IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

COMMUNITY INSURANCE COMPANY D/B/A ANTHEM BLUE CROSS AND BLUE SHIELD, Plaintiff, v. HALOMD, LLC, ALLA LAROQUE, SCOTT LAROQUE, MPOWERHEALTH PRACTICE MANAGEMENT, LLC, EVOKES, LLC, MIDWEST NEUROLOGY, LLC, ONE CARE MONITORING, LLC, and VALUE MONITORING LLC, Defendants.	Civil Action No. 1:25-cv-00388-MWM District Judge: Matthew W. McFarland

DEFENDANTS' MOTION FOR LEAVE TO FILE THIRD NOTICE OF SUPPLEMENTAL AUTHORITY

Pursuant to Local Rule 7.2(a)(2) and the Court's inherent authority, Defendants respectfully request leave to file the attached Third Notice of Supplemental Authority in support of their Motions to Dismiss the Amended Complaint (R. 38, R. 39, R. 40).

On April 13, 2026, Defendants moved for leave to file their first Notice of Supplemental Authority to notify the court of the order dismissing the action captioned *Anthem Blue Cross Life and Health Insurance Company, et al. v. HaloMD LLC, et al.*, No. 8:25-cv-01467-KES (C.D. Cal. Apr. 9, 2026) (R. 52). Plaintiff Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield ("Anthem") filed its response to Defendants' first notice on April 15, 2026 (R. 53).

On April 16, 2026, the United States District Court for the Middle District of Florida issued an order dismissing the Amended Complaint in *Aetna Health, Inc. et al. v. Radiology Partners, Inc. et ano.*, No. 3:24-cv-01343-BJD-LLL (M.D. Fl. Apr. 16, 2026), a similar lawsuit filed by another large commercial healthcare insurer who had asserted fraud claims against an alleged aggregator of radiology practices based on the initiation of Independent Dispute Resolution ("IDR") proceedings under the No Surprises Act ("NSA").

On April 17, 2026, Defendants moved for leave to file their Second Notice of Supplemental Authority to notify the Court of the order dismissing the *Aetna Health* action. (R. 54).

On April 28, 2026, the United States District Court for the Eastern District of Pennsylvania issued its Memorandum Order ("Order") granting a motion to dismiss in *UnitedHealthcare of Pennsylvania, Inc. v. NorthStar Anesthesia of Pennsylvania*, LLC, No. 2:25-cv-07187-MAK (E.D. Pa. April 28, 2026) (the "Pennsylvania Action"). As described in the attached Third Notice, the Pennsylvania Action involves claims by an insurance provider, UnitedHealthcare, against an anesthesia services provider, NorthStar Anesthesia, arising from a dispute over out-of-network services for which NorthStar Anesthesia initiated the NSA IDR process. The court dismissed

without prejudice UnitedHealthcare's claims for lack of subject matter jurisdiction.

For the same reasons set forth in Defendants' prior motions for leave, Defendants seek leave to file the attached Third Notice to bring the Court's attention to this additional supplemental authority, which is also "directly relevant to the motion before the Court" given similar claims, allegations, and arguments. *See Chhajed v. Jaddou*, No. 2:23-cv-483, 2024 WL 1332258, at *3 n.2 (S.D. Ohio Mar. 27, 2024). The Order is directly relevant to and will assist the Court in resolving the Defendants' Motions to Dismiss the Amended Complaint.

Defendants thus respectfully move for leave to file the attached Third Notice of Supplemental Authority in support of their Motions to Dismiss the Amended Complaint (R. 38, R. 39, R. 40).

Respectfully submitted.

[SIGNATURES ON FOLLOWING PAGE]

Dated: May 1, 2026

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CERTIFICATE OF SERVICE

I hereby certify that on May 1, 2026, a copy of the foregoing Defendants' Motion for Leave to File Third Notice of Supplemental Authority was electronically filed with the Clerk of the United States District Court for the Southern District of Ohio, Western Division, using the CM/ECF system, which will send notification of such filing to all counsel of record in this matter.

/s/ Heidi Gutierrez
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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

COMMUNITY INSURANCE COMPANY D/B/A ANTHEM BLUE CROSS AND BLUE SHIELD, Plaintiff, v. HALOMD, LLC, ALLA LAROQUE, SCOTT LAROQUE, MPOWERHEALTH PRACTICE MANAGEMENT, LLC, EVOKES, LLC, MIDWEST NEUROLOGY, LLC, ONE CARE MONITORING, LLC, and VALUE MONITORING LLC, Defendants.	Civil Case No. 1:25-cv-00388-MWM District Judge: Matthew W. McFarland

DEFENDANTS' THIRD NOTICE OF SUPPLEMENTAL AUTHORITY IN SUPPORT OF THEIR MOTIONS TO DISMISS

Defendants respectfully submit this Third Notice of Supplemental Authority in support of their pending motions to dismiss Plaintiff Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield's ("Anthem") Amended Complaint, namely, an April 28, 2026 order dismissing a similar lawsuit filed by another large commercial healthcare insurer asserting fraud-based claims on the initiation of Independent Dispute Resolution ("IDR") proceedings under the No Surprises Act ("NSA").

On April 28, 2026, the United States District Court for the Eastern District of Pennsylvania issued its Order ("Order") granting without prejudice the defendant's motion to dismiss filed in *UnitedHealthcare, Inc. v. NorthStar Anesthesia of Pennsylvania, LLC*, No. 2:25-cv-07187-MAK (E.D. Pa. Apr. 28, 2026) (the "Pennsylvania Action"), a copy of which is attached as **Exhibit A**.

The Complaint in the Pennsylvania Action is attached as **Exhibit B**. In it, UnitedHealthcare asserted factual allegations substantially similar to Anthem's allegations in this lawsuit and alleged causes of action including: (i) declaratory judgment under 28 U.S.C. §§ 2201, 2202; and (ii) common law fraud.

The Order in the Pennsylvania Action is relevant to this Action. In pursuing its declaratory relief and fraud claim, UnitedHealthcare asserted similar arguments to those Plaintiff asserts here. In dismissing the Pennsylvania Action, the court noted:

> We decline to . . . bypass Congress's intent in the No Surprises Act. We are guided by thoughtful analysis including Judge Scott's *Anthem* decision in concluding UnitedHealthcare is trying to evade Congress's policy choices in limiting judicial review[.]

Order at 21-22.

Respectfully submitted,

Dated: May 1, 2026

/s/Michael J. Summerhill

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CERTIFICATE OF SERVICE

I hereby certify that on May 1, 2026, a copy of the foregoing Defendants' Third Notice of Supplemental Authority in Support of Their Motions to Dismiss was electronically filed with the Clerk of the United States District Court for the Southern District of Ohio, Western Division, using the CM/ECF system, which will send notification of such filing to all counsel of record in this matter.

/s/ Heidi Gutierrez
Heidi Gutierrez

EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITEDHEALTHCARE OF PENNSYLVANIA, INC.	:	**CIVIL ACTION**
v.	:	**NO. 25-7187**
NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC	:	

MEMORANDUM

KEARNEY, J. **April 28, 2026**

An anesthesia company working in a hospital provided services to a patient. The provider billed these services to a health insurer. The patient qualified for Medicaid. The health insurer declined payment beyond the amount owed under Medicaid. The provider disagreed as to the amount of the insurer's payment and—either mistakenly as it contends or fraudulently as the insurer contends—started a Congressionally-mandated dispute resolution process everyone agrees does not apply to Medicaid patients. Congress passed the "No Surprises Act" four years ago defining how the insurer and provider resolve this disputed balance through a third-party decision-maker. We today address what happens when the insurer does not like the way Congress mandated the protocol for resolving reimbursement disputes. The insurer now invokes our limited subject matter jurisdiction asking us to declare the provider's conduct in seeking payment on services rendered to a Medicaid patient it knew is ineligible for the dispute resolution process is unlawful and fraudulent, declare Medicaid and Medicare claims are not eligible for the dispute resolution process under the No Surprises Act, declare awards issued on unqualified services are non-binding and not payable, and enjoin the provider from continuing to submit false attestations and ineligible

claims under the process set by Congress in the No Surprises Act. The insurer misunderstands the limited nature of our subject matter jurisdiction.

The insurer essentially asks us, through a common law fraud claim, to disregard Congress's specific language limiting judicial review of dispute resolution awards except in the absence of fraud and other prescribed conditions. But the insurer does not ask us to vacate the award under the statutory scheme; it instead asks us to enter declaratory and injunctive relief to remedy what it believes is a broken system under the No Surprises Act. The insurer argues it has no recourse under the No Surprises Act because the Act never applied to the Medicaid patient's claim in the first place but at the same time invokes our subject matter jurisdiction over its common law fraud claim as necessarily turning on our construction of the Act. We cannot do so. We lack subject matter jurisdiction to address Congress's policy decisions absent a substantial federal question. The insurer does not plead facts, nor can it, allowing us to plausibly infer a basis to exercise our limited subject matter jurisdiction. We dismiss the insurer's claim here but it may challenge its approximately $5,000.00 reimbursement obligation to the extent the provider still seeks the reimbursement after admitting it is not entitled to the payment for a Medicaid-eligible patient. We have no basis for subject matter jurisdiction to resolve an insurer's unhappiness with a Congressional mandate as some form of policy fiat. We leave those policy decisions to our elected officials.

I. Alleged Facts

Pennsylvania contracted with UnitedHealthcare of Pennsylvania, Inc. to provide health insurance coverage to Medicaid-eligible Pennsylvanians.[1] A Pennsylvanian eligible for Medicaid required anesthesia services while delivering a baby at St. Mary's Hospital in Langhorne, Pennsylvania in January 2025.[2] An anesthesiologist affiliated with NorthStar Anesthesia of

Pennsylvania, LLC provided her with anesthesia.[3] NorthStar is not an "in-network" approved provider to be reimbursed by UnitedHealthcare.[4] Out-of-network provider NorthStar submitted a claim to UnitedHealthcare on February 7, 2025 for its anesthesia services provided to the Medicaid patient in the amount of $6,450.00.[5] UnitedHealthcare calculated the payment due to NorthStar at $1,440.72 as determined by the government-mandated reimbursement amount for its insured under its managed Medicaid plan.[6] NorthStar did not appeal UnitedHealthcare's payment on the claim.[7]

How reimbursement works among medical providers and commercial health insurers of patients not covered by a federal health insurance program like Medicare and Medicaid.

