No. 24-20051

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

GUARDIAN FLIGHT, L.L.C.,
Plaintiff-Appellee,
v.
MEDICAL EVALUATORS OF TEXAS ASO, L.L.C.,
Defendant-Appellant.
consolidated with

No. 24-20204

GUARDIAN FLIGHT, L.L.C.; REACH AIR MEDICAL SERVICES, L.L.C.; CALSTAR AIR MEDICAL SERVICES, L.L.C.,
Plaintiffs-Appellants,
v.
AETNA HEALTH, INCORPORATED; KAISER FOUNDATION HEALTH PLAN, INCORPORATED,
Defendants-Appellees.

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

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE IN SUPPORT OF MEDICAL EVALUATORS OF TEXAS ASO, L.L.C.

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INTERESTS OF AMICUS CURIAE

The United States has a strong interest in the stability and sustainability of the independent dispute resolution (IDR) process established by the No Surprises Act. The Act protects patients from certain potentially ruinous surprise medical bills and takes patients out of the middle of certain surprise billing disputes between medical providers and insurers.[1] In service of those goals, the Act created a mechanism—the IDR process—for resolving payment disputes between medical providers and insurers and for ensuring that medical providers receive appropriate compensation for their services in instances where the Act applies. The IDR process is thus integral to the No Surprises Act. IDR proceedings are adjudicated by federally certified private entities, known as certified independent dispute resolution entities (CIDREs). These CIDREs collectively adjudicate hundreds of thousands of payment disputes each year under the No Surprises Act. Lawsuits against CIDREs challenging these payment determinations have the potential to impose prohibitive litigation costs, which in turn are likely to cause CIDREs to withdraw from the IDR program altogether. As a result, the United States has a strong interest in ensuring that CIDREs are not subjected to improper lawsuits that would disrupt the operation of the congressionally authorized IDR program.

[1] This brief uses the term "insurers" to refer to "group health plans" and "health insurance issuers." *See* 42 U.S.C. § 300gg-111(a)(1).

STATEMENT OF THE ISSUE

Whether CIDREs are proper parties to lawsuits challenging their payment determinations under the No Surprises Act.

STATEMENT OF THE CASE

A. Statutory Background

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

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

that circumstance, the patient is responsible for the balance of the bill, and because the rate charged was not pre-negotiated by the patient's health plan, this practice of "balance billing" may result in the patient being held personally responsible for immensely more than the same item or service would have cost had the rate been pre-negotiated.

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

One notable study found that, from 2010 to 2016, the incidence of out-of-network billing in connection with emergency department visits increased from 32.3% to 42.8%, while the average potential amount of such bills to patients increased from $220 to $628. 86 Fed. Reg. at 36,874; *see also* 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); Erin L. Duffy et al., *Prevalence and Characteristics of Surprise Out-of-Network Bills from Professionals in Ambulatory Surgery Centers*, 39 Health Aff. 783, 785 (2020) (finding an 81% increase in the average amount of patient liability in connection with surprise bills at ambulatory surgical centers from 2014 to 2017). For inpatient admissions, the incidence of such billing rose from 26.3% to 42.0%, while the average potential amount of the bills rose from $804 to $2,040. 86 Fed. Reg. at 36,874.

Under these circumstances, before the No Surprises Act, a patient with health insurance could receive a surprise medical bill. *See* 86 Fed. Reg. at 36,874. Indeed, "[t]he financial liability imposed on patients by surprise medical bills can be staggering." H.R. Rep. No. 116-615, pt. 1, at 52 (2020). As Congress recognized, "[t]hese unexpected medical bills can result in financial ruin, as nearly four in ten American adults are unable to cover a $400 emergency expense, yet the average surprise balance bill by emergency physicians in 2014 and 2015 was an estimated $620 greater than the Medicare rate for the same service." *Id.* (footnote omitted). The potentially devastating effects on patients are well documented. *See, e.g.*, *id.* (referring to a "shocking" example of "a spinal surgery patient who received a bill of $101,000" after her surgeon mistakenly informed her that

he was in-network); Fuse Brown et al., *supra* (noting that "[m]edian charges for a rotary-wing air ambulance transport spiked over the past decade, nearly tripling from $12,500 to $35,900 between 2008 and 2017").

