No. 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,

(Caption Continued on Inside Cover)

On Appeal from the United States District Court
for the Eastern District of New York, No. 2:21-cv-7208

BRIEF FOR APPELLEES U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, XAVIER BECERRA, U.S. OFFICE OF PERSONNEL MANAGEMENT, KIRAN AHUJA, U.S. DEPARTMENT OF LABOR, JULIE SU, U.S. DEPARTMENT OF THE TREASURY, JANET YELLEN

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Defendants-Appellees.

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INTRODUCTION

Millions of Americans pay substantially less for healthcare services received from "in network" providers—that is, from providers that are under contract with the patient's health plan or insurer— as compared to "out of network" providers. In many cases, however, a patient may be unable to avoid out-of-network care. In an emergency, a patient may have no control over where she receives treatment. And even in non-emergency situations, a patient who selects an in-network facility may nonetheless unknowingly receive treatment from an out-of-network provider at the facility, such as an anesthesiologist. Historically, patients in these situations would often find that their insurer would leave them individually responsible for much or all of the cost of this out-of-network care and the patient would receive a surprise bill from the out-of-network provider—often for an amount far beyond what the patient would have owed for the same treatment had it been provided by an in-network provider.

In 2020, Congress responded to this state of affairs by passing the No Surprises Act, which protects patients with employer-sponsored health plans or group or individual health insurance from surprise bills while allowing medical providers to seek further compensation from their patients' insurers. *See* Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 1182, 2757-2890 (2020). Two features of the Act are relevant here. *First*, the Act prevents surprise billing by capping patients' individual responsibility for the cost of certain out-of-network care at an amount comparable to what the patient would have owed had the patient received that

same care in-network. *Second*, the Act enables out-of-network providers to seek compensation from their patients' insurers (instead of from their patients individually). To that end, the Act creates a procedure for resolving potential disputes between providers and insurers whereby independent arbitrators may determine how much compensation a provider is entitled to receive from an insurer. Both the Act's limitation on surprise billing and its creation of a mechanism allowing out-of-network providers to receive compensation from insurers follow in the footsteps of legislation from a number of states, including New York, which had already enacted laws protecting patients covered by state-regulated health plans.

Plaintiffs here—a New York surgeon and his surgical practice—believe the Act to be "bad public policy" and wish to be able to send their individual patients balance bills for emergency care. *See* Corrected Brief for Plaintiffs-Appellants (Br.) 47-48, 53. Plaintiffs principally allege that the Act violates the Seventh Amendment on the theory that they are entitled to have a jury determine the value of their services. But plaintiffs make no real effort to defend the position that they asserted in district court and, instead, ask this Court to reverse the dismissal of their Seventh Amendment claim based on an entirely different theory than the one presented to the district court—a theory that they previously expressly disclaimed and that would require plaintiffs to prevail on a series of contested questions, several of which are not even addressed in plaintiffs' opening brief to this Court. Plaintiffs also renew their argument that the Act effects an

unconstitutional taking. But, as the district court correctly determined, the Takings Clause does not prevent Congress from protecting patients from surprise medical bills.

STATEMENT OF JURISDICTION

Plaintiffs invoked the district court's jurisdiction under 28 U.S.C. § 1331. JA-13. The district court granted the government's motion to dismiss and denied plaintiffs' motion for a preliminary injunction on August 10, 2022, JA-73, and entered judgment on August 11, 2022, JA-74-75. On October 31, 2022, plaintiffs' counsel moved for an extension of the time to file a notice of appeal. The district court granted the motion on November 3, 2022, finding that plaintiffs had shown excusable neglect. Text Order (Nov. 3, 2022). The district court set a deadline of November 17, 2022, for filing a notice of appeal. Text Order (Nov. 9, 2022). Plaintiffs filed a timely notice of appeal on November 17, 2022. Plaintiffs re-filed their notice of appeal under the correct ECF category on November 30, 2022. JA-77. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether plaintiffs have stated a claim that the No Surprises Act violates the Seventh Amendment.

2. Whether plaintiffs have stated a Takings Clause claim based on their assertion that the Act will deprive them of income that they hoped to gain from future out-of-network patients.

STATEMENT OF THE CASE

Plaintiffs Daniel Haller and Long Island Surgical PLLC brought suit in the U.S. District Court for the Eastern District of New York, alleging that certain provisions of the No Surprises Act—specifically, 42 U.S.C. §§ 300gg-111(c), 300gg-131, and 300gg-132—are unconstitutional. JA-13.[1] Plaintiffs sought declaratory and injunctive relief. JA-13. Ultimately, the district court denied plaintiffs' motion for a preliminary injunction and granted defendants' motion to dismiss, holding, as relevant here, that plaintiffs had not stated cognizable Seventh Amendment or Takings Clause claims. JA-71. The district court's decision is reported at 621 F. Supp. 3d 343.

A. Statutory Background

Congress passed the No Surprises Act in December 2020 to combat the devastating financial effects of surprise medical bills and to address a market failure that had been reflected in exorbitant bills to patients and inflated payment rates for those services. *See* H.R. Rep. No. 116-615, pt. I, at 53 (2020).

[1] The Act makes parallel amendments to the Public Health Service Act (administered by the Department of Health and Human Services), the Employee Retirement Income Security Act (administered by the Department of Labor), and the Internal Revenue Code (administered by the Internal Revenue Service within the Department of the Treasury). In addition, the Act requires the Office of Personnel Management to ensure that its contracts with carriers for federal employee health benefits conform to the same terms as those applicable to other insurers. 5 U.S.C. § 8902(p). For ease of reference, this brief cites to the Act's amendments to the Public Health Service Act.

1. Most group health plans and health insurance issuers (referred to collectively in this brief as insurers) "have a network of providers and health care facilities . . . who agree by contract to accept a specific amount for their services." *Requirements Related to Surprise Billing; Part I*, 86 Fed. Reg. 36,872, 36,874 (July 13, 2021). These negotiated in-network rates are usually less than the rates charged by out-of-network providers. *Id.* When a patient receives out-of-network care, her insurer might decline to pay for the services altogether or might pay just a portion of the out-of-network provider's bill, leaving the provider to "balance bill" the patient for the remainder of the charge. *Id.*

In some situations, patients have little or no control over whether they are treated by an out-of-network provider. In an emergency, for example, a patient may be transported by an out-of-network air ambulance, taken to an out-of-network hospital, or treated by out-of-network providers. *See* H.R. Rep. No. 116-615, pt. I, at 51. Even where a patient schedules a medical procedure in advance at an in-network facility, she may unknowingly receive services from out-of-network anesthesiologists, radiologists, or other ancillary providers. *Id.* As a result, patients in these situations often ended up receiving surprising—and sometimes substantial—balance bills. *Id.* at 51-52; 86 Fed. Reg. at 36,874; Erin L. Duffy et al., *Policies to Address Surprise Billing Can Affect Health Insurance Premiums*, 26 Am. J. Managed Care 401, 401 (2020).

This lack of patient control created a distortion in the market. Because providers in no-choice specialties may be able to increase their prices without significantly reducing patient demand, those providers have little incentive to negotiate fair prices in

advance for their services or to moderate charges for out-of-network care. If they remain out-of-network, they can bill patients "at essentially any rate they choose" without losing demand. *Examining Surprise Billing: Protecting Patients from Financial Pain: Hearing Before the H. Comm. on Educ. and Labor, Subcomm. on Health, Employment, Labor and Pensions*, 116th Cong. 8 (2019) (statement of Christen Linke Young, Brookings Inst.). Indeed, "physician specialties that are able to bill out-of-network have extraordinarily high charges compared to other doctors." *Id.*

This market distortion led to an increase in out-of-network billing. Eric C. Sun et al., *Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals*, 179 JAMA Internal Med. 1543, 1544 (2019). And as out-of-network billing grew more widespread, so too did surprise balance bills. *See, e.g.*, Erin L. Duffy et al., *Prevalence and Characteristics of Surprise Out-Of-Network Bills From Professionals in Ambulatory Surgery Centers*, 39 Health Affairs 783, 785 (2020) (finding 81 percent increase in average amounts of surprise bills at ambulatory surgical centers from 2014 to 2017, from $819 in 2014 to $1,483 in 2017); Zack Cooper et al., *Surprise! Out-Of-Network Billing for Emergency Care in the United States*, 128 J. Pol. Econ. 3626, 3627 (2020) (noting that "nearly half of individuals in the United States do not have the liquidity to pay an unexpected $400 expense without taking on debt").