A little side analysis will help understand this dispute. An in-network provider may bill the patient at the rate the provider agreed to accept under its contract with an insurer or health plan, like UnitedHealthcare, and the in-network provider may not bill patients for additional amounts.[8] But an out-of-network provider may charge the patient for services at a rate it determines.[9] This may not be a problem for a patient who selects medical providers and services on a routine basis with the time to select providers and stay "in-network." But there are some cases where a patient covered by a health plan does not have control over whether he or she seeks in-network medical care: where the patient receives emergency medical services, receives non-emergency care from an out-of-network provider at an in-network facility, or receives services from an out-of-network air ambulance service provider. In these situations, an out-of-network provider is free to bill a patient who is then responsible for paying the difference between the out-of-network provider's charge and the amount the patient's health plan will pay. The out-of-network provider can seek payment from the patient in a practice called "balance billing," often "surprising" patients with medical bills when seeking emergency medical care or receiving medical care at an in-network facility from an out-of-network provider.[10]

The No Surprises Act provides the defined remedy.

To protect patients from "surprise" medical bills from out-of-network providers, Congress passed the No Surprises Act effective January 1, 2022.[11] The Act does ***not*** apply to patients covered by Medicare or Medicaid, Veterans Affairs Health Care, and TRICARE (federal insurance for active and retired military personnel and their families) because those federal insurance programs have separate protections against balance billing.[12]

Congress, through the Act, shifts payment disputes from patients and onto providers and insurers by creating an Independent Dispute Resolution ("IDR") process for billing disputes.[13] The process is triggered when an out-of-network provider and an insurer dispute the cost of services to be reimbursed. The provider and insurer first try to agree on a cost of the services through a thirty-day "open negotiation" period.[14] If the parties cannot agree during the open negotiation period, a party may initiate the Independent Dispute Resolution process to be resolved by an "independent dispute resolution entity" certified by the Department of Health and Human Services.[15]

The certified Independent Dispute Resolution entity determines the amount the insurer owes the provider in a "baseball-style" dispute resolution process where the insurer and provider submit to the entity an offer of payment.[16] The Independent Dispute Resolution entity must select one party's offer as the award based on considerations mandated in the No Surprises Act.[17]

The Independent Dispute Resolution entity's award determination "shall be binding . . . in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the [Independent Dispute Resolution] entity involved regarding such claim" and "shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a)" of the Federal Arbitration Act.[18]

UnitedHealthcare and NorthStar dispute the insurer's reimbursement obligation.

We return to NorthStar's unpaid bill for approximately $5,000.00. NorthStar began a dispute resolution process for the anesthesia services rendered to the Medicaid patient under the federal No Surprises Act covering disputes between providers and commercial insurers two months after UnitedHealthcare paid it the Medicaid rate for its services.[19] Despite the Medicaid payment of $1,440.72, NorthStar, through HaloMD, sought $7,075.00 for the disputed claim—$625.00 more than the $6,450.00 NorthStar initially billed UnitedHealthcare.[20] UnitedHealthcare alleges NorthStar added $625.00 to the disputed claim to cover HaloMD's contingent fee.[21]

UnitedHealthcare immediately objected to the Independent Dispute Resolution process based on the patient's Medicaid status, asserted the claim is not eligible for the Independent Dispute Resolution process, and provided documentation of the patient's status as Medicaid insured.[22] UnitedHealthcare told the Independent Dispute Resolution entity the claim is not eligible for dispute resolution because the patient is enrolled in Medicaid.[23]

Despite UnitedHealthcare's objection to the dispute resolution process based on the patient's Medicaid status, the Independent Dispute Resolution entity found in favor of NorthStar on May 2, 2025, and ordered UnitedHealthcare to pay NorthStar $7,075.00, ignoring UnitedHealthcare's documents confirming the patient is enrolled in Medicaid making the claim ineligible for the dispute resolution process under the Act.[24] NorthStar later agreed before us it should not have disputed the charge and conceded the No Surprises Act and its dispute resolution process does not apply to Medicaid patients.[25] Its post-hoc explanation is a data processor incorrectly selected the wrong UnitedHealthcare plan from a drop-down menu, selecting a UnitedHealthcare commercial plan instead of the UnitedHealthcare Medicaid plan covering the particular patient.[26]

UnitedHealthcare sued NorthStar for common law fraud seeking declaratory and injunctive relief.

UnitedHealthcare sued NorthStar seven months after the Independent Dispute Resolution entity found in favor of NorthStar. It claims we enjoy federal question jurisdiction over its state law claim because resolution of its claim raises disputed and substantial questions under, and will require us to interpret, the federal No Surprises Act.[27] UnitedHealthcare alleges NorthStar "fraudulently attested" its anesthesia claim is within the scope of the federal Independent Dispute Resolution process with full knowledge, or at least with reckless disregard, the patient is in the Medicaid program and not eligible for the Independent Dispute Resolution process under the No Surprises Act.[28]

UnitedHealthcare alleges a claim for common law fraud, seeking an award of compensatory, punitive, and exemplary damages, an award of attorney's fees, costs, and interests, and any other relief we find just and proper, as well as declaratory and injunctive relief under the Declaratory Judgment Act.[29] UnitedHealthcare does not allege paying NorthStar the difference between the $7,075.00 Independent Dispute Resolution award and the $1,440.00 UnitedHealthcare paid in February 2025. UnitedHealthcare paid NorthStar $1,440.00 for the anesthesia claim and a $115.00 administration fee to the Independent Dispute Resolution entity EdiPhy Advisors.[30]

UnitedHealthcare broadly alleges it has "no adequate recourse under" the No Surprises Act because the Independent Dispute Resolution process is categorically "broken" and providers like NorthStar are "intentionally submitting ineligible Medicare and Medicaid-related disputes" for Independent Dispute Resolution in violation of the Act and, even though UnitedHealthcare objected to the resolution process because the Act does not apply to Medicaid patients, Independent Dispute Resolution entities "are illegally exercising authority over the ineligible disputes and are issuing awards in favor of providers at indefensibly high amounts . . . ."[31]

UnitedHealthcare concedes the Department of Labor and Department of Treasury issued in June 2025 "Technical Assistance" instructions for certified Independent Dispute Resolution entities and disputing parties where there are errors identified after closure of a dispute, including a category of cases defined as "jurisdictional error" when a certified Independent Dispute Resolution entity incorrectly determines eligibility for the dispute resolution process because the claims involve patients under the Medicare and Medicaid programs.[32] But UnitedHealthcare alleges the instructions issued by the Department of Labor and Department of Treasury leave it without an adequate remedy because of conflicts of interests within the Departments' procedures, including referring the closed dispute back to the same Independent Dispute Resolution entity "who made the erroneous eligibility determination in the first place to attempt to correct its decision."[33]

UnitedHealthcare asks us to remedy the process set by Congress through a state common law fraud claim. It asks us under the Declaratory Judgment Act to:

- Declare NorthStar's conduct in initiating the Independent Dispute Resolution procedure ***in this case*** (the Medicaid patient receiving anesthesia at St. Mary's Hospital) "was unlawful and fraudulent;"
- Declare, presumably in all cases:
    - Medicare and Medicaid-related claims are not eligible for Independent Dispute Resolution under the No Surprises Act; and
    - Unidentified and future Independent Dispute Resolution awards "issued on unqualified items or services are non-binding and are not payable;" and,
- Enjoin NorthStar in matters not before us "from continuing to submit false attestations and initiate the [No Surprises Act Independent Dispute Resolution] process for items or services that are not qualified for [No Surprises Act Independent Dispute Resolution], or from seeking to enforce non-binding awards entered on items and services not qualified for the [No Surprises Act Independent Dispute Resolution] process."[34]

II. Analysis

NorthStar moved to dismiss arguing: (1) UnitedHealthcare does not allege fraud with particularity, specifically the justifiable reliance and causation elements; (2) we lack subject matter jurisdiction; (3) NorthStar's "prompt corrective action" to improve claims processing and conceding Medicaid claims are not subject to the Act making UnitedHealthcare's claims moot; and, alternatively, (4) we should dismiss without prejudice and defer the matter to the Centers for Medicare & Medicaid Services under the primary jurisdiction doctrine.

We lack subject matter jurisdiction and dismiss without prejudice to allow UnitedHealthcare to pursue its common law fraud claim against NorthStar in state court. UnitedHealthcare does not plead facts allowing us to plausibly infer its common law fraud claim comes within the "special and small category" of cases giving rise to federal jurisdiction under Supreme Court precedent.[35] Lacking subject matter jurisdiction, we will not address the other arguments raised in NorthStar's Motion to dismiss.

UnitedHealthcare's common law fraud claim seeking money damages and declaratory and injunctive relief does not fit within our limited subject matter jurisdiction absent a federal question. Congress through the Declaratory Judgment Act does not itself create an independent basis for federal jurisdiction; it provides "a remedy for controversies otherwise properly within the court's subject matter jurisdiction."[36] Because federal law does not create UnitedHealthcare's common law fraud claim, its claim can only "aris[e] under the Constitution, laws, or treaties of the United States" if the "state-law claim necessarily raise[s] a stated federal issue, actually disputed and substantial, which a federal forum may entertain without disturbing any congressionally approved balance of federal and state judicial responsibilities."[37]

The Supreme Court in two cases—*Grable & Sons Metal Products, Inc. v. Darue Engineering & Manufacturing* and *Gunn v. Minton*—developed a four-part test to determine whether a federal court may exercise its jurisdiction: "federal jurisdiction over a state law claim will lie if a federal issue is (1) necessarily raised, (2) actually disputed, (3) substantial, and (4) capable of resolution in federal court without disrupting the federal-state balance approved by Congress."[38] All four prongs of the *Grable/Gunn* test must be met for federal jurisdiction to attach.[39] Only a "slim category" of cases asserting state-law claims satisfy the *Grable/Gunn* test.[40] We determine our jurisdiction "based only on the allegations in [UnitedHealthcare's] 'well-pleaded complaint'—not on any issue [NorthStar] may raise."[41]

NorthStar challenges the second and third elements of the *Grable/Gunn* test.[42] UnitedHealthcare argues it meets all four prongs of the *Grable/Gunn* test. We conclude UnitedHealthcare does not meet the first and third elements of the test required for federal question jurisdiction.

