appellants, like so many other medical providers have suffered a 50% decrease in gross revenue in the past year. Cases at the IDR are not moving forward, the harm is irreparable. Moreover any Constitutional violation amounts to irreparable harm. Based on the merits of the Takings claim, Plaintiff-Appellants are likely to succeed on the merits. Finally, again given the collapse of medical practices and availability of quality medical care, the public interest is existentially harmed by the Act. Thus the public's interest weighs in favor of injunction. Therefore the preliminary injunction should have been granted.

The District Court's dismissal of Count IV for the Takings violation was erroneous. The United States Court of Appeals reviews a dismissal of a complaint

pursuant to Rule 12(b)(6) *de novo*. "The court accepts all well-pleaded allegations in the complaint as true, drawing all reasonable inferences in the plaintiff's favor." *Operating Local 649 Annuity v. Smith Barney Fund*, 595 F. 3d 86, 91 (2nd Cir. 2010). Accepting all the allegations set forth in the complaint and as amplified in the record, the motion to dismiss this Count was in error.

## CONCLUSION

For all of the aforementioned reasons, Plaintiffs-Appellants respectfully request this Court reverse the District Court's Order denying a preliminary injunction and dismissing the complaint.

Dated: New York,
New York, May 4, 2023

Respectfully Submitted,

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This brief complies with the type-volume limitation of Fed.R.App.P.32(a)(7)(B) because:
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Dated: May 4, 2023

## CERTIFICATE OF SERVICE

On May 4, 2023 I filed and served the foregoing CORRECTED BRIEF FOR PLAINTIFFS–APPELLANTS via this Court's electronic-filing system.

14-point font, Times New Roman.

Dated: New York,
New York, May 4, 2023

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