Beyond the financial consequences in individual cases, the market distortion created by surprise billing has had the broader effect of driving up health care costs for everyone. When health care providers can readily bill out of network, they are also able

to demand higher in-network rates. "These higher payments get passed along to all consumers (including those who do not even access care) in the form of higher insurance premiums." Zach Cooper et al., *Out-of-Network Billing and Negotiated Payments for Hospital-Based Physicians*, 39 Health Affairs 24, 24 (2020). For example, emergency room physicians typically have been able to command higher in-network payment rates, a phenomenon "caused not by supply or demand but rather by the ability to ambush the patient." Cooper, *Surprise! Out-Of-Network Billing for Emergency Care in the United States*, *supra*, at 3628. Because emergency department care is so common, this practice "raise[s] overall health spending." *Id.* This has resulted in "commercial health insurance premiums as much as 5% higher than they otherwise would be in the absence of this market failure," Duffy, *Policies to Address Surprise Billing Can Affect Health Insurance Premiums*, *supra*, at 403, placing a financial burden "on employer plan sponsors as well as individuals," *Examining Surprise Billing: Protecting Patients from Financial Pain: Hearing Before the H. Comm. on Educ. and Labor, Subcomm. on Health, Employment, Labor and Pensions*, 116th Cong. 39 (statement of Ilyse Schuman, Vice-President, American Benefits Council).

2. Many states have enacted legislation aimed to curb the growing trend of surprise medical bills and rising health care costs. For example, New York, California, and Texas have prohibited balance billing of patients with state-regulated health insurance plans and created independent dispute resolution procedures for providers and insurers to negotiate payments directly without burdening patients. *See, e.g.*, N.Y.

Fin. Serv. Law §§ 603-605; Cal. Health & Safety Code §§ 1371.9, 1371.30; Tex. Ins. Code §§ 1271.155, 1271.157, 1271.158, 1467.051, 1467.084. In New York, the 2014 New York State Emergency Medical Services and Surprise Bill Law protects certain patients from surprise bills and establishes an arbitration system, which yields payment determinations that are binding on the insurer, provider, and patient and that are admissible in court proceedings. N.Y. Fin. Serv. Law. §§ 606-607. These state laws do not apply to self-funded group health plans, because the Employee Retirement Income Security Act (ERISA) governs those plans and generally preempts any contrary state laws.

3. To address surprise billing practices not covered by state laws, to take patients out of the middle of surprise billing disputes, and to rein in the cost of health care, Congress enacted the No Surprises Act in December 2020. Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. at 2758-2890.

Since its effective date of January 1, 2022, the Act has protected patients with private health coverage from the most common forms of surprise billing. If a covered patient receives emergency care, or if she receives care that is scheduled at an in-network facility, providers are generally prohibited (absent, in certain circumstances, the patient's consent) from balance billing the patient or taking her to court for the balance of the bill, even if she received services from an out-of-network provider. *See* 42 U.S.C. §§ 300gg-131, 300gg-132. Nor may patients face cost-sharing responsibilities beyond

what "would apply if such services were provided by a participating provider or a participating emergency facility." *Id.* § 300gg-111(a)(1)(C)(ii), (b)(1)(A).

The Act also enables providers to obtain compensation from insurers and establishes a procedure for resolving disputes between providers and insurers over out-of-network bills. After a provider submits a bill for its out-of-network service to the insurer, the insurer must respond by either issuing an initial payment determination or a notice of denial of payment. 42 U.S.C. § 300gg-111(a)(1)(C)(iv), (b)(1)(C). If the payment amount for a specific service is set by state law or by a state's all-payer model agreement under 42 U.S.C. § 1315a, that amount governs. 42 U.S.C. § 300gg-111(a)(3)(K); *id.* § 300gg-111(a)(1)(C)(iv), (b)(1)(C). Otherwise, if the provider is not satisfied with the insurer's response, either party may initiate a "30-day period" of "open negotiation." *Id.* § 300gg-111(c)(1)(A). If negotiations are unsuccessful, either party may—"during the 4-day period beginning on the day after [the] open negotiation period"—initiate the arbitration process (referred to in the Act as the independent dispute resolution, or IDR, process). *Id.* § 300gg-111(c)(1)(B).

The Act employs a "baseball style" arbitration system, in which each party must submit a proposed payment amount and justification, and the arbitration entity—certified under a government-established process—selects one of the proposals. 42 U.S.C. § 300gg-111(c)(5)(A)(i). Congress directed that in determining which proposal to select, arbitrators must consider the "qualifying payment amount" for a particular service—an amount that approximates the amount the provider would have received

under the terms of the patient's health plan had the provider been in-network. *Id.* § 300gg-111(c)(5)(C); *see also id.* § 300gg-111(a)(3)(E)(i) (defining "qualifying payment amount"). Arbitrators must also consider "information on any circumstance described in" a list of "[a]dditional circumstances," as well as any information "relating to" a party's offer that is either requested by the arbitrator or submitted by the party. *Id.* § 300gg-111(c)(5)(C)(i)-(ii), (c)(5)(B)(i)(II), (c)(5)(B)(ii). The list of "[a]dditional circumstances" for arbitrators to consider includes, for example, the provider's level of training and experience and the acuity of the patient or complexity of the procedure. *Id.* § 300gg-111(c)(5)(C)(ii). The arbitrator may not consider the provider's usual and customary charges for the service, the amount the provider would have billed in the absence of the Act, or the reimbursement rates for the service under public programs such as Medicare or Medicaid. *Id.* § 300gg-111(c)(5)(D). The arbitrator's decision is binding on the parties and is not subject to judicial review except under circumstances described in the Federal Arbitration Act. *Id.* §§ 300gg-111(c)(5)(E), 300gg-112(b)(5)(D).

If the final payment amount identified either through negotiation or arbitration is greater than the initial amount paid to the provider for the services furnished, the insurer must pay the provider the final amount for the services, offset by the patient's cost-sharing obligation and the amount already paid to the provider. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(II), (b)(1)(D).

B. Factual and Procedural Background

1. Plaintiff Daniel Haller is an acute care surgeon who practices at plaintiff Long Island Surgical PLLC in Rockville Center, New York. JA-15. Dr. Haller and the other surgeons of Long Island Surgical perform emergency consultations and surgical procedures on patients admitted to hospitals through emergency departments. JA-15. Plaintiffs are out-of-network providers for approximately 78% of their patients. JA-15.

Plaintiffs filed suit against the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, and the Office of Personnel Management—the agencies charged with implementing the Act, referred to here as the Departments—in December 2021, a year after the Act's passage and the day before the Act went into effect. JA-29. Plaintiffs sought a declaration that three provisions of the Act were unconstitutional, as well as a permanent injunction barring enforcement of those provisions against them. JA-13. As is relevant here, plaintiffs argued that 42 U.S.C. § 300gg-111(c), which establishes the arbitration process, exceeds Congress's authority and violates the Seventh Amendment by requiring plaintiffs to adjudicate common-law claims before an administrative tribunal rather than a jury. JA-22-23. Plaintiffs further argued that 42 U.S.C. §§ 300gg-131 and 300gg-132, which forbid providers from recovering the balance of their bills directly from patients, violate the Takings Clause by depriving them of property without just compensation. JA-25-26.

Four months after filing suit, plaintiffs sought a preliminary injunction prohibiting enforcement of the challenged provisions during the litigation. JA-44. The government opposed and moved to dismiss plaintiffs' suit for failure to state a claim.