A. UnitedHealthcare's common law fraud claim does not "necessarily raise" a federal issue.

The first element of the *Grable/Gunn* test requires UnitedHealthcare to show its common law fraud claim "necessarily raise[s]" a federal issue. A federal issue is "necessarily raised" where the "vindication of a right under state law . . . necessarily turn[s] on some construction of federal law.[43]

UnitedHealthcare argues its fraud claim necessarily requires us to construe the No Surprises Act on three legal issues: (1) whether NorthStar's false attestation the patient's Medical claim is eligible for the Act's Independent Dispute Resolution "constitutes fraud;" (2) whether an Independent Dispute Resolution award issued on an ineligible claim, and thus outside the Independent Dispute Resolution entity's jurisdiction, is binding on the parties; and (3) whether the

Act's administrative remedies preclude, or must be exhausted before, seeking judicial relief for fraud.[44]

We measure the "necessarily raised" element guided by the Supreme Court's decision in *Grable*. The Internal Revenue Service seized a business to satisfy a federal tax delinquency.[45] The Service sold the property to another business and gave the buying business a quitclaim deed. The Grable company then brought a quiet title action in state court arguing the buyer's purchase of the property is invalid because no one gave it notice of the Internal Revenue Service's seizure in the exact manner required by the Internal Revenue Code.[46] The buyer removed the case invoking the court's federal question jurisdiction because the quiet title action depended on the interpretation of the Internal Revenue Service code regarding notification of seizure.[47] Judge McKeague found he had jurisdiction and the United States Court of Appeals for the Sixth Circuit affirmed. The Supreme Court held Grable's quiet title action necessarily raised a federal issue because "whether Grable was given notice within the meaning of the federal statue is . . . an essential element of its quiet title claim."[48]

We see no similarity between the quiet title action requiring analysis of the Internal Revenue Service notice regulation as an element of the claim to be determined in *Grable* and UnitedHealthcare's fraud claim here. The elements of fraud under Pennsylvania law are: "(1) a representation; (2) which is material to the transaction at hand; (3) made falsely, with knowledge of its falsity or recklessness as to whether it is true or false; (4) with the intent of misleading another into relying on it; (5) justifiable reliance on the misrepresentation; and (6) the resulting injury was proximately caused by the reliance."[49]

UnitedHealthcare's state law fraud claim does not arise under federal law and does not necessarily raise a federal issue. United Healthcare's allegation is NorthStar "fraudulently

attested" to the Independent Dispute Resolution entity the services at issue are qualified items and services within the scope of the Independent Dispute Resolution process; NorthStar initiated the Independent Dispute Resolution process "with full knowledge of, or at the very least with reckless disregard to, the falsity of [its] attestation;" NorthStar "knew that the dispute it was initiating was ineligible for the [Independent Dispute Resolution] process;" NorthStar knowingly submitted the false attestations with the intent for the Independent Dispute Resolution entity and United Healthcare to rely on them and continued to "deliberate[ly] misrepresen[t]" to the Independent Resolution entity its claim is a qualified service within the scope of the Independent Dispute Resolution process all in an effort to receive a "windfall" for itself through an award five times what NorthStar conceded is the "qualified payment amount" on the claim never eligible for the No Surprises Act Independent Dispute Resolution process in the first place.[50]

We disagree a federal issue is necessarily raised in UnitedHealthcare's common law fraud claim. UnitedHealthcare argues the question of whether NorthStar's false attestation "constitutes fraud" necessarily requires our construction of the No Surprises Act. But there is no dispute the Act does not apply to Medicare, Medicaid, and other federal insurance programs. UnitedHealthcare's common law fraud claim does not necessarily depend on a resolution of the No Surprises Act.

Congress provided a specific remedy under the No Surprises Act which UnitedHealthcare elected not to pursue. Award determinations made by an Independent Dispute Resolution entity are binding except in "the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the [Independent Dispute Resolution] entity involved regarding such claim" and "shall not be subject to judicial review, except in a case described in any of the paragraphs" in section 10(a) of the Federal Arbitration Act.[51] Congress through Sections 10(a)(1) and (4) of the

Federal Arbitration Act allows us to vacate an award "procured by corruption, fraud, or undue means" and 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."[52] UnitedHealthcare could have, but chose not to, pursue the defined remedy set by Congress under the Act. It instead elected to allege a common law fraud claim and bootstrap the common law claim into declaratory and injunctive relief with no federal jurisdictional basis.

We disagree with UnitedHealthcare's argument its fraud claim necessarily requires construction of the No Surprises Act because we must determine "whether [Independent Dispute Resolution] awards issued on ineligible claims, and thus outside the [Independent Dispute Resolution] entity's jurisdiction, are binding on the parties."[53] There is no dispute awards issued outside the Independent Dispute Resolution entity's jurisdiction are not binding on the parties and the No Surprises Act provides a remedy to challenge both fraudulent awards and extrajurisdictional awards.[54] The Departments of Health and Human Services, Labor, and the Treasury issued Technical Assistance for handling jurisdictional errors including "where the eligibility of the item or service was incorrectly determined based on . . . an item or service payable by Medicare, Medicaid" and other federal insurance programs.[55] The Departments "determined jurisdictional errors should be corrected by reopening a dispute to ensure compliance" with the No Surprises Act's requirements.[56] We see no need for statutory interpretation as UnitedHealthcare argues.[57]

And we disagree with UnitedHealthcare's argument resolving its common law fraud claim necessarily requires we interpret the No Surprises Act on whether the Act's administrative remedies preclude, or must be exhausted before pursuing, judicial relief for fraud. NorthStar asserted the administrative remedies argument in its Motion to dismiss in the context of its argument UnitedHealthcare cannot show proximate cause. It argued Congress, and the Centers for

Medicare & Medicaid Services (through the power delegated to it by Congress), created administrative and judicial remedies for resolving disputes and UnitedHealthcare chose to bypass those remedies and seek judicial relief. NorthStar's argument does not "necessarily raise" a federal question through interpretation of the No Surprises Act. As directed by the Supreme Court, we determine jurisdiction by UnitedHealthcare's well-pleaded complaint and not on affirmative defenses raised by NorthStar.[58] UnitedHealthcare's "complaint—[its] own claims and allegations—[is] the key to 'arising under' jurisdiction" and "[i]f the complaint presents no federal question, a federal court may not hear the suit."[59]

B. UnitedHealthcare's common law fraud claim does not fall within the narrow category of claims raising a substantial federal issue.

The third element of the *Grable/Gunn* test requires UnitedHealthcare to show its common law fraud claim is "substantial" to be able to proceed.

We assess the substantiality factor by considering "the importance of the issue to the federal system as a whole," primarily focusing our inquiry "not on the interests of the litigants themselves, but rather on the broader significance for the Federal Government."[60] Our Court of Appeals instructs a claim is more likely to be "substantial" if it presents "a pure question of law, the resolution of which will govern numerous future cases."[61] "Fact-bound and specific situation" claims are "less likely to present a substantial federal issue."[62]

Using *Grable* as an example, the Supreme Court in *Gunn* explained the United States had a "strong interest" in being able to recover delinquent taxes through the seizure and sale of property "which in turn" required clear terms of notice to allow buyers to satisfy themselves the Internal Revenue Service passed clear title.[63] The Internal Revenue Service's interest in "the availability of a federal forum to vindicate its own administrative action" made the quiet title action in *Grable*

"an important issue of federal law that sensibly belong[ed] in a federal court."[64] We see no such federal interest in UnitedHealthcare's allegation NorthStar defrauded it.

UnitedHealthcare's fraud claim does not fall within the narrow category of claims raising substantial federal issues. This is not a pure question of law as in *Grable*. We disagree with UnitedHealthcare's characterization its concern presents a question of law and not fact; it argues the "central factual question [is] whether or not the claim NorthStar falsely attested was eligible for the [Independent Dispute Resolution] process was, in fact, eligible" and that issue "is not disputed."[65] UnitedHealthcare asserts "the core factual questions are undisputed" and the substantial question arises out of the "legal significance of those facts and whether NorthStar's action amounts to fraud."[66] UnitedHealthcare's argument flips the facts on their head. Everyone agrees the patient's Medicaid claim here is not eligible for the Independent Dispute Resolution process under the Act. The question is whether NorthStar knew the Medicaid claim is not eligible for the Independent Dispute Resolution process but fraudulently initiated the process anyway in an attempt to secure "a windfall for itself."[67] We are presented with a question of fact.

C. UnitedHealthcare has not pleaded a basis to find its common law fraud claim arises under federal law.

UnitedHealthcare did not cite authority to support the "necessarily raised" or "substantial" elements of the *Grable/Gunn* test in the context of the No Surprises Act. Our search of relevant authority did not find a decision from a federal court finding a state common law claim turns on substantial questions of federal law under the No Surprises Act.

For example, in *Kennedy* a provider sued UnitedHealthcare in state court for common law breach of implied-in-fact contract and unjust enrichment, alleging UnitedHealthcare unlawfully denied reimbursement for emergency medical services rendered to a UnitedHealthcare plan member.[68] The provider alleged UnitedHealthcare opened an investigation into the provider's

billing practices and stopped payment on claims suspecting fraud.[69] UnitedHealthcare removed the action from state court arguing the state law claims raised substantial federal questions under the Affordable Care Act and the Emergency Medical Treatment and Labor Act.[70] The provider moved to remand arguing the court lacked subject matter jurisdiction under section 1331.

Judge Engelmayer agreed, concluding the provider did not bring claims under federal law and the two state law claims did not fit within the "special and small category" of state law claims "that embed federal issues so as to give rise to federal question jurisdiction."[71] Judge Engelmeyer applied the *Grable/Gunn* test to find the provider's claims did not meet the "necessarily raised," substantial, or federal-state balance factors and remanded the action to state court.