2. In 2020, Congress enacted the No Surprises Act to combat the growing crisis of surprise medical bills. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 1182, 2757-2890 (2020) (codified in relevant part at 42 U.S.C. § 300gg-111 *et seq.*).[2] The Act protects insured patients from unexpected liabilities arising from common forms of balance billing. When applicable, the Act caps a patient's share of liability to an out-of-network provider at an amount comparable to what the patient would have owed had she received care from an in-network provider. *See* 42 U.S.C. §§ 300gg-111(a)(1)(C)(ii)-(iii), (3)(H)(ii), (b)(1)(A)-(B), 300gg-112(a)(1)-(2).[3] The

[2] For ease of reference, this brief cites the Act's amendments to the Public Health Service Act and the regulations implemented by HHS. The Act made parallel amendments to the Employee Retirement Income Security Act (administered by the Department of Labor) and the Internal Revenue Code (administered by the Department of the Treasury), and the implementing regulations likewise contain parallel provisions implemented by the different Departments. The Act also affects the Office of Personnel Management (OPM) by requiring, in a provision not directly at issue in this case, that OPM's contracts with the Federal Employees Health Benefits Program require the carrier to comply with applicable provisions of the No Surprises Act. *See* 5 U.S.C. § 8902(p).

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

Act also creates procedures that allow the provider to seek further compensation from the patient's health plan. Those separate procedures further Congress's goal of "taking the consumer out of the middle" of billing disputes. *See* H.R. Rep. No. 116-615, pt. 1, at 55 (quotation marks omitted).

To that end, the Act allows the out-of-network provider to submit a bill to the patient's insurer and establishes a process for resolving disputes between insurers and out-of-network providers over how much the insurer will pay for the care. If the insurer and provider are not able to agree on a payment amount, either may initiate the IDR process. 42 U.S.C. §§ 300gg-111(c)(1)(B), 300gg-112(b)(1)(B). The IDR process involves "baseball-style" arbitration, whereby the decisionmaker selects one of the parties' proposed payment amounts. *Id.* § 300gg-111(c)(5).

IDR proceedings are adjudicated by private entities (CIDREs) certified for that purpose by the Departments of Health and Human Services, Labor, and the Treasury (the Departments). These CIDREs conduct IDR proceedings pursuant to statutory and regulatory parameters and are compensated through fees determined in part by the Departments. 42 U.S.C. § 300gg-111(c); *Federal Independent Dispute Resolution (IDR) Process Administrative Fee and Certified IDR Entity Fee Ranges*, 88 Fed. Reg. 88,494, 88,499, 88,510 (Dec. 21, 2023). A CIDRE's payment determination is binding on the parties and is not subject to judicial review except under circumstances described in the Federal Arbitration Act (FAA). 42 U.S.C. § 300gg-111(c)(5)(E) (citing 9 U.S.C. § 10(a)(1)-(4)). As a result, a CIDRE's determination is only subject to judicial review "where the award

was procured by corruption, fraud, or undue means"; "where there was evident partiality or corruption in the arbitrators"; "where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced"; or "where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made." 9 U.S.C. § 10(a).

B. Factual and Procedural Background

1. Plaintiff Guardian Flight, LLC provided air ambulance services to a patient insured by Aetna Health, Inc. in February 2022. Doc. 1 ¶¶ 14-16.[4] Guardian Flight is out-of-network for Aetna. Doc. 1 ¶ 4. When Guardian Flight and Aetna could not agree on the amount that Aetna would pay Guardian Flight for the services, Guardian Flight initiated the IDR process. *See* Doc. 1 ¶ 6. The parties selected a CIDRE called Medical Evaluators of Texas ASO, LLC (MET) to adjudicate the payment dispute. Doc. 1 ¶ 6. After considering the parties' submissions, MET selected Aetna's proposed payment amount. Doc. 1 ¶¶ 6, 24. Guardian Flight then sued both Aetna and MET, arguing that Aetna had misrepresented facts in its submissions to MET and that MET's determination was contrary to statute. Doc. 1 ¶ 6.