2. The district court dismissed the case, noting that, "[w]hen Congress creates new statutory 'public rights,' it may assign their adjudication to an administrative agency . . . without violating the Seventh Amendment's injunction that jury trial is to be 'preserved' in 'suits at common law.'" JA-56 (quoting *Atlas Roofing Co. v. Occupational Safety & Health Review Comm'n*, 430 U.S. 442, 455 (1977)). Plaintiffs had asserted that they had a New York common law right to bring quantum meruit claims against patients for the balance of their bills. *See* ECF No. 23, at 12. Plaintiffs argued that the Act violated the Seventh Amendment and Article III by requiring them to litigate these claims before an arbitrator, rather than a jury. *Id.* at 9. The district court explained, however, that the Act's arbitration scheme does not adjudicate disputes between providers and patients—it adjudicates disputes between providers and insurers. JA-57. And plaintiffs had conceded that "out-of-network providers have no right of action under New York law to recover directly from health insurers." JA-57-58. As a result, "the Act does not compel providers to arbitrate state common law claims to which they had a right to a jury trial." JA-58. Any similarity between a provider's claims against patients versus insurers did not warrant a contrary conclusion, the court held, as "Congress may fashion causes of action that are closely analogous to common-law claims and place them beyond the ambit of the Seventh Amendment by assigning their

resolution to a forum in which jury trials are unavailable." JA-59 (quoting *Granfinanciera, S.A. v. Nordberg*, 492 U.S. 33, 52 (1989)).

The district court also rejected plaintiffs' Takings Clause challenge. The court held that the Act did not deprive plaintiffs of any protected property interest, JA-67-70, and instead "squarely [fell] within the category of legislation that serves to adjust the benefits and burdens of economic life on behalf of the common good." JA-66 (quoting *In re Chateaugay Corp.*, 53 F.3d 478, 496 (2d Cir. 1995)). The fact that the Act provided a mechanism for plaintiffs to receive from insurers the value of their services to patients only reinforced this conclusion. JA-67; JA-70.[2]

SUMMARY OF ARGUMENT

The No Surprises Act shields patients from surprise medical bills and, in return, provides a negotiation and arbitration mechanism that enables providers to seek compensation for their services from insurers. Plaintiffs' constitutional challenges to Congress's decision to regulate the health care market in this way are without merit.

I. Plaintiffs have not stated a viable Seventh Amendment claim. In district court, plaintiffs argued that their right to a jury trial was infringed because the Act preempts

[2] In district court, plaintiffs also argued that the Act's arbitration process violated due process, JA-24, and that an interim final rule issued by the Departments implementing the Act should be set aside under the Administrative Procedure Act, JA-26. Plaintiffs abandoned the latter challenge when the interim final rule was set aside in unrelated litigation. JA-48. And the district court dismissed plaintiffs' due process claim without prejudice as unripe. JA-65. Plaintiffs do not pursue either claim on appeal. *See* Br. 10.

their common law right to bill and to sue their patients. In making this argument, plaintiffs expressly conceded that they had no pre-existing "right of action under New York law to recover directly from health insurers," JA-57-58, and that the Act only limited their rights to sue their patients directly. On that understanding, the district court correctly concluded that plaintiffs' Seventh Amendment rights could not be infringed by the Act's arbitration mechanism, which is used to adjudicate providers' disputes with insurers, and not common law claims against individual patients. Claims against patients therefore cannot provide a basis for a Seventh Amendment violation.

Before this Court, plaintiffs provide no reasoned argument that the district court's ruling was incorrect on its own terms. Instead, plaintiffs attempt to retract concessions they made in district court and now present the entirely new argument that the Act violates the Seventh Amendment by interfering with supposedly pre-existing rights of out-of-network providers to obtain compensation from insurers (not just patients). But this novel argument is plainly forfeited, so the Court need not decide in the first instance whether plaintiffs' newly articulated position is correct. Nor is there any reason to excuse plaintiffs' forfeiture. Indeed, this case is a particularly poor candidate in which to excuse plaintiffs' forfeiture, as doing so could require the Court to resolve several complex and contested issues that were not briefed below and that the district court had no chance to address. For instance, the Court would need to decide whether plaintiffs had a common law right to bring unjust enrichment claims against insurers and, if so, whether such claims were legal or equitable in nature. And it

might need to pass on the argument raised by the American Association of Neurological Surgeons and the other provider amici that the Act's arbitration system "merely offers a voluntary alternative to civil litigation." Amicus Brief of Am. Ass'n of Neurological Surgeons et al. (Provider Amicus Br.) 4.

II. Plaintiffs' Takings Clause claim is similarly meritless. Plaintiffs have failed to identify any protected property interest impaired by the Act. Plaintiffs suggest that they have a property interest in the income they expected to make by balance billing patients. *See* Br. 56-57. But plaintiffs do not have a property interest in the money they hope to make in the future. To the extent that plaintiffs argue that they have a property interest in any future legal claims they might attempt to assert against their future patients absent the Act, that fails as well. Supreme Court case law "clearly establishe[s] that '[a] person has no property, no vested interest, in any rule of the common law.'" *Duke Power Co. v. Carolina Envtl. Study Grp., Inc.*, 438 U.S. 59, 88 n.32 (1978) (second alteration in original). Moreover, the impact of the statute on plaintiffs remains uncertain given their ability to obtain compensation from their patients' insurers.

STANDARD OF REVIEW

The district court's grant of a motion to dismiss is reviewed de novo. *Apotex Inc. v. Acorda Therapeutics, Inc.*, 823 F.3d 51, 59 (2d Cir. 2016).

ARGUMENT

I. Plaintiffs have not stated a Seventh Amendment claim.

1. The Seventh Amendment provides that "the right of trial by jury shall be preserved" in "[s]uits at common law, where the value in controversy shall exceed twenty dollars." U.S. Const. amend. VII. However, "when Congress properly assigns a matter to adjudication in a non-Article III tribunal, 'the Seventh Amendment poses no independent bar to the adjudication of that action by a nonjury factfinder.'" *Oil States Energy Servs., LLC v. Greene's Energy Grp., LLC*, 138 S. Ct. 1365, 1379 (2018) (quoting *Granfinanciera, S.A. v. Nordberg*, 492 U.S. 33, 53-54 (1989)). And even when an action must be tried under the auspices of an Article III court, the Seventh Amendment affords the parties a right to a jury trial only when "the cause of action is legal in nature." *Granfinanciera*, 492 U.S. at 53; *see id.* at 41 (explaining that the Seventh Amendment does not apply to suits in which "equitable rights alone were recognized, and equitable remedies were administered," as opposed to "suits in which *legal* rights were to be ascertained and determined" (quoting *Parsons v. Bedford, Breedlove & Robeson*, 28 U.S. (3 Pet.) 433, 447 (1830))).

Supreme Court precedent establishes that Article III courts (and by extension, juries) need not be available for the adjudication of so-called "public rights." *Granfinanciera*, 492 U.S. at 53-54; *Atlas Roofing Co. v. Occupational Safety & Health Review Comm'n*, 430 U.S. 442, 455 (1977). Public rights may be "closely *analogous* to common-law claims." *Granfinanciera*, 492 U.S. at 52. But "what makes a right 'public' rather than

private is that the right is integrally related to particular Federal Government action." *Stern v. Marshall*, 564 U.S. 462, 490-91 (2011). While the government need not be a party, the case must be one "in which the claim at issue derives from a federal regulatory scheme, or in which resolution of the claim by an expert Government agency is deemed essential to a limited regulatory objective within the agency's authority." *Id.* at 490. Where the federal government is not a party to the proceeding, the question "is whether 'Congress, acting for a valid legislative purpose pursuant to its constitutional powers under Article I, [has] create[d] a seemingly "private" right that is so closely integrated into a public regulatory scheme as to be a matter appropriate for agency resolution with limited involvement by the Article III judiciary.'" *Granfinanciera*, 492 U.S. at 54 (alterations in original) (quoting *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 593-94 (1985)).