On the "necessarily raised" factor, Judge Engelmayer reasoned the provider pleaded an independent state law claim under New York's public health statute as the basis of the unjust enrichment claim because the New York statute required the provider to perform the services for which the provider claimed he was unjustly denied compensation. Judge Engelmayer concluded the federal Emergency Medical Treatment and Labor Act is not "essential" to the unjust enrichment claim and the case is capable of resolution without reaching federal law issues.[72]

On the "substantial" factor, Judge Engelmayer concluded to the extent the federal Emergency Medical Treatment and Labor Act may require application to the provider's state law claims, such an application is "narrow, fact-bound and lacking systemic importance" and the federal statute would "play a peripheral role in resolving" the state law claim.[73] Judge Engelmayer rejected UnitedHealthcare's argument the parties' dispute is a purely legal question because it requires a determination of whether the provider's status as an on-call emergency physician at an out-of-network hospital triggers the federal Emergency Medical Treatment and Labor Act making

it a "substantial" federal issue.[74] Judge Engelmayer concluded the "dispute has been manufactured by United" and United failed to show the significance of the issue to the federal government.[75]

Judge Engelmayer also rejected UnitedHealthcare's argument the No Surprises Act supplies the "exclusive remedy" for out-of-work healthcare providers seeking payment for emergency services and thus supplants state-law remedies.[76] Judge Engelmayer found United's argument "not anchored in any legal authority" and it did not identify authority holding the No Surprises Act bars medical providers from bringing state law claims against the patient's insurer.[77] Judge Engelmayer found the No Surprises Act itself provides it "shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" under the Act.[78]

Judge Engelmayer's decision in *Kennedy* offers persuasive guidance today. UnitedHealthcare argued to Judge Engelmayer the provider's state law claims necessarily raised federal questions under both the Affordable Care Act and Emergency Medical Treatment and Labor Act as it does today with the No Surprises Act. But UnitedHealthcare lost the "necessarily raised," "substantial," and "federal-state balance" factors of the *Grable/Gunn* test. Judge Engelmayer's reasoning informs our conclusion UnitedHealthcare does not meet the "necessarily raised" and "substantial" prongs of the *Grable/Gunn* test.[79]

We are also guided by Judge Calvert's analysis last month in *Neuroshield Network SE, LLC* remanding a state law complaint seeking to enforce arbitration awards through the No Surprises Act Independent Dispute Resolution process for lack of jurisdiction.[80] Providers sued health plans in Georgia state court asserting Georgia statutory claims and common law claims for

"action for payment" of Independent Dispute Resolution determinations, unjust enrichment, quantum meruit, and "money had and received."[81]

The health plan removed the action, arguing the federal court enjoyed subject matter jurisdiction over the state law claims under the *Grable/Gunn* test.[82] Judge Calvert disagreed, finding the state law claims "do not fall into the narrow category of claims raising substantial federal issues."[83] We recognize Judge Calvert analyzed jurisdiction through the lens of the enforcement of an Independent Dispute Resolution award through state law claims. But we do not find Judge Calvert's analysis in *Neuroshield Network* distinguishable simply because UnitedHealthcare is not seeking to enforce the Independent Dispute Resolution award.[84]

Judge Calvert reasoned the providers' state law claims did not meet the substantiality requirement of *Grable/Gunn*; the claims did not raise a pure question of law because the providers sought enforcement of the Independent Dispute Resolution award, "not merely interpret the [No Surprises Act]"; her decision whether to enforce the Independent Dispute Resolution award will affect only the enforcement of the award in this particular case; and the federal government does not have a strong interest in litigating the claim in a federal forum.[85] We find Judge Calvert's reasoning persuasive.

We are also guided by the analysis offered by Judges Anderson, Whitehead, and Flanagan over the past two years remanding state law claims for lack of subject matter jurisdiction in the context of No Surprises Act cases. In *Bishop*, Judge Anderson considered a state unfair competition claim and claim for declaratory relief asserted by a patient who alleged her insurer wrongfully processed medical services as out-of-network violating the No Surprises Act and violating unfair billing practices prohibited by California law.[86] The insurer removed asserting a question of federal law embedded in the state law claim under *Grable/Gunn*. The insurer argued

the patient's claim is "entirely premised" on an alleged violation of the No Surprises Act, the state law unfair competition claim is based on the alleged violation of the No Surprises Act, and the claim under the Declaratory Judgment Act asks the court to interpret the No Surprises Act.[87] Judge Anderson disagreed and remanded. He reasoned the patient alleged violations of both federal and state law theories of liability, the patient's right to relief did not necessarily depend on the resolution of the No Surprises Act, and he could find no basis to conclude the No Surprises Act grants exclusive jurisdiction to federal courts or provides the sole remedy for the injury alleged in the complaint.[88]

In *Billing*, a provider sued an insurer under the Washington state Uniform Arbitration Act seeking judicial confirmation of three awards in the provider's favor in an Independent Dispute Resolution process under the No Surprises Act.[89] The insurer removed claiming the provider raised a significant question of federal law under *Grable/Gunn* and subject to federal question jurisdiction. Judge Whitehead disagreed and remanded the case. Judge Whitehead reasoned the provider sought to enforce payment of the Independent Dispute Resolution award through a state law mechanism, the claim did not require an interpretation of the No Surprises Act "disturb[ing] any congressionally approved balance of federal and state judicial responsibilities," distinguished *Grable* because the provider's state law claim did not dispute the meaning of the No Surprises Act or assert the Independent Dispute Resolution award should be enforced under the No Surprises Act, unlike the IRS regulation disputed in *Grable*.[90]

And in *Columbus Emergency Group, LLC*, Judge Flanagan remanded unjust enrichment and unfair and deceptive trade practices claims under North Carolina law brought by a group of providers against an insurer.[91] The providers alleged the insurer refused to pay awards as determined in the Independent Dispute Resolution process. The insurer removed arguing the

providers' claims raised a federal question under *Grable/Gunn*.[92] Judge Flanagan found the insurer did not meet either the necessarily raised or substantiality prongs of the *Grable/Gunn* test.[93] Judge Flanagan concluded the state law claims did not require interpretation of the No Surprises Act. She rejected the insurer's argument the providers' claim the insurer owed them money required resolution of whether the Independent Dispute Resolution entity "validly awarded" claims in favor of the providers, whether the awards are enforceable, and whether federal law allows a judicial remedy.[94] Judge Flanagan found the insurer conflated the legal elements of the state law claims with the facts of the case and to the extent the case involved questions of federal law, they arose as a defense to the claims.[95] On the substantiality prong, Judge Flanagan concluded the providers' claims were retrospective and not substantial enough to give rise to federal question jurisdiction.[96] We find Judge Flanagan's reasoning persuasive. We conclude UnitedHealthcare does not meet its burden of pleading facts allowing us to plausibly infer its state law fraud claim "necessarily raises" a federal issue or is "substantial" to a federal issue.

NorthStar cited Judge Scott's analysis earlier this month in *Anthem Blue Cross Life and Health Insurance Company.*[97] Insurer Anthem Blue Cross sued providers and HaloMD under the Racketeering Influenced and Corruption Organizations Act (RICO) and the Employee Retirement Income Security Act (ERISA), sought vacatur of the Independent Dispute Resolution award under the No Suprises Act, sought declaratory and injunctive relief, and asserted state law claims of fraudulent misrepresentation, negligent misrepresentation, and unfair competition.

Anthem alleged the providers and their agent used "tactics" to turn the Independent Dispute Resolution process under the No Surprises Act "into a vehicle for fraud" by manipulating the process through the submission of ineligible claims to the process including Medicaid and Medicare claims, making inflated payment offers for their charges, and making false statements,

representations, and attestations of eligibility to Anthem, the Independent Dispute Resolution entities, and federal agencies.[98] Judge Scott reviewed Anthem's vacatur claim before concluding it did not meet the substantive requirements for vacatur under section 10(a)(1) or (4) incorporated into the No Surprises Act.[99] Judge Scott then analyzed whether she had subject matter jurisdiction over the remaining federal claims including under RICO and ERISA and claims for declaratory and injunctive relief.[100] Judge Scott concluded she did not have subject matter jurisdiction over the claims because Anthem's RICO and ERISA claims sought review of Independent Dispute Resolution determinations "regardless of the legal label."[101] Judge Scott rejected Anthem's argument Congress's limit, under the No Surprises Act, on judicial review only applied to payment determinations and not eligibility determinations. Judge Scott reasoned if she read the No Surprises Act in the manner suggested by Anthem, there would be "***no*** limits on judicial review of [Independent Dispute Resolution entities'] eligibility determinations, . . . clearly contrary to the streamlined dispute resolution process that Congress intended when it created the [No Surprises Act's Independent Dispute Resolution] process."[102]

Judge Scott also rejected Anthem's policy argument she should not apply the limits on judicial review imposed by the No Surprises Act "because the [Independent Review Process] is deeply flawed and there is no readily available remedy for erroneous [Independent Dispute Resolution] awards."[103] Judge Scott concluded "such policy-based arguments would be better directed at Congress which alone has the power to rewrite the [No Surprises Act]."[104] Judge Scott also rejected Anthem's request for a "follow-the-law injunction" prohibiting the Defendant providers "from making future false eligibility attestations . . . [because] [Anthem] would be able to come back into court to request a contempt remedy for violations of such an injunction, a remedy

that would require litigating whether the challenged attestation was false . . . [and] are all end runs around the [No Surprises Act's] limits on judicial review."[105]

UnitedHealthcare argues Judge Scott's analysis in *Anthem* is "irrelevant" and distinguishable because, unlike Anthem, UnitedHealthcare did not plead RICO or ERISA claims and did not seek vacatur of the one Medicaid claim at issue in this case made by the Independent Dispute Resolution entity under the No Surprises Act.[106] UnitedHealthcare also argues the *Anthem* case is distinguishable because Judge Scott found Anthem did not list all the Independent Dispute Resolution determinations it sought to vacate and, in contrast, UnitedHealthcare here pleaded fraud with specificity with regard to the one Medicaid claim.[107]

We are not persuaded by UnitedHealthcare's attempts to distinguish *Anthem*. Unlike UnitedHealthcare here, Anthem at least asserted federal claims under RICO and ERISA affording Judge Scott federal question jurisdiction making a *Grable/Gunn* theory of federal jurisdiction unnecessary. And even with the asserted RICO and ERISA claims, Judge Scott concluded claims under those statutes essentially sought review of the Independent Dispute Resolution entities' determinations, are contrary to Congress's limitations on judicial review in the No Surprises Act, Anthem made policy arguments better directed to Congress, and a "follow-the-law injunction" allowing Anthem to return to enforce the injunction are "end runs around" the No Surprises Act's limits on judicial review.

UnitedHealthcare makes essentially the same arguments today as Judge Scott rejected in *Anthem*. UnitedHealthcare alleges it has "no adequate recourse" under the No Surprises Act, the "system is broken," and has "no adequate remedy without judicial relief," the same "the [Independent Dispute Resolution] process is deeply flawed" argument rejected by Judge Scott.[108]

We decline to remedy what UnitedHealthcare believes is a "broken system" and bypass Congress's intent in the No Surprises Act. We are guided by thoughtful analysis including Judge Scott's *Anthem* decision in concluding UnitedHealthcare is trying to evade Congress's policy choices in limiting judicial review because UnitedHealthcare believes the No Surprises Act leaves it with an inadequate remedy.