[4] Unless otherwise noted, "Doc." citations refer to the ECF document numbers on the consolidated district court docket, No. 4:22-cv-3805 (S.D. Tex.).

2. Plaintiffs REACH Air Medical Services LLC, CALSTAR Air Medical Services, LLC, and Guardian Flight filed a similar suit after providing air ambulance services to multiple patients insured by Kaiser Foundation Health Plan Inc. in early 2022. Doc. 1 ¶¶ 4, 17-22 (Dkt. 4:22-cv-3979). MET adjudicated those payment disputes as well, issuing determinations in favor of Kaiser. Doc. 1 ¶ 1 (Dkt. 4:22-cv-3979). Plaintiffs sued Kaiser and MET, arguing that Kaiser had misrepresented facts in its submissions to MET and that MET's determinations were contrary to statute. Doc. 1 ¶¶ 47-48 (Dkt. 4:22-cv-3979).

3. The district court consolidated the cases and Aetna, Kaiser, and MET moved to dismiss. The court ruled on the motions on January 5, 2024. The court first dismissed REACH's claims as collaterally estopped by a recent decision on the same issues in Florida district court. ROA.1875-76 (citing *Med-Trans Corp. v. Capital Health Plan, Inc.*, 700 F. Supp. 3d 1076 (M.D. Fla. 2023), *appeal docketed*, No. 24-10135 (11th Cir. Jan. 16, 2024)). As for the remaining plaintiffs' claims against MET, the court concluded that the No Surprises Act provided a cause of action against CIDREs, that MET was not entitled to arbitrator immunity, and that plaintiffs had alleged that MET may have exceeded its powers in violation of Section 10 of the FAA. ROA.1879-80. The district court dismissed plaintiffs' claims against the insurers with leave to amend, concluding that plaintiffs had failed to allege corruption or other conduct by the insurers that would trigger judicial review of the payment determinations. ROA.1877-79.

4. On February 5, 2024, MET filed an interlocutory appeal. Doc. 77. Plaintiffs declined to amend their complaint and instead asked the district court to enter final judgment against the insurers. Doc. 79 at 4; Doc. 88 at 3. The district court did so on April 9, 2024. ROA.1963-65. Plaintiffs appealed on May 6, 2024, ROA.1966, and this Court consolidated the appeals on May 16, 2024.

SUMMARY OF ARGUMENT

1. CIDREs are not proper parties to suits challenging payment determinations under the No Surprises Act. CIDREs are quasi-judicial entities entitled to arbitrator immunity—a widely accepted and well-established concept that protects neutral third-party decision-makers from undue influence and from reprisals by dissatisfied litigants—and the No Surprises Act did not create a cause of action against CIDREs. Congress established the IDR process to provide a sustainable and efficient way to resolve payment disputes between medical providers and insurers. Consistent with that goal, CIDREs conduct baseball-style arbitrations when insurers and providers are not able to negotiate a payment amount themselves. Like other arbitrators—and like judges—the fact that a CIDRE has rendered a decision that a party dislikes does not mean that the CIDRE itself is a proper defendant to a lawsuit. The dispute remains between the provider and the insurer.

2. The district court's reasoning to the contrary is unpersuasive. The fact that the Act does not use the terms "arbitration" or "arbitrator" to refer to IDR proceedings and CIDREs does not change the fact that these proceedings are a form of arbitration.

Nor was the district court correct to conclude that CIDREs must be a party to litigation to effectuate relief.

3. Permitting suits against CIDREs threatens the viability of the IDR system. CIDREs typically receive less than $1,000 to adjudicate a given payment dispute. If they can then be haled into court by whichever party is dissatisfied with their decision and subjected to the financial and practical burdens of motions practice and potentially discovery, CIDREs will not be willing or able to continue adjudicating these disputes. The IDR system is already struggling with a higher-than-expected volume of disputes and a lower-than-expected number of CIDREs. If the few existing CIDREs stop providing their services, the IDR system will not be able to function and Congress's intentions under the No Surprises Act will be thwarted.