2. In district court, plaintiffs argued that the No Surprises Act violated the Seventh Amendment by preventing them from bringing common law quantum meruit claims against their patients for the value of their services beyond what they could obtain from insurers. *See, e.g.*, JA-17 ("[T]he physician is entitled under New York law to be paid for the services he or she has rendered on the basis of an implied contract with the patient."); JA-23 ("A physician's action to recover the reasonable value of services rendered to a patient is an action at law where the measure of damages is *quantum meruit*."); *see also* ECF No. 23, at 12 (asserting a jury trial right for "lawsuits by an out-of-network physician against patients with whom the physician has no contract

to recover the value of services rendered"). Consistent with that patient-focused theory, plaintiffs conceded in district court that "out-of-network providers have no right of action under New York law to recover directly from health insurers." *See* JA-57-58; *see also Buffalo Emergency Assocs., LLP v. Aetna Health, Inc.*, 195 A.D.3d 1403, 1404 (N.Y. App. Div.) (discussing precedent that an out-of-network provider lacks common-law claims against an insurer independent of New York's analogue to the No Surprises Act), *leave to appeal denied*, 178 N.E.3d 941 (N.Y. 2021).

On this understanding, the district court concluded that "the Act does not compel providers to arbitrate state common law claims to which they had a right to a jury trial," JA-58, and therefore did not violate the Seventh Amendment, JA-57. The challenged arbitration system "does not adjudicate payment disputes between out-of-network doctors and their patients." JA-57. On the contrary, it aims to eliminate surprise-billing disputes between providers and patients. H.R. Rep. No. 116-615, pt. I, at 55 ("There is widespread agreement that any surprise billing solution must comprehensively protect consumers by 'taking the consumer out of the middle' of surprise billing disputes."). The challenged arbitration system only adjudicates claims against insurers, not patients, *see, e.g.*, 42 U.S.C. § 300gg-111(c)(1)(B); claims against patients are therefore irrelevant to the Seventh Amendment analysis. And, likewise, the Seventh Amendment cannot be violated by Congress's creation of a "new public right" that allows "health care providers to recover payment directly from insurers for out-of-network services." JA-59.

In this Court, plaintiffs do not meaningfully challenge the district court's rejection of plaintiffs' Seventh Amendment claim as it was framed in district court. They briefly assert that "[f]orbidding a physician from recouping compensation for saving a person's life by sending a bill to him or her" violates the Seventh Amendment. *See* Br. 47; *see also* Br. 50. But plaintiffs offer no analysis to support that assertion. And to the extent plaintiffs believe that the Seventh Amendment provides an affirmative right to the adjudication of any and all common law claims—much less an immutable right to balance bill their patients—they are mistaken. The Seventh Amendment does not require that any claims be available—only that, when certain types of claims are adjudicated, the litigants have a right to a jury trial. And it is well settled that Congress can extinguish common law claims altogether. *See Duke Power Co. v. Carolina Envtl. Study Grp., Inc.*, 438 U.S. 59, 88 n.32 (1978) (explaining that the Constitution does not forbid the "the abolition of old [rights] recognized by the common law to attain a permissible legislative object" (citation omitted)).

3. Plaintiffs' principal theory on appeal is not that the district court erred in rejecting the argument they made below but, rather, that the district court should have found a Seventh Amendment violation based on a theory entirely different from the one they had pressed. Plaintiffs acknowledge in their brief to this Court that "counsel for Plaintiffs below conceded that that a medical provider cannot sue an insurer." Br. 32 n.2. But plaintiffs now argue that this concession was "made in error." Br. 32 n.2. They assert that "there is an abundance of common law demonstrating that providers

do indeed have a common law right to sue insurers in Article III [c]ourts[] for compensation for services to out-of-network patients." Br. 26. And on that basis, plaintiffs now argue that the Act violates the Seventh Amendment by assigning these supposed pre-existing claims that providers had against insurers (not patients) to resolution by an arbitrator.

This Court need not reach the merits of this argument because it has been squarely forfeited. "It is well settled that arguments not presented to the district court are considered waived and generally will not be considered for the first time on appeal." *In re Anderson*, 884 F.3d 382, 388 (2d Cir. 2018) (quoting *Anderson Grp., LLC v. City of Saratoga Springs*, 805 F.3d 34, 50 (2d Cir. 2015)); *accord United States ex rel. Keshner v. Nursing Pers. Home Care*, 794 F.3d 232, 234 (2d Cir. 2015); *Wal-Mart Stores, Inc. v. Visa U.S.A., Inc.*, 396 F.3d 96, 124 n.29 (2d Cir. 2005).

Plaintiffs note that this Court could nonetheless choose to take the unusual step of excusing their forfeiture. But plaintiffs identify no reason for their failure to raise this argument below. Nor is their argument on appeal based on new information—rather, all but one of the decisions on which their new argument relies predates its suit. *See* Br. 37. Under the circumstances, there is no reason to excuse the forfeiture. *See In re Anderson*, 884 F.3d at 389 (recognizing "the circumstances normally do not militate in favor of an exercise of discretion to address . . . new arguments on appeal where those arguments were available to the parties below and they proffer no reason for their

failure to raise the arguments below" (alteration in original) (quoting *In re Nortel Networks Corp. Sec. Litig.*, 539 F.3d 129, 133 (2d Cir. 2008) (per curiam))).

There are several reasons why this case would be a particularly inappropriate instance in which to allow plaintiffs to present a novel claim on appeal. For one thing, plaintiffs' newly minted Seventh Amendment claim is disconnected from the heart of their grievance with the No Surprises Act. The Act implements two reforms: (1) limiting the ability of out-of-network providers to bill and sue their patients; and (2) creating a process through which providers can recover from insurers, including through arbitration. As framed in this Court, plaintiffs' Seventh Amendment claim targets the second of these reforms (which assigns the allegedly pre-existing common law claims against insurers to a non-Article III forum). Yet plaintiffs' brief repeatedly makes clear that their core objection to the Act is not that it requires them to use arbitration when pursuing compensation from insurers but, rather, that they can no longer bill and sue their patients. *See, e.g.*, Br. 50 ("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."); *see* Br. 49 ("The Act's absolute prohibition against sending a bill to a patient is a far greater Constitutional violation than even the required [arbitration] process . . . ."). Plaintiffs do not appear to be interested only in invalidation of the Act's arbitration provisions. Given that plaintiffs' new legal theory is tangential to plaintiffs' alleged injury, the Court should not take the unusual step of considering it in the first instance.

Reaching the merits of plaintiffs' reformulated Seventh Amendment claim could also require the Court to resolve several issues that were not briefed below and that the district court has had no chance to address. *First*, the Court would need to determine whether plaintiffs are correct that providers had a pre-existing right to seek recovery from insurers. *Second*, if so, the Court would need to determine the scope of that right. *Third*, the Court would need to determine whether the putative pre-existing right was legal or equitable in nature. *Finally*, if the claims are legal, the Court would need to determine whether the No Surprises Act deprives plaintiffs of the opportunity to bring a claim before a jury in an Article III court.

Each of these questions is contested and plaintiffs' briefing fails to provide any basis to conclude that plaintiffs will successfully establish even one, let alone all, of the propositions necessary to their newly formulated claim. As to the threshold issue of whether out-of-network providers had a pre-existing right to sue insurers with whom they had no contractual relationship, plaintiffs previously found the law clear enough that they conceded that no such right existed. *See Buffalo Emergency Assocs.*, 195 A.D.3d at 1404 (suggesting providers did not have such a right); *see also Pekler v. Health Ins. Plan of Greater N.Y.*, 67 A.D.3d 758, 760 (N.Y. App. Div. 2009) ("As the complaint alleges that medical services were performed by the plaintiff doctors at the behest of their patients, no claim in quantum meruit can be asserted against the defendants . . . ."); *Kirell v. Vytra Health Plans Long Island, Inc.*, 29 A.D.3d 638, 639 (N.Y. App. Div. 2006). While plaintiffs now insist that case law provides robust support for the existence of

such a right, they cite little more than scattered trial court decisions. *See* Br. 37 (citing *Josephson v. Oxford Health Ins., Inc.*, No. 0443/07, 2014 WL 12879617 (N.Y. Sup. Ct. Aug. 26, 2014); *Josephson v. Oxford Health Ins., Inc.*, No. 0443/07, 2012 WL 3449413 (N.Y. Sup. Ct. July 31, 2012); *New York City Health & Hosps. Corp. v. Wellcare of N.Y., Inc.*, 937 N.Y.S.2d 540 (Sup. Ct. 2011); *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, No. 20-cv-9183 (JGK), 2023 WL 2772285 (S.D.N.Y. Apr. 4, 2023); *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, No. 20-cv-9183 (AJN), 2021 WL 4437166 (S.D.N.Y. Sept. 28, 2021)). These are not authoritative determinations by New York courts. Moreover, any analysis of the question would need to consider the possible impact of New York's enactment of its own law regulating surprise billing, which post-dated several of the decisions on which plaintiffs rely.