Our colleague Judge Wolson's decision earlier this month in *Advanced Vascular Associates* further supports our conclusion the No Surprises Act limits judicial review.[109] The provider began the Independent Dispute Resolution process for claims submitted to the insurer and the Independent Dispute Resolution entity awarded the amount requested by the provider. The insurer failed to pay the amounts either because it underpaid or failed to timely pay the awards. The provider sued the insurer seeking confirmation of the awards under section 9 of the Federal Arbitration Act and alleged the insurer violated the No Surprises Act by failing to comply with the Independent Dispute Resolution determinations.[110]

Judge Wolson concluded the No Surprises Act did not authorize either form of judicial relief sought by the provider and granted the insurer's motion for judgment on the pleadings.[111] Judge Wolson rejected the provider's argument the administrative remedies under the No Surprises Act are "inadequate" because it is not for the court to decide, Congress decided how to structure the remedies under the Act, and he could not "rewrite [the No Surprises Act] just because [provider] or some other provider is dissatisfied with Congress's choice. [Provider's] remedy is with Congress, not me, to fix the statute if it thinks there is a problem."[112]

Judge Wolson considered different facts and claims than those we consider today. But his decision informs our assessment UnitedHealthcare's theory we should provide it a remedy because it has no adequate recourse under the No Surprises Act is without merit.

III. Conclusion

We dismiss UnitedHealthcare's claims for lack of subject matter jurisdiction.

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[1] ECF 1 ¶ 7. Medicaid is a joint federal and state program providing health coverage to income-eligible individuals. *What is the Medicaid program?*, U.S. Dep't of Health & Hum. Servs., https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-medicaid-program/index.html [https://perma.cc/L97L-4Z2X] (last visited April 23, 2026).

The program is administered by the individual states within federal guidelines set by the Centers for Medicare & Medicaid, an agency within the Department of Health and Human Services. *Medicaid*, Medicaid.gov, https://www.medicaid.gov/medicaid#:~:text=Medicaid%20provides%20health%20coverage%20to,states%20and%20the%20federal%20government [https://perma.cc/W45T-JLSN] (last visited April 27, 2026).

[2] ECF 1 ¶¶ 55, 57.

[3] *Id.* ¶ 57. NorthStar is an anesthesia management company. *Id.* ¶ 8.

[5] *Id.* ¶ 59.

[6] *Id.* ¶ 60.

[7] *Id.* ¶ 66.

[8] *No Surprises: Understand your rights against surprise medical bills*, CMS.gov, https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills [https://perma.cc/7MRY-X9RH] (last visited April 23, 2026).

[9] https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/ publications/avoid-surprise-healthcare-expenses [https://perma.cc/AX5M-DP23] (last visited April 23, 2026).

[10] *No Surprises: Understand your rights against surprise medical bills*, *supra* note 8.

[11] *See* 42 U.S.C. §§ 300gg-111, 300gg-112; *see also No Surprises: Understand your rights against surprise medical bills*, *supra* note 8.

[12] *The No Surprises Act at a Glance: Protecting Consumers Against Unexpected Medical Bills*, CMS.gov, https://www.cms.gov/files/document/nsa-at-a-glance.pdf [https://perma.cc/WCD7-HC5V] (last visited April 23, 2026).

[13] 42 U.S.C. § 300gg-111(c).

[14] *Id.* § 300gg-111(c)(1)(A).

[15] *Id.* §§ 300gg-11(c)(1)(B), (c)(4).

[16] *Id.* § 300gg-111(c)(5); *Guardian Flight, LLC v. Health Care Serv. Corp.*, 140 F.4th 271, 273–74 (5th Cir. 2025), *cert. denied*, No. 25-441, 2026 WL 79855 (Jan. 12, 2026) (describing the Independent Dispute Resolution process under the No Surprises Act).

[17] *Guardian Flight*, 140 F.4th at 273–74.

[18] 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I)–(II) (incorporating 9 U.S.C. § 10(a)(1)–(4).

[19] ECF 1 ¶ 67; 42 U.S.C. §§ 300gg-111, 300gg-112.

[20] ECF 1 ¶ 70. HaloMD, LLC is not a party to this action but NorthStar alleges it works for providers like NorthStar for a contingent fee, alleging HaloMD, as one of "the three most prolific filers of [Independent Dispute Resolution] process disputes," initiated over 134,000 disputes in the last half of 2024, exceeding the Centers for Medicare & Medicaid Services' original estimate for total annual disputes more than sixfold. *Id.* ¶ 68 & n.36. Although it did not sue HaloMD, UnitedHealthcare appears to suggest it has complicity as the agent of NorthStar.

[21] *Id.* ¶ 70.

[22] *Id.* ¶¶ 73–74.

[23] *Id.* ¶ 75.

[24] *Id.* ¶¶ 76–79. UnitedHealthcare did not sue the Independent Dispute Resolution entity, EdiPhy Advisors, LLC, but expends ten paragraphs of its Complaint alleging EdiPhy Advisors lacked jurisdiction over resolution of a Medicaid claim, EdiPhy Advisors acted in "derelict[ion] [of] its duty to determine eligibility of the Medicaid claim submitted by NorthStar," its failure to distinguish between an ineligible Medicaid claim and an eligible commercial insurance claim "raises serious doubts about whether it has the requisite expertise to continue to qualify as a certified [Independent Dispute Resolution entity]," EdiPhy Advisors is "incentivized" to find in favor of providers, and EdiPhy Advisors "blatantly exceeded its authority and jurisdiction" under the No Surprises Act. *Id.* ¶¶ 80–94.

[25] ECF 26-1 at 17–19.

[26] *Id.* at 6–7; ECF 26-2, Declaration ¶ 32. NorthStar submits the Declaration of a NorthStar Vice President swearing to facts regarding the processing of the Medicaid patient's claim properly asserted in a Rule 56 motion, not a motion to dismiss.

[27] ECF 1 ¶ 9; 28 U.S.C. § 1331.

[28] ECF 1 ¶¶ 72, 108–112.

[29] ECF 1, Complaint at 34-35, Prayer for Relief ¶¶ A–G.

[30] ECF 1 ¶¶ 60–61, 69, 113. Counsel for UnitedHealthcare certified a demand of $915. *See* ECF 1-1 at 1.

[31] *Id.* ¶¶ 95–96.

[32] *Id.* ¶ 96, n. 51 (citing *Errors Identified After Dispute Closure, CMS.gov* https://www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf).

[33] *Id.*

[34] ECF 1, Complaint at 34, Prayer for Relief ¶¶ A–D.

[35] *Gunn v. Minton*, 568 U.S. 251, 258 (2013) (quoting *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 699 (2006)).

[36] *Auto-Owners Ins. Co. v. Stevens & Ricci Inc.*, 835 F.3d 388, 394 (3d Cir. 2016).

[37] 28 U.S.C. § 1331; *Gunn,* 568 U.S. at 258 (quoting *Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 545 U.S. 308, 314 (2005)).

[38] *Gunn*, 568 U.S. at 258 (quoting *Grable*, 545 U.S. at 313–14).

[39] *Id.*

[40] *Manning v. Merrill Lynch Pierce Fenner & Smith, Inc.*, 772 F.3d 158, 163 (3d Cir. 2014), *aff'd sub nom., Merrill Lynch, Pierce, Fenner & Smith Inc. v. Manning*, 578 U.S. 374 (2016) (quoting *Empire Healthchoice,* 547 U.S. at 701).

[41] *Royal Canin U.S.A., Inc. v. Wullschleger*, 604 U.S. 22, 26 (2025) (quoting *Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Tr. for S. Cal.*, 463 U.S. 1, 9–10 (1983)).

[42] ECF 26-1 at 15-16.

[43] *Johnson v. Mazie*, 144 F.4th 146, 152 (3d Cir. 2025) (quoting *Manning*, 772 F.3d at 163).

[44] ECF 37 at 14.

[45] *Grable*, 545 U.S. at 310.

[46] *Id.* at 311.

[47] *Id.*

[48] *Id.* at 314–15.

[49] *Marion v. Bryn Mawr Tr. Co.*, 288 A.3d 76, 87–88 (Pa. 2023) (quoting *Gibbs v. Ernst*, 647 A.2d 882, 889 (Pa. 1994)).

[50] ECF 1 ¶¶ 108–115. The "qualified payment amount" is the basis for determining individual cost sharing for items and services covered by the prohibition on balance billing under the No Surprises Act. Federal regulations implementing the No Surprises Act requires certified Independent Dispute Resolution entities to consider the "qualified payment amount" when selecting between the offers submitted by a health plan or insurer and the provider when determining the total out-of-network payment rate subject to the Independent Dispute Resolution process. Federal regulation defines the methodology for calculating the qualifying payment amount. 49 C.F.R. § 149.140. An insurer's "qualifying payment amount" is a "heavily regulated rate that reflects the 'median of the contracted rates recognized by the plan or issuer … for the same or a similar item or service' offered in the same insurance market and geographic area." *Guardian Flight*, 140 F.4th at 273–74 (quoting 42 U.S.C. § 300gg-11(a)(3)(E)(i)).

[51] 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I)–(II) (incorporating 9 U.S.C. § 10(a)(1)–(4)) (emphasis added).

[52] 9 U.S.C. §§ 10(a)(1), (4).

[53] ECF 37 at 14.

[54] 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II) (incorporating the Federal Arbitration Act at 9 U.S.C. § 10(a)).

[55] *Errors Identified After Dispute Disclosure,* CMS.gov www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf [https://perma.cc/5T5V-D2CK] (last visited April 23, 2026).

[56] *Id.* at 3.

[57] ECF 37 at 14.

[58] *Royal Canin*, 604 U.S. at 26.

[59] *Id.*

[60] *Gunn*, 568 U.S. at 260 (examining the substantiality prong in *Grable*).

[61] *Apex Constr. Co. v. U.S. Virgin Islands*, Nos. 24-2530, 24-2531, 24-2532, 24-2533, 24-2534, 24-2535, 2026 WL 311946, at *3 (3d Cir. Feb. 5, 2026) (citing *Empire Healthchoice*, 547 U.S. at 700).

[62] *Id.*

[63] *Id.* (quoting *Grable*, 545 U.S. at 315).

[64] *Id.*

[65] ECF 37 at 16.

[66] *Id.*

[67] ECF 1 ¶ 112.

[68] *Kennedy v. UnitedHealth Grp. Inc.*, No. 25-432, 2025 WL 1725147 (S.D.N.Y. June 20, 2025).

[69] *Id.* at *2, n.4.

[70] *Id.* at *3.

[71] *Id.* (quoting *Gunn*, 568 U.S. at 258).

[72] *Id.* at *4–5.

[73] *Id.* at *5.

[74] *Id.* at *6.

[75] *Id.* at *6–7.

[76] *Id.* at *8.