ARGUMENT

CERTIFIED INDEPENDENT DISPUTE RESOLUTION ENTITIES ARE NOT PROPER PARTIES TO CHALLENGES TO PAYMENT DETERMINATIONS UNDER THE NO SURPRISES ACT.

1. CIDREs are not proper parties to suits challenging payment determinations under the No Surprises Act. CIDREs are entitled to arbitrator immunity, and the Act does not create a cause of action against CIDREs. The claims against MET should therefore be dismissed.

a. CIDREs are quasi-judicial entities and are entitled to arbitrator immunity. Arbitrator immunity is a widely accepted and well-established concept that courts have applied to various adjudicatory bodies. "Because an arbitrator's role is functionally

equivalent to a judge's role, courts of appeals have uniformly extended judicial and quasi-judicial immunity to arbitrators." *New England Cleaning Servs., Inc. v. American Arbitration Ass'n*, 199 F.3d 542, 545 (1st Cir. 1999) (quoting *Olson v. National Ass'n of Sec. Dealers*, 85 F.3d 381, 382 (8th Cir. 1996)); *accord Hawkins v. National Ass'n of Sec. Dealers Inc.*, 149 F.3d 330, 332 (5th Cir. 1998) (per curiam), *abrogated on other grounds by Merrill Lynch, Pierce, Fenner & Smith Inc. v. Manning*, 578 U.S. 374, 379 (2016); *Olson*, 85 F.3d at 382; *Austern v. Chicago Bd. Options Exch., Inc.*, 898 F.2d 882, 886 (2d Cir. 1990); *Wasyl, Inc. v. First Bos. Corp.*, 813 F.2d 1579, 1582 (9th Cir. 1987); *Corey v. New York Stock Exch.*, 691 F.2d 1205, 1209 (6th Cir. 1982); *Tamari v. Conrad*, 552 F.2d 778, 780-81 (7th Cir. 1977); *see also Jason v. American Arbitration Ass'n*, 62 F. App'x 557, 2003 WL 1202934, at *1 (5th Cir. 2003) (per curiam) (affirming dismissal based on arbitral immunity).

Congress is presumed to have been aware of this backdrop when it established the No Surprises Act's IDR system, which incorporates the FAA's judicial review standards. 42 U.S.C. §§ 300gg-111(c)(5)(E)(i), 300gg-112(b)(5)(D); *see Miles v. Apex Marine Corp.*, 498 U.S. 19, 32 (1990) ("We assume that Congress is aware of existing law when it passes legislation."). Moreover, the logic underpinning arbitrator immunity applies equally to CIDREs. Arbitrator immunity "protect[s] decision-makers from undue influence and the process from reprisals by dissatisfied litigants." *Jason*, 2003 WL 1202934, at *1 (quoting *New England Cleaning*, 199 F.3d at 545). CIDREs are neutral arbiters of payment disputes between providers and insurers. They have no stake in litigation over payment determinations, just as a trial judge has no stake in—and is not

a party to—an appellate proceeding reviewing its decision. And the absence of arbitrator immunity would discourage arbitrators from providing their services. *See Austern*, 898 F.2d at 886 ("[I]ndividuals . . . cannot be expected to volunteer to arbitrate disputes if they can be caught up in the struggle between the litigants and saddled with the burdens of defending a lawsuit." (second alteration in original) (quoting *Tamari*, 552 F.2d at 781)). Indeed, if CIDREs are subjected to suits over their payment determinations, they will no longer be willing to adjudicate disputes under the No Surprises Act. *See infra* pp. 15-16.