If the Court were to determine that providers had a cause of action against insurers in some circumstances, it would then need to determine the extent of that right. Plaintiffs' cases do not support the existence of a right for out-of-network providers to collect from insurers in every payment dispute. The analysis in *Wellcare*, for example, is tied to the insurer's status as a Medicare Advantage plan that had assumed "responsib[ility] for paying providers, whether contracted providers or non-contract providers, for services provided to stabilize an emergency condition." 937 N.Y.S.2d at 542. Even then, the opinion contemplated only that a hospital might bring an unjust enrichment claim "for the costs incurred in rendering the necessary treatment to the insurer's enrollees" where the "hospital is required by law to treat patients in an

emergency room." *Id.* at 545; *see also Emergency Physician Servs.*, 2021 WL 4437166, at *12; *Emergency Physician Servs.*, 2023 WL 2772285, at *3. And although plaintiffs imply that all of their bills fall under this category, *see* Br. 28, 44, their own materials do not bear that out, *see, e.g.*, JA-38 (plaintiffs "often render" "covered non-emergency services to include treatment, equipment and devices, and preoperative and postoperative services."). An unreported state trial court decision did say that, "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." *Josephson*, 2012 WL 3449413. But that case involved rights that had by assigned by patients to the provider in question and thus does not establish any right of a provider to assert its own, non-derivative claim against an insurer with whom the provider lacks any contractual relationship. *Id.* And the same trial court later concluded that many of the provider's claims would be preempted by ERISA because they were "not based upon a duty independent of [the insurer's] duty to pay benefits pursuant to [an] ERISA plan." *Josephson*, 2014 WL 12879617, at *4.

Next, even if the Court were satisfied that plaintiffs had common law claims against insurers that predated the No Surprises Act that were of sufficient scope to support a facial challenge to the Act's arbitration scheme, the Court would then need to decide whether these common law claims were legal or equitable. The Seventh Amendment is not applicable to claims that sound in equity. Yet, plaintiffs nowhere attempt to demonstrate that providers had a right to a jury trial in suits against insurers.

And at least some New York authority suggests otherwise. *See Connolly v. Griffin*, 201 A.D.2d 371, 372 (N.Y. App. Div. 1994) ("[I]nasmuch as plaintiff, in his fourth cause, seeks recovery under the equitable doctrine of quantum meruit, he has no statutory right to a jury trial on that cause . . . ."); *see also* Provider Amicus Br. 25 (acknowledging "state law varies, so some providers' state-law claims could conceivably be considered equitable, and thus beyond the Seventh Amendment's protections").

Finally, the Act's arbitration scheme can only raise constitutional concerns if it is mandatory and deprives providers of any common law rights that they may have to assert claims in court against insurers. Notably, the Provider Amici dispute that proposition and argue that the Act "merely offers a voluntary alternative to civil litigation." Provider Amicus Br. 4. To be clear, the Departments do not endorse the Provider Amici's reading of the Act. *See, e.g.*, 42 U.S.C. § 300gg-111(c)(5)(B)(i) (once an arbitrator has been selected, the provider and insurer "shall each submit to the [arbitrator] . . . an offer for a payment amount"); *id.* § 300gg-111(a)(1)(C)(iv)(II), (b)(1)(C) (requiring insurers to pay the provider the "out-of-network rate," which—if not determined by state law—is either an agreed-on amount or the amount determined by the arbitrator); *see also id.* § 300gg-111(a)(3)(K). But this additional point of contention underscores the number of questions this Court would need to decide in the first instance were it to excuse plaintiffs' forfeiture and consider their new Seventh Amendment argument.

For these reasons, the Court should decide this case on the premise on which it was litigated below and avoid the series of contested questions that would be necessary to resolve plaintiffs' new claim. The Court need not endorse a view of whether the premise on which the case was litigated is correct. Rather, it is sufficient to hold that these plaintiffs in this particular case have failed to state a viable Seventh Amendment claim.[3]

4. Plaintiffs' brief is also replete with arguments as to why, in plaintiffs' view, it would be better public policy to allow them to bill and sue their patients. *See, e.g.*, Br. 47-50. But this policy judgment—with which Congress has plainly disagreed—does not establish a constitutional violation. And in the absence of any constitutional defect, there is no basis for setting aside Congress's policy determination.

II. Plaintiffs have not stated a Takings Clause claim.

1. The Takings Clause of the Fifth Amendment states that "private property [shall not] be taken for public use, without just compensation." U.S. Const. amend. V. "The Fifth Amendment's Takings Clause prevents the Legislature . . . from depriving private persons of vested property rights . . . ." *Landgraf v. USI Film Prods.*, 511 U.S. 244, 266 (1994). As a result, there can be no Takings Clause violation if the plaintiff does

[3] If this Court were to disagree and to take the unusual step of allowing plaintiffs to maintain a theory they disclaimed in district court, it would be appropriate to remand to allow the district court to have the opportunity to address the novel questions implicated by plaintiffs' new argument.

not identify a property interest of which they were deprived. *See Knick v. Township of Scott*, 139 S. Ct. 2162, 2169-70 (2019).

If government action does impair a plaintiff's protected property interest, the court must then decide "whether a governmental action has gone beyond 'regulation' and effect[ed] a 'taking.'" *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1005 (1984). In answering this question, the court will consider, *inter alia*, "the character of the governmental action, its economic impact, and its interference with reasonable investment-backed expectations." *Id.* (quoting *PruneYard Shopping Ctr. v. Robins*, 447 U.S. 74, 83 (1980)); *Penn Cent. Transp. Co. v. City of New York*, 438 U.S. 104, 124 (1978). Unsurprisingly, "[a] 'taking' may more readily be found when the interference with property can be characterized as a physical invasion by government than when interference arises from some public program adjusting the benefits and burdens of economic life to promote the common good." *Penn Cent.*, 438 U.S. at 124 (citation omitted).

2. The Act has not deprived plaintiffs of any property interest. Congress has limited plaintiffs' ability to bring future suits against their future patients seeking compensation for certain out-of-network care. But Supreme Court case law "clearly establishe[s] that '[a] person has no property, no vested interest, in any rule of the common law.'" *Duke Power Co.*, 438 U.S. at 88 n.32 (second alteration in original). Consistent with that principle, "[t]he 'Constitution does not forbid the creation of new rights, or the abolition of old ones recognized by the common law, to attain a

permissible legislative object,' despite the fact that 'otherwise settled expectations' may be upset thereby." *Id.* (citation omitted). Unsurprisingly, therefore, "statutes limiting liability are relatively commonplace and have consistently been enforced by the courts." *Id.*

This principle is illustrated by litigation over the Protection of Lawful Commerce in Arms Act, which extinguished certain preexisting causes of action against firearms manufacturers. *See* 15 U.S.C. §§ 7901-7903. Parties across the country challenged the law, arguing in part that it effectuated an unconstitutional taking. Every court to address the argument rejected it. *See Ileto v. Glock, Inc.*, 565 F.3d 1126, 1141 (9th Cir. 2009) (no unconstitutional taking because a plaintiff's property rights in a "cause of action do[] not vest until a final unreviewable judgment is obtained" (quotation marks omitted)); *District of Columbia v. Beretta U.S.A. Corp.*, 940 A.2d 163, 180-82 (D.C. 2008) (same); *see also City of New York v. Beretta U.S.A. Corp.*, 401 F. Supp. 2d 244, 294 (E.D.N.Y. 2005) (no due process violation because the city lacked a protectable interest in its prospective tort claim), *aff'd in part, rev'd in part*, 524 F.3d 384 (2d Cir. 2008).