[77] *Id.*

[78] *Id.*

[79] United Healthcare argued to Judge Engelmayer federal jurisdiction would not disturb the balance of judicial responsibilities because federal court dockets will not be flooded with state-law claims by providers against insurers, citing the No Surprises Act. *Id.* at *8. Judge Engelmayer rejected this argument because the Act prevents providers from holding patients liable for the balance of a bill and there is nothing in the Act barring providers from bringing state-law claims against the patient's insurer. *Id.* UnitedHealthcare makes the same argument to us on the fourth prong, arguing once we rule on whether "false eligibility attestations constitute actionable fraud and whether an ineligible [Independent Dispute Resolution] award entered in the absence of jurisdiction is binding, subsequent cases can be adjudicated in state court." ECF 37 at 17–18. This is essentially the same argument rejected by Judge Engelmayer last year.

[80] *Neuroshield Network SE, LLC v. S&S Healthcare Strategies*, Nos. 25-4127, 25-6710, 2026 WL 743000 (N.D. Ga. Mar. 16, 2026).

[81] *Id.* at *2.

[82] *Id.* at *6.

[83] *Id.*

[84] Judge Calvert used the test applied by the United States Court of Appeals for the Eleventh Circuit to assess the substantiality prong of the *Grable/Gunn* test: "(1) whether it is a 'pure question of law,' (2) whether the 'question [ ] will control many other cases,' and (3) whether 'the [federal] government has a strong interest in litigating in a federal forum . . .'" *Id.* (quoting *AST & Sci. LLC v. Delclaux Partners SA*, 143 F.4th 1249, 1253 (11th Cir. 2025), *cert. denied*, 146 S. Ct. 370 (2025)). This test is similar to our Court of Appeals's factors for substantiality. *See Apex Constr. Co.*, 2026 WL 311946 at * 3–4.

[85] *Neuroshield,* 2026 WL 743000 at *6–7.

[86] *Bishop v. Blue Shield of Ca. Life & Health Ins. Co.*, No. 25-1350, 2025 WL 603693 (C.D.Cal. Feb. 24, 2025).

[87] *Id.* at *2.

[88] *Id.*

[89] *Billing v. Premera Blue Cross*, No. 25-442, 2025 WL 2921909 (W.D.Wash. Oct. 15, 2025).

[90] *Id.* at *4.

[91] *Columbus Emergency Grp., LLC v. Blue Cross & Blue Shield of N.C.*, No. 23-1601, 2024 WL 1342764 (E.D.N.C. Mar. 29, 2024).

[92] *Id.* at *2.

[93] *Id.* at *2–4.

[94] *Id.* at *3.

[95] *Id.*

[96] *Id.*

[97] *Anthem Blue Cross Life and Health Ins. Co. v. HaloMD* LLC, No. 25-1467, 2026 WL 982629 (C.D. Cal. Apr. 9, 2026).

[98] *Id.* at *4. Anthem asserted a claim for vacatur of Independent Dispute Resolution determinations under section 300gg-111(c)(5)(E) of the No Surprises Act allowing for judicial review of Independent Dispute Resolution determinations in circumstances described in section 10(a)(1) through (4) of the Federal Arbitration Act under which a district court may vacate an arbitrator's award.

[99] *Id.* at *5–9.

[100] *Id.* at *9.

[101] *Id.*

[102] *Id.* (emphasis in original).

[103] *Id.*

[104] *Id.*

[105] *Id.* at *10. Judge Scott declined to exercise supplemental jurisdiction over the state law claims having no basis for federal subject matter jurisdiction once she dismissed the federal claims. *Id.*

[106] ECF 40.

[107] We disagree with UnitedHealthcare *Anthem* is distinguishable because Judge Scott found Anthem "did not list all the [Independent Dispute Resolution] determinations they seek to vacate." *Anthem*, 2026 WL 982629 at *7. Judge Scott's observation regarding Anthem's failure to list all determinations was not dispositive to her decision. Judge Scott instead found Anthem's claim for vacatur failed because, at least as to the allegation of fraud, Anthem could not identify an example of an Independent Dispute Resolution determination it "could amend and allege that [a provider] made a false eligibility attestation based on facts [Anthem] did not know, and could not reasonably have known, before or during the [Independent Dispute Resolution] process." *Id.* at *8. Judge Scott reasoned Anthem's allegations did not establish the "kind of 'fraud'" justifying vacatur under section 10(a)(1) of the Federal Arbitration Act (incorporated into the No Surprises Act) because Anthem knew of the fraud during the Independent Dispute Resolution process and disclosed it to the Independent Dispute Resolution entity. *Id.* UnitedHealthcare alleges it knew NorthStar sought payment for anesthesia services provided to a Medicaid covered patient and, with knowledge of the Medicaid coverage, initiated the Independent Dispute Resolution process. We also find UnitedHealthcare's distinction of the facts without a difference, as UnitedHealthcare admits it did not seek vacatur under the No Surprises Act.

[108] ECF 1 ¶¶ 95–96.

[109] *Advanced Vascular Assocs. v. Horizon Blue Cross Blue Shield of N.J.*, No. 25-5068, 2026 WL 935833 (E.D. Pa. Apr. 7, 2026).

[110] *Id.* at *2.

[111] *Id.* at *2–3.

[112] *Id.* at *3. Judge Wolson further found no private right of action, either express or implied, in the No Surprises Act. *Id*. at *3–5.

EXHIBIT B

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITEDHEALTHCARE OF PENNSYLVANIA, INC. d/b/a UNITEDHEALTHCARE COMMUNITY PLAN, *Plaintiff*, vs. NORTHSTAR ANESTHESIA OF PENNSYLVANIA LLC, *Defendant*.	Case No. 25-cv-7187 **COMPLAINT**

TABLE OF CONTENTS

Plaintiff UnitedHealthcare of Pennsylvania, Inc. d/b/a UnitedHealthcare Community Plan ("United") hereby alleges as follows for its complaint against Defendant NorthStar Anesthesia of Pennsylvania, LLC ("NorthStar").

INTRODUCTION

1. Defendant has weaponized a federal law intended to shield commercially insured patients from surprise out-of-network medical bills, transforming it into a vehicle to obtain a windfall for its private equity backers. The federal No Surprises Act ("NSA") was designed to establish a fair and balanced process—called Independent Dispute Resolution ("IDR")—for determining out-of-network reimbursement rates for services performed by certain medical providers. Congress's goals were clear: protect patients, encourage equitable payments between out-of-network providers and commercial health plans, and rein in soaring healthcare costs. Crucially, only claims related to commercial insurance plans are eligible for this process; Medicare- and Medicaid-related claims (for which patients are already protected from surprise bills) are ineligible.

2. NorthStar, however, is abusing the NSA by knowingly and illegally submitting ineligible claims to the IDR process, securing excessive, windfall awards to which it has no legitimate right. This scheme has nothing to do with seeking fair payment but rather is about attempting to funnel outsized profits into the pockets of its private-equity owners, all at the expense of United and the Medicare and Medicaid programs.

3. Congress enacted the NSA with a clear purpose: to establish an independent system to resolve payment disputes in a manner that is "fair to both providers and plans that also does not

increase aggregate healthcare system costs."[1] Yet, the NSA's IDR process is now being used as a tool for exploitation by certain unethical provider groups and the private equity investors that have acquired them. Those provider groups and their billing companies have manipulated the process, securing massive awards—oftentimes exceeding four hundred percent of the government-mandated Medicaid rates, as detailed herein—for claims that were, at all times, outside the scope and jurisdiction of the NSA's IDR process.

4. Here, NorthStar committed fraud by knowingly providing false certifications to United, the NSA IDR entities ("IDREs"), and the U.S. Department of Health & Human Services ("HHS") that "the item(s) and/or service(s) at issue [we]re qualified item(s) and/or service(s) within the scope of the Federal IDR process." It did so with full knowledge that the claim described herein was ineligible for the NSA's IDR process because, among other things, United's Provider Remittance Advice clearly and unequivocally informed NorthStar that the claim at issue was for a patient covered under a Pennsylvania managed Medicaid plan.

5. Data indicates that NorthStar recently decided to make abuse of the NSA IDR process central to its business. Prior to December 2024, United had no NSA IDR proceedings involving NorthStar. But, in December 2024, NorthStar and its affiliated entities initiated 115 NSA IDR disputes against United. Through the first ten months of 2025, NorthStar and its affiliated entities initiated 6,214 NSA IDR disputes against United (an average of more than 620 new disputes each month), including disputes that were ineligible for NSA IDR, like the Medicaid claim described herein. NorthStar's abuse of the NSA IDR process is fraudulent, egregious, and

[1] Lawson Mansell and Sage Mehta, Niskanen Center, *New data shows No Surprises Act arbitration is growing healthcare waste* (June 18, 2025), https://www.niskanencenter.org/new-data-shows-no-surprises-act-arbitration-is-growing-healthcare-waste/#:~:text=In%20December%202020%2C%20Congress%20passed,out-of-network%20care.

intentionally designed to undermine the very integrity of the protections Congress intended to create.

6. United brings this action to put an end to NorthStar's exploitation of the NSA IDR process.

PARTIES

7. Plaintiff UnitedHealthcare of Pennsylvania, Inc. d/b/a UnitedHealthcare Community Plan is a corporation organized under the laws of the Commonwealth of Pennsylvania, with its principal place of business in Pennsylvania. United is a managed care organization contracted with the Commonwealth of Pennsylvania to arrange for the provisions of medical and related services and benefits to members of the Commonwealth's Medicaid program, also known as "Medical Assistance" and/or "HealthChoices."

8. Defendant NorthStar Anesthesia of Pennsylvania LLC is a restricted professional limited liability company that is actively registered to do business in the Commonwealth of Pennsylvania. NorthStar's principal place of business is 6225 N. State Highway 161, Suite 200, Irving, Texas 75038-2241. Upon information and belief, NorthStar Anesthesia of Pennsylvania LLC is owned by NorthStar Anesthesia P.A., which was originally founded in 2004 by an anesthesiologist and a certified registered nurse anesthetist practicing in the Dallas area. In 2018, NorthStar Anesthesia P.A. was fully acquired by the Cranemere Group, a private equity firm based in New York City. Today, NorthStar Anesthesia P.A. is one of the largest anesthesia management companies in the United States. It currently employs over 4,000 clinicians and has agreements to provide anesthesia staffing and management services at more than 280 hospitals, ambulatory surgery centers, and other medical institutions in over 20 states, including Pennsylvania.