b. Nor does the No Surprises Act create a cause of action against CIDREs, as the Act contains no "rights-creating language" that would establish such a cause of action, nor any evidence of congressional intent to allow such suits. *See Alexander v. Sandoval*, 532 U.S. 275, 288 (2001).[5] The No Surprises Act states that the "determination of a [CIDRE] . . . shall not be subject to judicial review, except in a case described in" the FAA—specifically, in "any of paragraphs (1) through (4) of section 10(a) of title 9." 42 U.S.C. § 300gg-111(c)(5)(E)(i); *see id.* § 300gg-112(b)(5)(D) (confirming that this limitation also applies to air ambulance services). The FAA in turn provides that an arbitral award may be vacated by a United States court "where the award was procured

[5] By contrast, as the United States has explained in a recent amicus brief, the No Surprises Act does establish a cause of action against insurers to enforce IDR awards, because the Act contains rights-creating language to that effect. *See* Brief for the United States as Amicus Curiae 7-15, *Guardian Flight, L.C.C. v. Health Care Serv. Corp.*, No. 24-10561 (5th Cir.) (Oct. 4, 2024).

by corruption, fraud, or undue means"; "where there was evident partiality or corruption in the arbitrators"; "where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced"; or "where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made." 9 U.S.C. § 10(a).

In short, the Act states that CIDREs' determinations are generally not reviewable except in narrow circumstances. 42 U.S.C. § 300gg-111(c)(5)(E)(i). And the Act makes no suggestion that CIDREs can properly be named as parties to such suits. On the contrary, the Act presumes that any disputes will be between medical providers and insurers and sets out a detailed scheme for the resolution of such disputes. 42 U.S.C. § 300gg-111(b)-(c). And nowhere does the Act contemplate that a CIDRE's status will change from that of an adjudicator to that of a litigant.

2. The district court reasoned that CIDREs were not entitled to arbitral immunity because the No Surprises Act refers to the decisionmaking bodies "as IDR entities, not arbitrators" and the proceedings as "IDRs, not arbitrations." ROA.1879. But the IDR system is a system of arbitration, and the logic underlying arbitral immunity applies regardless of the particular nomenclature. *See Arbitration*, Black's Law Dictionary (12th ed. 2024) ("A dispute-resolution process in which the disputing parties choose one or more neutral third parties to make a final and binding decision resolving the

dispute."). The fact that Congress incorporated the portion of the FAA governing judicial review into the No Suprises Act reinforces the conclusion that the IDR system is a form of arbitration. *See* 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). And the legislative history provides further confirmation that Congress understood as much. *See* H.R. Rep. No. 116-615, pt. 1, at 56 (noting, in a section titled "resolving payment disputes between providers and health plans," that "the IDR process" is "also referred to as arbitration"); *Examining Surprise Billing: Protecting Patients from Financial Pain: Hearing Before the Subcomm. on Health, Emp't, Labor, & Pensions of the H. Comm. on Educ. & Labor*, 116th Cong. 27 (2019) (statement of Christen Linke Young, Fellow, USC-Brookings Schaeffer Initiative on Health Policy) ("Using Arbitration to Determine Payment"); *id.* at 27-29 (recommending baseball style arbitration); *id.* at 174, 191-92, 201-02 (referencing "arbitration" in the questions and responses for the record alike).

The district court further suggested that, because some of the bases for vacating IDR payment determinations relate to the arbitrator's conduct, "it would seem that parties to the IDR must be able to assert claims against the IDR entity if the IDR entity's conduct falls within" one of those bases. ROA.1880 n.4. But the same bases for judicial review apply to arbitrations subject to the FAA—a context in which arbitral immunity is widely accepted. The fact that a CIDRE cannot itself be sued does not mean that its payment determination cannot be vacated if the CIDRE was corrupt or was otherwise guilty of misconduct. *See* 9 U.S.C. § 10(a)(2)-(3); *cf. PoolRe Ins. Corp. v. Organizational Strategies, Inc.*, 783 F.3d 256, 259 (5th Cir. 2015) (affirming district court's decision to

vacate arbitration award under FAA in litigation to which the arbitrator was not a party). In short, there is no need for a CIDRE to be party to litigation over its payment determination in order for an IDR participant to obtain any relief to which it is entitled under the Act.