Similarly here, plaintiffs cannot claim that an abrogation of a right to bring future suits against their future patients constitutes an impermissible taking.

3. Plaintiffs fare no better in characterizing their claim as one of entitlement to "their property rights to the reasonable value of the services they have rendered." JA-25. By this, plaintiffs mean that they have a property interest in "[t]he reasonable calculation of [their] future income stream," Br. 56, and in "all of the projections of

investment-backed expectations and uncertainties of compensation," Br. 57. According to plaintiffs, they "can reasonably calculate [their] expected income for any given year." Br. 56. Even if that is so, plaintiffs do not have a property interest in the money they hope—or even expect—to make in the future. *See College Sav. Bank v. Florida Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 672, 675 (1999) (rejecting the argument that there is a property right "to be secure in one's business interests" because "the activity of making a profit is not property in the ordinary sense" (emphasis omitted)). A "unilateral expectation" is not enough. *Monsanto*, 467 U.S. at 1005-06 (quoting *Webb's Fabulous Pharmacies, Inc. v. Beckwith*, 449 U.S. 155, 161 (1980)).

Plaintiffs' unsupported assertion (Br. 59) that they "have suffered a 50% decrease in gross revenue in the past year" is no answer. Even if that were related to the Act (a connection that plaintiffs make no attempt to establish), it would not establish that plaintiffs had a property interest in that revenue or that the loss of it constitutes a taking. As a preliminary matter, plaintiffs had a year's notice that they would not be able to balance bill for any services covered by the Act provided on or after the Act's effective date. *See* 42 U.S.C. §§ 300gg-131(a), 300gg-132(a). And, "[g]overnment hardly could go on if to some extent values incident to property could not be diminished without paying for every such change in the general law." *Penn Cent.*, 438 U.S. at 124 (quoting *Pennsylvania Coal Co. v. Mahon*, 260 U.S. 393, 413 (1922)). Unsurprisingly, therefore, the Court has "recognized, in a wide variety of contexts, that government may execute laws or programs that adversely affect recognized economic values." *Id.* Nor do

governmental programs need to impose identical burdens across society—"[l]egislation designed to promote the general welfare commonly burdens some more than others." *74 Pinehurst LLC v. New York*, 59 F.4th 557, 568 (2d Cir. 2023) (alteration in original) (quoting *Penn Cent.*, 438 U.S. at 133).

The authorities relied on by plaintiffs are far afield. In *Monsanto*, the Supreme Court did not, as plaintiffs claim, conclude that Monsanto had a property interest in "the future value of a trade secret, which had not yet vested." *See* Br. 56. Rather, it concluded that Monsanto's existing trade secrets—which predated the challenged law and which were expressly recognized as property by Missouri state law—constituted the sort of property protected by the Takings Clause. *Monsanto*, 467 U.S. at 1001, 1003-04. That holding did not turn on whether a precise "assessment of damages" (Br. 56) was possible at that moment but on whether Monsanto had a protected property interest. *Monsanto*, 467 U.S. at 1003-04. Moreover, the Court ultimately concluded that the government had not, for the most part, effected a taking of that property interest. *Id.* at 1007-10. Once the statute in question was amended to authorize disclosure of certain data submitted to the agency, "Monsanto could not have had a reasonable, investment-backed expectation that [the agency] would keep the data confidential beyond the limits prescribed in the amended statute itself." *Id.* at 1006. Here, too, plaintiffs can have no investment-backed expectations in their ability to obtain compensation from their patients (rather than insurers) for any patient treated after the

Act went into effect. *See supra* at 29. Nor have plaintiffs alleged that they have been stymied in any attempts to be compensated for health services before that date.

Cienega Gardens v. United States, 331 F.3d 1319, 1328 (Fed. Cir. 2003), is even further afield. *See* Br. 57-58. There, the plaintiffs had received federally insured loans to build low-income housing on the land they owned. *Cienega Gardens*, 331 F.3d at 1325, 1328. The Federal Circuit held that the plaintiffs' real property interests had vested "upon execution of the mortgage loan agreement and the purchase of the land," long before the challenged statutes were enacted. *Id.* at 1328-29 ("'[E]very sort of [real property] interest the citizen may possess' counts as a property interest under the Fifth Amendment." (second alteration in original)). Those real property rights were nothing like plaintiffs' contingent interest in future profits.

4. Plaintiffs' Takings claim also fails because it is speculative and premature. A Takings claim is premature when the claimant's property has not, in fact, been taken. *See Horne v. Department of Agric.*, 569 U.S. 513, 525 (2013). "This requirement ensures that a plaintiff has actually 'been injured by the Government's action' and is not prematurely suing over a hypothetical harm." *Pakdel v. City & County of San Francisco*, 141 S. Ct. 2226, 2230 (2021) (per curiam) (quoting *Horne*, 569 U.S. at 525). Here, plaintiffs brought suit before the effective date of the Act and, thus, before they could demonstrate any experience with the Act's arbitration system. Plaintiffs assert that the

arbitration system will not provide them with fair value for their services. But on the record before this Court, that is only speculation.[4]

CONCLUSION

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

Respectfully submitted,

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[4] Plaintiffs ask this Court to reverse the district court's denial of their motion for a preliminary injunction. *See* Br. 52-53, 59. If this Court reverses the grant of the Departments' motion to dismiss, it should remand and allow the district court to weigh the equitable factors and determine in the first instance whether a preliminary injunction is warranted. *Cf. Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 32 (2008).

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 8,241 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Word for Microsoft 365 in Garamond 14-point font, a proportionally spaced typeface.

/s/ Sarah J. Clark
SARAH J. CLARK

ADDENDUM

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42 U.S.C. § 300gg-111

§ 300gg-111. Preventing surprise medical bills

(a) Coverage of emergency services

(1) In general

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

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

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

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

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

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

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

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

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

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

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

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

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

* * *

(3) Definitions

In this part and part E:

* * *

(E) Qualifying payment amount

(i) In general

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

(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer,

respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market (specified in subclause (I), (II), (III), or (IV) of clause (iv)) as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

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

(ii) New plans and coverage

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

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

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

(iii) Insufficient information; newly covered items and services

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

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

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

index for all urban consumers (United States city average) over such previous year;

(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term qualifying payment amount in clause (i)(I), except that in applying such clause to such item or service, the reference to "furnished during 2022" shall be treated as a reference to furnished during such first sufficient information year, the reference to "in 2019"[1] shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

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

(iv) Insurance market

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

(I) The individual market.

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

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

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

(v) Definitions

For purposes of this subparagraph:

(I) First coverage year

The term "first coverage year" means, with respect to a group health plan or group or individual health insurance

coverage offered by a health insurance issuer and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

(II) First sufficient information year

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

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

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

(III) Newly covered item or service

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

* * *

(K) Out-of-network rate

The term "out-of-network rate" means, with respect to an item or service furnished in a State during a year to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage

offered by a health insurance issuer receiving such item or service from a nonparticipating provider or nonparticipating emergency facility-

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

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

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

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

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

* * *

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

(1) In general

In the case of items or services (other than emergency services to which subsection (a) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering group or individual health insurance coverage furnished to a participant, beneficiary, or enrollee of such plan or coverage by a

nonparticipating provider (as defined in subsection (a)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 300gg–132(d) of this title) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively-

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

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

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

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

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

* * *

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

(1) Determination through open negotiation

(A) In general

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

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

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

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

(A) Establishment

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

(B) Authority to continue negotiations

Under the independent dispute resolution process, in the case that the parties to a determination for a qualified IDR item or service agree on a payment amount for such item or service during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of subsection (a)(3)(K)(ii) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

(C) Clarification

A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 300gg–132 of this title with respect to such item or service pursuant to subsection (b) of such section.