JURISDICTION AND VENUE

9. This Court has federal question subject-matter jurisdiction over this matter pursuant to 28 U.S.C. § 1331 because resolution of the claims in this Complaint raises disputed and substantial questions under the NSA, a federal statute, and will require judicial interpretation of the NSA.

10. This Court has general jurisdiction over Defendant because it maintains an active business registration in the Commonwealth and it regularly conducts business in the Commonwealth.

11. This Court has specific jurisdiction over Defendant because this dispute arises out of, relates to, and has a substantial connection with Defendant's actions in this Commonwealth. NorthStar purposefully availed itself of this forum when it submitted claims for payment for services provided (a) to a Commonwealth resident, (b) in the Commonwealth, and (c) to an individual covered by a Pennsylvania Medicaid plan.

12. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b) because (a) a substantial portion of the events giving rise to the claims herein occurred within this District; and (b) the Defendant is subject to this Court's personal jurisdiction with respect to this Complaint.

FACTUAL ALLEGATIONS

I. BACKGROUND

13. In order to fully appreciate the origin and intent of the NSA, one must first understand the different types of health insurance plans offered in America, the process by which medical providers are typically paid for their services, and the ways in which "out-of-network" providers like NorthStar have historically manipulated the system through surprise medical bills that drive up healthcare costs for Americans.

A. Types of Health Insurance Plans

14. Over 90% of Americans maintain some form of health insurance to help cover the costs associated with the medical care they receive from health care providers.

15. There are three general categories of health insurance: private commercial plans, Medicare plans, and Medicaid plans.

1) Private Commercial Health Insurance Plans

16. United provides health care insurance, administration, and/or benefits pursuant to group and individual commercial plans. These commercial plans are privately-funded either directly by United ("fully-insured" individual or group plans) or by employers who wish to offer commercial health insurance for their employees and their families ("self-funded employer sponsored" group plans).

17. Notably, it is ***only*** claims submitted to and paid by qualifying commercial health plans that are eligible for the NSA's IDR process.[2]

2) Medicare and Medicare Advantage Plans

18. Medicare is a federally-funded health insurance program managed by the Centers for Medicare & Medicaid Services ("CMS") within HHS. Medicare is generally available for all individuals aged 65 and over.[3]

19. Medicare-eligible individuals may select from two primary forms of Medicare coverage. First, there are Medicare Parts A & B, which are managed directly by CMS. Second, Medicare-eligible individuals can alternatively elect to participate in Medicare Part C, also known

[2] *See* 42 U.S.C. §§ 300gg-111(c)(1)(A).
[3] There are some categories of individuals who may be eligible for Medicare prior to the age of 65, such as individuals with a qualifying disability (e.g., end-stage renal disease or amyotrophic lateral sclerosis) or individuals receiving social security disability insurance benefits for 24 months.

as "Medicare Advantage." That program was enacted by the federal government to allow Medicare Advantage organizations like United, who are pre-approved by CMS, to provide insurance coverage for Medicare beneficiaries who choose to enroll in a privately administered Medicare Advantage plan.

20. The federal government, through CMS, sets the rates that providers must accept for treating Medicare patients.[4] Because providers are obligated to accept the CMS-mandated rates, the NSA IDR process is inapplicable to Medicare-related claims.[5]

3) Medicaid and Managed Medicaid Plans

21. The Medicaid program is a jointly funded federal and state program that generally provides health insurance to low-income state residents who meet certain eligibility criteria. While each state operates its own state-based Medicaid program, the federal government (through CMS) provides funding to the states for those programs. Some states manage and administer their own Medicaid plans. Many other states contract with private managed care organizations ("MCOs"), such as United, who agree to provide coverage under privately managed Medicaid plans, similar to the Medicare Advantage program described above.

22. Pennsylvania's Medicaid program provides access to health care for nearly three million people in Pennsylvania, including certain qualifying children, pregnant women, adults, and

[4] Healthcare providers can elect whether they want to participate in Medicare. "Medicare 'participation' means you agree to accept claims assignment for all Medicare-covered services to your patients. By accepting assignment, you agree to accept Medicare-allowed amounts as payment in full. You may not collect more from the patient than the Medicare deductible and coinsurance or copayment." *See Annual Medicare Participation Announcement*, Centers for Medicare & Medicaid Services, https://www.cms.gov/medicare-participation (last visited Dec. 8, 2025).

[5] "The Federal IDR process **does not apply** to items and services payable by Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE." *Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process*, Centers for Medicare & Medicaid Services (Jan. 13, 2023), https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf.

people with disabilities.[6] Pennsylvania is among those states that choose to have their Medicaid program managed by private MCOs; currently the Commonwealth contracts with several different MCOs, including United.

23. United contracts with the Commonwealth to manage Pennsylvania's Medicaid program in exchange for a fixed per-member-per-month payment. When a covered individual receives medical services, United makes payments to the healthcare providers using these funds in accordance with Pennsylvania's Medicaid fee schedules governing rates of payment to providers.

24. Similar to Medicare, healthcare providers must accept the Commonwealth's mandated rates for services provided to Medicaid beneficiaries. In fact, for certain Medicaid claims, in the event that a provider obtains any payment beyond the amount so authorized, Pennsylvania law expressly requires that provider to return any such supplemental payment.[7] Because providers are obligated to accept the Medicaid rates, the NSA IDR process is inapplicable to Medicaid-related claims.[8]

B. The Billing and Payment Process

25. As demonstrated above, there are different categories of insurance plans (commercial, Medicare Advantage, managed Medicaid), each with a variety of different benefit designs. For example, while one health plan may fully cover a certain procedure, another health plan may have only limited coverage or no coverage at all. Given this variability, it is important

[6] *See Medicaid in Pennsylvania*, KFF (May 2025), https://files.kff.org/attachment/fact-sheet-medicaid-state-PA.

[7] *See* 62 P.S. § 1406(a) ("All payments made to providers under the medical assistance program shall constitute full reimbursement to the provider for covered services rendered."); 55 Pa. Code § 1101.63(a) ("A provider who seeks or accepts supplementary payment of another kind from the Department, the recipient or another person for a compensable service or item is required to return the supplementary payment.").

[8] *See id*.

for providers to obtain and verify a patient's insurance information, typically through the patient's insurance card. Among other things, the insurance card identifies which insurance plan should be billed for the health care services and what category of insurance the patient has (i.e., commercial, Medicare Advantage or managed Medicaid). Health care professionals rely on this information in order to bill for the care they provide. Indeed, it is why patients are asked to show their ID and health insurance card when they check in at a provider's office for medical care.

26. After they provide medical services to patients, providers submit claims for payment to health insurers on standardized claim forms. Today, these claim forms are usually submitted electronically. Claim forms include, among other items, specific information about the patient, the medical provider who rendered the care at issue, the healthcare services provided, and the amount charged by the provider.

27. The patient's insurer then processes the claim by first determining whether the patient is a member of one of the benefit plans offered by the insurer. If the patient has coverage under one of the insurer's plans, the insurer assesses the benefits available through the patient's specific insurance plan for the services at issue. Based on the terms of the patient's specific plan, the insurer makes a determination about whether the claim is covered, how much of the claim, if any, must be paid by the patient (for example, a patient might be responsible for copays, coinsurance, and/or the full cost of services if she has not yet met her annual deductible), and how much the health plan will ultimately pay for the patient's care.

28. After the health insurer makes these coverage and payment determinations, the insurer issues an Explanation of Benefits ("EOB") to the patient and a Provider Remittance Advice ("PRA") to the medical provider. The EOB and PRA explain to the patient and the provider, respectively, how the specific claim was processed and paid. Both the EOB and PRA identify the

amount billed by the provider, the amount allowed by the health plan based on the benefits available under the patient's specific insurance plan, the amount paid by the patient's plan, the amount owed by the patient, and the reasoning for the insurer's payment determination.

C. Out-of-Network Providers' Calculated Abuse of the Billing and Payment Process

29. In most cases the aforementioned billing and payment process is predictable for providers and affordable for patients.

30. As noted, Medicare- and Medicaid-related plans have rates established by the federal and state authorities charged with overseeing those programs. Medicare- and Medicaid-related plans pay the established rates and providers must accept those rates without billing patients for any additional amounts.

31. And patients with commercial insurance plans usually receive care from medical providers who have agreed on predetermined rates with insurance companies. Specifically, United negotiates set rates for care provided by a broad network of credentialed healthcare professionals who offer United's commercial plan members quality, affordable health care services. Healthcare providers who are part of United's network are called "in-network" providers. In-network providers enter into agreements with United that, among other things, govern the amount that United and United's commercial plan members will pay for healthcare services. When a United member receives services from an in-network provider, the provider is prohibited from billing above the predetermined network rate. As a result, the billing and payment process is predictable; in-network providers must accept the predetermined network rates without billing patients for any additional amounts.

32. However, there are certain medical providers, known as "out-of-network" providers, who have not entered into an agreement with United. United has not performed

credentialing on these providers, nor has it agreed to pay these providers any predetermined amount for services rendered to commercially insured patients.

33. Fortunately, commercially insured patients can generally avoid the unpredictable costs associated with out-of-network providers. Patients most often seek out and receive services from medical providers who are in-network with their health insurance plans. And in the rare instance where a patient does seek care from an out-of-network provider, it is almost always by choice and with knowledge of the costs and complications involved with out-of-network care.

34. But in some situations, patients have no ability to control who provides their medical care. For instance, a patient may carefully schedule her surgery with an in-network surgeon at an in-network hospital but be unaware that the hospital staffs its operating rooms with independent contractor anesthesiologists and radiologists who have refused to enter into network agreements with health insurance companies like United. In this scenario, the patient reasonably (though incorrectly) assumes that all health care professionals working at the in-network hospital are also in-network with her insurance plan. The patient has no way of knowing that the anesthesiologist and radiologist involved in her surgery are out-of-network until it is too late.

35. Out-of-network providers are not limited in the amounts that they can charge for medical services provided to commercial health plan members; they set their rates however they want and without any logical connection to (a) their actual costs for delivering care, or (b) prevailing market rates and competitive dynamics.

36. Out-of-network providers know, however, that the patient's commercial health insurance plan is not obligated to pay their full billed charges. Rather, payments for out-of-network services are governed by the terms of the patient's specific commercial insurance plan. The out-of-network reimbursement varies from plan to plan—while some pay a percentage of the

applicable Medicare rate, others pay the average in-network rate for a given market, and yet others pay a percentage of the provider's billed charges.