3. The consequences of permitting suits against CIDREs would be significant: suits such as this one present a major threat to the viability of the No Surprises Act's IDR system. Simply naming a CIDRE as a defendant forces it, at the very least, to engage in costly motions practice seeking dismissal as a party, which in turn takes time away from the CIDREs' work adjudicating payment disputes. And litigation may also open the CIDRE up to the potentially exorbitant costs of discovery. These burdens are particularly cost-prohibitive when measured against a CIDRE's compensation for adjudicating a payment dispute, which currently ranges from $375 to $800 for single determinations and from $490 to $1,170 for batched determinations. *See* Ctrs. for Medicare & Medicaid Servs., *List of Certified Independent Dispute Resolution Entities*, https://perma.cc/SZ2E-BN34. If the losing party in every IDR proceeding could name the adjudicating CIDRE as a defendant following every payment determination, it would stop making financial sense for CIDREs to participate in the IDR system. And were the IDR fees increased to offset these costs to CIDREs, it could become cost-prohibitive for providers and insurers to arbitrate lower-dollar-amount disputes. *See* 88 Fed. Reg. at 88,498 (noting that "the Departments received many comments stating that the administrative fee amount and the certified IDR entity fee ranges create a

barrier to accessing the Federal IDR process for many parties, particularly small, rural, or independent providers"); *see also id.* at 88,512.

Indeed, the IDR system is already under strain, experiencing a higher-than-expected volume of disputes and a lower-than-expected number of CIDREs. The Departments had originally estimated that parties would submit approximately 17,000 IDR disputes each year. *Requirements Related to Surprise Billing: Part II*, 86 Fed. Reg. 55,980, 56,056 (Oct. 7, 2021). Instead, parties have submitted hundreds of thousands of disputes each year, including 200,112 in 2022 and 679,156 in 2023. *See* Ctrs. for Medicare & Medicaid Servs., *Supplemental Background on Federal Independent Dispute Resolution Public Use Files* 2 (June 13, 2024), https://perma.cc/DF7G-2RFG. Exacerbating this heavy volume, there are only 13 IDR entities that have qualified for certification, where the Departments had anticipated 50 CIDREs would seek to participate. 86 Fed. Reg. at 56,002 n.41; *List of Certified Independent Dispute Resolution Entities*, *supra*.

The IDR system is integral to the Act. If some or all of the CIDREs withdraw their services, the IDR system could cease to function, thwarting Congress's desire to create a low-cost, efficient means of dispute resolution between providers and insurers.

CONCLUSION

For the foregoing reasons, the claims against MET should be dismissed.

Respectfully submitted,

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OCTOBER 2024

CERTIFICATE OF SERVICE

I hereby certify that on October 15, 2024, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system.

s/ Sarah Clark Griffin
Sarah Clark Griffin

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rules of Appellate Procedure 29(a)(5) and 32(a)(7)(B) because it contains 4,212 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 Clark Griffin
Sarah Clark Griffin

ADDENDUM

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9 U.S.C. § 10

§ 10. Same; vacation; grounds; rehearing

(a) In any of the following cases the United States court in and for the district wherein the award was made may make an order vacating the award upon the application of any party to the arbitration—

(1) where the award was procured by corruption, fraud, or undue means;

(2) where there was evident partiality or corruption in the arbitrators, or either of them;

(3) where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or

(4) where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made.

(b) If an award is vacated and the time within which the agreement required the award to be made has not expired, the court may, in its discretion, direct a rehearing by the arbitrators.

(c) The United States district court for the district wherein an award was made that was issued pursuant to section 580 of title 5 may make an order vacating the award upon the application of a person, other than a party to the arbitration, who is adversely affected or aggrieved by the award, if the use of arbitration or the award is clearly inconsistent with the factors set forth in section 572 of title 5.

42 U.S.C. § 300gg-111

§ 300gg-111. Preventing surprise medical bills

. . .

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

. . .

(5) Payment determination

. . .

(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.

. . .

42 U.S.C. § 300gg-112

§ 300gg-112. Ending surprise air ambulance bills

. . .

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

. . .

(5) Payment determination

. . .

(D) Effects of determination

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

. . .