(3) Treatment of batching of items and services

(A) In general

Under the IDR process, the Secretary shall specify criteria under which multiple qualified IDR dispute items and services are permitted to be

considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the IDR process. Such items and services may be so considered only if-

(i) such items and services to be included in such determination are furnished by the same provider or facility;

(ii) payment for such items and services is required to be made by the same group health plan or health insurance issuer;

(iii) such items and services are related to the treatment of a similar condition; and

(iv) such items and services were furnished during the 30 day 4 period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by the Secretary, for use in limited situations, such as by the consent of the parties or in the case of low-volume items and services, to encourage procedural efficiency and minimize health plan and provider administrative costs.

(B) Treatment of bundled payments

In carrying out subparagraph (A), the Secretary shall provide that, in the case of items and services which are included by a provider or facility as part of a bundled payment, such items and services included in such bundled payment may be part of a single determination under this subsection.

(4) Certification and selection of IDR entities

(A) In general

The Secretary, in consultation with the Secretary of Labor and Secretary of the Treasury, shall establish a process to certify (including to recertify) entities under this paragraph. Such process shall ensure that an entity so certified-

(i) has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to make determinations described in paragraph (5) on a timely basis;

(ii) is not-

(I) a group health plan or health insurance issuer offering group or individual health insurance coverage, provider, or facility;

(II) an affiliate or a subsidiary of such a group health plan or health insurance issuer, provider, or facility; or

(III) an affiliate or subsidiary of a professional or trade association of such group health plans or health insurance issuers or of providers or facilities;

(iii) carries out the responsibilities of such an entity in accordance with this subsection;

(iv) meets appropriate indicators of fiscal integrity;

(v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations;

(vi) does not under the IDR process carry out any determination with respect to which the entity would not pursuant to subclause (I), (II), or (III) of subparagraph (F)(i) be eligible for selection; and

(vii) meets such other requirements as determined appropriate by the Secretary.

(B) Period of certification

Subject to subparagraph (C), each certification (including a recertification) of an entity under the process described in subparagraph (A) shall be for a 5-year period.

(C) Revocation

A certification of an entity under this paragraph may be revoked under the process described in subparagraph (A) if the entity has a pattern or practice of noncompliance with any of the requirements described in such subparagraph.

(D) Petition for denial or withdrawal

The process described in subparagraph (A) shall ensure that an individual, provider, facility, or group health plan or health insurance issuer offering group or individual health insurance coverage may petition for a denial of a certification or a revocation of a certification with respect to an entity under this paragraph for failure of meeting a requirement of this subsection.

(E) Sufficient number of entities

The process described in subparagraph (A) shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (5).

(F) Selection of certified IDR entity

The Secretary shall, with respect to the determination of the amount of payment under this subsection of an item or service, provide for a method-

(i) that allows for the group health plan or health insurance issuer offering group or individual health insurance coverage and the nonparticipating provider or the nonparticipating emergency facility (as applicable) involved in a notification under paragraph (1)(B) to jointly select, not later than the last day of the 3-business day period following the date of the initiation of the process with respect to such item or service, for purposes of making such determination, an entity certified under this paragraph that-

(I) is not a party to such determination or an employee or agent of such a party;

(II) does not have a material familial, financial, or professional relationship with such a party; and

(III) does not otherwise have a conflict of interest with such a party (as determined by the Secretary); and

(ii) that requires, in the case such parties do not make such selection by such last day, the Secretary to, not later than 6 business days after such date of initiation-

(I) select such an entity that satisfies subclauses (I) through (III) of clause (i)); 2 and

(II) provide notification of such selection to the provider or facility (as applicable) and the plan or issuer (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the "certified IDR entity" with respect to such determination.

(5) Payment determination

(A) In general

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

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

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

(B) Submission of offers

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

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

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

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

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

(C) Considerations in determination

(i) In general

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

(I) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are

comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

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

(ii) Additional circumstances

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

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

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

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

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

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

(D) Prohibition on consideration of certain factors

In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the

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

(E) Effects of determination

(i) In general

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

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

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

(ii) Suspension of certain subsequent IDR requests

In the case of a determination of a certified IDR entity under subparagraph (A), with respect to an initial notification submitted under paragraph (1)(B) with respect to qualified IDR items and services and the two parties involved with such notification, the party that submitted such notification may not submit during the 90-day period following such determination a subsequent notification under such paragraph involving the same other party to such notification with respect to such an item or service that was the subject of such initial notification.

(iii) Subsequent submission of requests permitted

In the case of a notification that pursuant to clause (ii) is not permitted to be submitted under paragraph (1)(B) during a 90-day period specified in such clause, if the end of the open negotiation period specified in paragraph (1)(A), that but for this clause would otherwise apply with respect to such notification, occurs during

such 90-day period, such paragraph (1)(B) shall be applied as if the reference in such paragraph to the 4-day period beginning on the day after such open negotiation period were instead a reference to the 30-day period beginning on the day after the last day of such 90-day period.

(iv) Reports

The Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall examine the impact of the application of clause (ii) and whether the application of such clause delays payment determinations or impacts early, alternative resolution of claims (such as through open negotiations), and shall submit to Congress, not later than 2 years after the date of implementation of such clause an interim report (and not later than 4 years after such date of implementation, a final report) on whether any group health plans or health insurance issuers offering group or individual health insurance coverage or types of such plans or coverage have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day period described in such clause, including recommendations on ways to discourage such a pattern or practice.

(F) Costs of independent dispute resolution process

In the case of a notification under paragraph (1)(B) submitted by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group or individual health insurance coverage and submitted to a certified IDR entity-

(i) if such entity makes a determination with respect to such notification under subparagraph (A), the party whose offer is not chosen under such subparagraph shall be responsible for paying all fees charged by such entity; and

(ii) if the parties reach a settlement with respect to such notification prior to such a determination, each party shall pay half of all fees charged by such entity, unless the parties otherwise agree.

(6) Timing of payment

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

under paragraph (1), shall be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made.

(7) Publication of information relating to the IDR process

(A) Publication of information

For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall make available on the public website of the Department of Health and Human Services-

(i) the number of notifications submitted under paragraph (1)(B) during such calendar quarter;

(ii) the size of the provider practices and the size of the facilities submitting notifications under paragraph (1)(B) during such calendar quarter;

(iii) the number of such notifications with respect to which a determination was made under paragraph (5)(A);

(iv) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made;

(v) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount, specified by items and services;

(vi) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

(vii) the total amount of fees paid under paragraph (8) during such calendar quarter; and

(viii) the total amount of compensation paid to certified IDR entities under paragraph (5)(F) during such calendar quarter.

(B) Information

For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under paragraph (1)(B) by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group or individual health insurance coverage-

(i) a description of each item and service included with respect to such notification;

(ii) the geography in which the items and services with respect to such notification were provided;

(iii) the amount of the offer submitted under paragraph (5)(B) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider or nonparticipating emergency facility (as applicable) expressed as a percentage of the qualifying payment amount;

(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider or facility (as applicable) and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

(v) the category and practice specialty of each such provider or facility involved in furnishing such items and services;

(vi) the identity of the health plan or health insurance issuer, provider, or facility, with respect to the notification;

(vii) the length of time in making each determination;

(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

(ix) any other information specified by the Secretary.

(C) IDR entity requirements

For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines necessary to carry out the provisions of this subsection.

(D) Clarification

The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

(8) Administrative fee

(A) In general

Each party to a determination under paragraph (5) to which an entity is selected under paragraph (3) 5 in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

(B) Amount of fee

The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

(9) Waiver authority

The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period described in paragraph (5)(E)(ii), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

* * *

42 U.S.C. § 300gg-131

§ 300gg-131. Balance billing in cases of emergency services

(a) In general

In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished during a plan year beginning on or after January 1, 2022, emergency services (for which benefits are provided under the plan or coverage) with respect to an emergency medical condition with respect to a visit at an emergency department of a hospital or an independent freestanding emergency department—

(1) in the case that the hospital or independent freestanding emergency department is a nonparticipating emergency facility, the emergency department of a hospital or independent freestanding emergency department shall not bill, and shall not hold liable, the participant, beneficiary, or enrollee for a payment amount for such emergency services so furnished that is more than the cost-sharing requirement for

such services (as determined in accordance with clauses (ii) and (iii) of section 300gg–111(a)(1)(C) of this title, of section 9816(a)(1)(C) of title 26, and of section 1185e(a)(1)(C) of title 29, as applicable); and

(2) in the case that such services are furnished by a nonparticipating provider, the health care provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing requirement for such services furnished by the provider (as determined in accordance with clauses (ii) and (iii) of section 300gg–111(a)(1)(C) of this title, of section 9816(a)(1)(C) of title 26, and of section 1185e(a)(1)(C) of title 29, as applicable).

(b) Definition

In this section, the term "visit" shall have such meaning as applied to such term for purposes of section 300gg–111(b) of this title.

42 U.S.C. § 300gg-132

§ 300gg-132. Balance billing in cases of non-emergency services performed by nonparticipating providers at certain participating facilities

(a) In general

Subject to subsection (b), in the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished during a plan year beginning on or after January 1, 2022, items or services (other than emergency services to which section 300gg–131 of this title applies) for which benefits are provided under the plan or coverage at a participating health care facility by a nonparticipating provider, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such an item or service furnished by such provider with respect to a visit at such facility that is more than the cost-sharing requirement for such item or service (as determined in accordance with subparagraphs (A) and (B) of section 300gg–111(b)(1) of this title [1] of section 9816(b)(1) of title 26, and of section 1185e(b)(1) of title 29, as applicable).

(b) Exception

(1) In general

Subsection (a) shall not apply with respect to items or services (other than ancillary services described in paragraph (2)) furnished by a nonparticipating provider to a

participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, if the provider satisfies the notice and consent criteria of subsection (d).

(2) Ancillary services described

For purposes of paragraph (1), ancillary services described in this paragraph are, with respect to a participating health care facility—

(A) subject to paragraph (3), items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists;

(B) subject to paragraph (3), diagnostic services (including radiology and laboratory services);

(C) items and services provided by such other specialty practitioners, as the Secretary specifies through rulemaking; and

(D) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

(3) Exception

The Secretary may, through rulemaking, establish a list (and update such list periodically) of advanced diagnostic laboratory tests, which shall not be included as an ancillary service described in paragraph (2) and with respect to which subsection (a) would apply.

(c) Clarification

In the case of a nonparticipating provider that satisfies the notice and consent criteria of subsection (d) with respect to an item or service (referred to in this subsection as a "covered item or service"), such notice and consent criteria may not be construed as applying with respect to any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished. For purposes of the previous sentence, a covered item or service shall not include an ancillary service described in subsection (b)(2).

(d) Notice and consent to be treated by a nonparticipating provider or nonparticipating facility

(1) In general

A nonparticipating provider or nonparticipating facility satisfies the notice and consent criteria of this subsection, with respect to items or services furnished by

the provider or facility to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, if the provider (or, if applicable, the participating health care facility on behalf of such provider) or nonparticipating facility—

> (A) in the case that the participant, beneficiary, or enrollee makes an appointment to be furnished such items or services at least 72 hours prior to the date on which the individual is to be furnished such items or services, provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) not later than 72 hours prior to the date on which the individual is furnished such items or services (or, in the case that the participant, beneficiary, or enrollee makes such an appointment within 72 hours of when such items or services are to be furnished, provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) on such date the appointment is made), a written notice in paper or electronic form, as selected by the participant, beneficiary, or enrollee, (and including electronic notification, as practicable) specified by the Secretary, not later than July 1, 2021, through guidance (which shall be updated as determined necessary by the Secretary) that—
>
> > (i) contains the information required under paragraph (2);
> >
> > (ii) clearly states that consent to receive such items and services from such nonparticipating provider or nonparticipating facility is optional and that the participant, beneficiary, or enrollee may instead seek care from a participating provider or at a participating facility, with respect to such plan or coverage, as applicable, in which case the cost-sharing responsibility of the participant, beneficiary, or enrollee would not exceed such responsibility that would apply with respect to such an item or service that is furnished by a participating provider or participating facility, as applicable with respect to such plan; and
> >
> > (iii) is available in the 15 most common languages in the geographic region of the applicable facility;
>
> (B) obtains from the participant, beneficiary, or enrollee (or from such an authorized representative) the consent described in paragraph (3) to be treated by a nonparticipating provider or nonparticipating facility; and
>
> (C) provides a signed copy of such consent to the participant, beneficiary, or enrollee through mail or email (as selected by the participant, beneficiary, or enrollee).

(2) Information required under written notice

For purposes of paragraph (1)(A)(i), the information described in this paragraph, with respect to a nonparticipating provider or nonparticipating facility and a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, is each of the following:

> (A) Notification, as applicable, that the health care provider is a nonparticipating provider with respect to the health plan or the health care facility is a nonparticipating facility with respect to the health plan.
>
> (B) Notification of the good faith estimated amount that such provider or facility may charge the participant, beneficiary, or enrollee for such items and services involved, including a notification that the provision of such estimate or consent to be treated under paragraph (3) does not constitute a contract with respect to the charges estimated for such items and services.
>
> (C) In the case of a participating facility and a nonparticipating provider, a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.
>
> (D) Information about whether prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility

(3) Consent described to be treated by a nonparticipating provider or nonparticipating facility

For purposes of paragraph (1)(B), the consent described in this paragraph, with respect to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer who is to be furnished items or services by a nonparticipating provider or nonparticipating facility, is a document specified by the Secretary, in consultation with the Secretary of Labor, through guidance that shall be signed by the participant, beneficiary, or enrollee before such items or services are furnished and that—

> (A) acknowledges (in clear and understandable language) that the participant, beneficiary, or enrollee has been—
>
> > (i) provided with the written notice under paragraph (1)(A);
> >
> > (ii) informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any

limitation that the plan or coverage places on cost-sharing, including an explanation that such payment may not apply to an in-network deductible applied under the plan or coverage; and

(iii) provided the opportunity to receive the written notice under paragraph (1)(A) in the form selected by the participant, beneficiary or enrollee; and

(B) documents the date on which the participant, beneficiary, or enrollee received the written notice under paragraph (1)(A) and the date on which the individual signed such consent to be furnished such items or services by such provider or facility.

(4) Rule of construction

The consent described in paragraph (3), with respect to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, shall constitute only consent to the receipt of the information provided pursuant to this subsection and shall not constitute a contractual agreement of the participant, beneficiary, or enrollee to any estimated charge or amount included in such information.

(e) Retention of certain documents

A nonparticipating facility (with respect to such facility or any nonparticipating provider at such facility) or a participating facility (with respect to nonparticipating providers at such facility) that obtains from a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer (or an authorized representative of such participant, beneficiary, or enrollee) a written notice in accordance with subsection (d)(1)(B), with respect to furnishing an item or service to such participant, beneficiary, or enrollee, shall retain such notice for at least a 7-year period after the date on which such item or service is so furnished.

(f) Definitions

In this section:

(1) The terms "nonparticipating provider" and "participating provider" have the meanings given such terms, respectively, in subsection (a)(3) of section 300gg–111 of this title.

(2) The term "participating health care facility" has the meaning given such term in subsection (b)(2) of section 300gg–111 of this title.

(3) The term "nonparticipating facility" means—

(A) with respect to emergency services (as defined in section 300gg–111(a)(3)(C)(i) of this title) and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

(B) with respect to services described in section 300gg–111(a)(3)(C)(ii) of this title and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

(4) The term "participating facility" means—

(A) with respect to emergency services (as defined in clause (i) of section 300gg–111(a)(3)(C) of this title) that are not described in clause (ii) of such section and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

(B) with respect to services that pursuant to clause (ii) of section 300gg–111(a)(3)(C) of this title, of section 9816(a)(3) of title 26, and of section 1185e(a)(3) of title 29, as applicable are included as emergency services (as defined in clause (i) of such section and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.