37. Despite knowing that commercial health insurance plans will not pay their full billed charges, out-of-network providers routinely submit astronomically high bills to commercial health insurance plans. Insurers process out-of-network provider bills in accordance with the terms of the patient's specific commercial insurance plan, which results in a payment that is less than the amount of the out-of-network provider's full billed charge. This results in a "balance" that is left unpaid.

38. Historically, out-of-network providers would often "balance bill" commercially insured patients for the difference between their charged amount and the amount the commercial health plan allowed. From the patient's perspective, this bill came as a surprise, hence the term "surprise billing" (the balance/surprise bill was in addition to the amount the health insurance plan covered and any amounts the patient had already paid in copays, coinsurance and/or deductible).

39. These balance bills were oftentimes massive and financially devastating for patients. To give just a few examples related specifically to NorthStar:

- A teacher giving birth at an in-network hospital received anesthesia from an out-of-network NorthStar provider. NorthStar sent the teacher a surprise balance bill for nearly $6,000. Only after NBC News reported on NorthStar's abuse did NorthStar agree to reduce the bill to $170—***a 97% reduction***.[9]
- NorthStar sent another patient a surprise balance bill for $13,000 for anesthesia services during an organ transplant. The patient was donating a kidney to his

[9] *See* Wayne Carter and Amanda Lane, "Woman Billed for Out-of-Network Doctor at Her In-Network Hospital," NBC 5 (January 16, 2017), https://www.nbcdfw.com/news/local/woman-billed-for-out-of-network-doctor-at-her-in-network-hospital/19218/.

cousin. After news of NorthStar's abuse hit the press, the patient "received a phone call from the CFO of NorthStar saying they would 'take care of the bill.'"[10]

Unfortunately, however, most NorthStar patients were not so lucky and were forced to pay NorthStar's inflated surprise bills or risk aggressive collection efforts.

II. CONGRESS PASSED THE NO SURPRISES ACT TO REIN IN BILLING ABUSES BY OUT-OF-NETWORK PROVIDERS LIKE NORTHSTAR

40. Congress recognized that providers like NorthStar held "substantial market power" and "face[d] highly inelastic demands for their services because patients lack[ed] the ability to meaningfully choose or refuse care."[11] Thus, providers like NorthStar could "charge amounts for their services that … result[] in compensation far above what is needed to sustain their practice."[12] Congress noted that this "market failure" was having "devastating financial impacts on Americans and their ability to afford needed health care."[13]

41. Congress enacted the NSA, effective January 1, 2022, "to protect consumers from surprise medical bills."[14] The NSA prohibits certain out-of-network healthcare providers—including emergency services providers and facilities, providers of non-emergency services operating at in-network facilities, and air ambulance providers—from engaging in surprise billing to members of private commercial health plans.[15]

42. Congress believed "that any surprise billing solution must comprehensively protect

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[10] *See "*Man Left With $13,000 Bill After Donating Kidney To Family Member," Newsweek (February 11, 2022), https://www.newsweek.com/man-left-13000-bill-after-donating-kidney-family-member-1678400. NorthStar's eagerness to abandon its outrageous collection efforts in the face of public scrutiny exposed the fictitious nature of NorthStar's greed-driven billed charges and revealed that NorthStar's charged amounts had no relation to its true costs of delivering the services.

[11] Ban Surprise Billing Act, H.R. Rep. No. 116-615 (2020), at 53.

[12] *Id.*

[13] *Id.* at 52-53.

[14] *Id.* at 47.

[15] *See* 42 U.S.C. §§ 300gg-131, 300gg-132, 300gg-135.

consumers by 'taking the consumer out of the middle' of surprise billing disputes."[16] Through passage of the legislation, Congress required healthcare providers (including hospitals and doctors) and payors (including insurance companies and self-funded employer sponsored plans) to attempt to resolve billing and payment disputes amongst themselves.[17]

43. Thus, as part of the NSA, Congress created a specific framework for health plans and providers to resolve specific types of ***eligible*** surprise billing disputes.[18] That framework, called IDR, was designed to establish a fair and balanced process for determining out-of-network reimbursement rates from commercial health plans for enumerated types of out-of-network services.

A. The NSA's IDR Process

44. If an out-of-network provider disputes the initial payment received from a commercial health plan, the parties are first required to participate in a 30-business-day "open negotiation" to try and resolve the dispute. Should that fail, either party has four business days to commence IDR, seeking a binding payment determination from a certified IDRE.

45. For valid, eligible commercial insurance claims, the IDR process is a binding "baseball-style" dispute resolution. The NSA requires the provider and insurer to each submit a proposed reimbursement amount and explanation to the IDRE.[19] The IDRE then selects one of the two proposed amounts, taking into account various criteria.[20] One of these criteria is the qualifying payment amount ("QPA"), which is a calculation that represents the median in-network

[16] H.R. Rep. No. 116-615, at 55.
[17] *See* Brady Opening Statement at Full Committee Markup of Health Legislation (Feb. 12, 2020), available at https://waysandmeans.house.gov/2020/02/12/brady-opening-statement-at-full-committee-markup-of-health-legislation-3/.
[18] *See* 42 U.S.C. § 300gg-111(c).
[19] *See* 42 U.S.C. § 300gg-111(c)(5)(B).
[20] *See id.* § 300gg-111(c)(5)(C)(i).

rate for a given service rendered by the same or similar medical provider in a given region. Congress expected that most items and services submitted to IDR would be paid at or around the QPA. Indeed, Congress' intent was to make the QPA a key metric in the NSA IDR process as opposed to an out-of-network provider's "billed charges," because Congress recognized that the out-of-network providers' billed charges were arbitrary amounts with no relation to the amounts health plans or individuals usually paid for the same services.[21]

46. Congress intended that this system would function in a manner that was "fair to both providers and plans [and] that also does not increase aggregate healthcare system costs."[22] It also intended that the IDR system would be used ***relatively infrequently***. In the regulations establishing the IDR system, federal agencies estimated that the IDR process would annually resolve 17,333 disputes, with an additional 4,899 disputes from air ambulance providers.[23] The reality, though, has been very different.

B. Out-of-Network Providers Intentionally Abuse the IDR Process and Thwart Congressional Intent

47. To say that out-of-network providers have filed far more IDR cases than anticipated would be a gross understatement. In only the first nine months after the IDR system opened in 2022, about 190,000 disputes were filed—more than ***ten times*** the number expected for the first full year alone.[24] The number of claims submitted to IDR has only increased. From mid-2022 to

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[21] *See* Requirements Related to Surprise Billing: Part II, 86 Fed. Reg. 55996 (Oct. 7, 2021) (median contracted rates typically represent reasonable market values because they "are established through arms-length negotiations between providers and facilities and plans and issuers (or their service providers).")

[22] Lawson Mansell and Sage Mehta, *New data shows No Surprises Act arbitration is growing healthcare waste*, Niskanen Center (June 18, 2025), https://www.niskanencenter.org/new-data-shows-no-surprises-act-arbitration-is-growing-healthcare-waste/.

[23] *See* Requirements Related to Surprise Billing: Part II, 86 Fed. Reg. at 56066, 56069 (Oct. 7, 2021).

[24] *See* Jack Hoadley and Kennah Watts, *The Substantial Costs Of The No Surprises Act Arbitration Process*, HealthAffairs (Aug. 25, 2025),

May 2025, more than ***3.3 million*** disputes were filed.[25] Private equity-backed providers were responsible for filing a majority of these disputes.[26] And far from leading to fair outcomes, the IDR process has been incredibly biased in favor of out-of-network providers. In 2024, for example, IDREs sided with out-of-network providers in 85% of claims decided.[27]

48. Not only do IDREs side with providers most of the time, but when they do, they almost always issue awards that are ***three to four times*** the QPA that Congress expected would prevail in most IDR proceedings. In the fourth quarter of 2024, the median amount awarded by IDREs was 459% of the QPA.[28]

49. Far from reining in soaring health care costs as Congress intended, the unforeseen volume of claim submissions and the outsized awards IDREs have routinely issued in favor of providers have had dramatic monetary costs for the healthcare system and patients. Ironically, the NSA IDR system has ***added at least $5 billion*** to overall health system costs since its inception—approximately $2 to $2.5 billion per year.[29]

C. Out-of-Network Providers Like NorthStar Have Routinely Submitted Ineligible Medicare and Medicaid Claims to the NSA IDR Process

50. One of the many things that Congress did not foresee in enacting the NSA was that providers like NorthStar would purposefully, fraudulently, and in violation of federal law submit clearly ineligible claims to IDR. Nor could Congress have foreseen that IDREs (who are certified

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https://www.healthaffairs.org/content/forefront/substantial-costs-no-surprises-act-arbitration-process.

[25] *Id.*

[26] *See Profiting on all Sides: Private Equity and the No Surprises Act*, Private Equity Stakeholder Project (Nov. 5, 2025), https://pestakeholder.org/news/profiting-on-all-sides-private-equity-and-the-no-surprises-act/#_ftn3.

[27] *See* Note 24, *supra.*

[28] *Id.*

[29] *Id.*

by CMS and should, therefore, be able to readily distinguish between an eligible commercial insurance claim and an ineligible Medicare or Medicaid claim) would blatantly ignore evidence of ineligibility, routinely exceed their jurisdiction, and issue 85% of decisions in favor of providers at amounts that are four hundred percent or more of the QPA that Congress intended would prevail in most disputes. Unfortunately, the NSA IDR system has perverse financial incentives that encourage providers to submit, and IDREs to improperly accept, ineligible claims. In fact, current data shows that ineligible claims constitute about 20% of all closed IDR disputes.[30]

51. This is a clear violation of the NSA. The IDR process is not available for services provided to patients covered by Medicare- or Medicaid-related plans. Rather, the process only applies to services furnished to patients covered by a private commercial "group health plan or health insurance issuer offering group or individual health insurance coverage."[31]

52. This fact could not come as a surprise to any healthcare provider or IDRE. Indeed, CMS—the federal agency that is primarily charged with administering the IDR process—has issued several resources to aid parties in determining whether a claim is eligible for IDR. These resources clearly explain that "[t]he Federal IDR process ***does not apply*** to items and services payable by Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE."[32]

53. Notwithstanding the clear limits of the NSA IDR process, out-of-network providers like NorthStar continue to fraudulently submit ineligible Medicare- and Medicaid-related claims in hopes of scoring exorbitant recoveries.

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[30] *Id.*
[31] 42 U.S.C. § 300gg-111(c)(1)(A).
[32] *See, e.g., Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process*, Centers for Medicare & Medicaid Services (Jan. 13, 2023), https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf.

III. NORTHSTAR FRAUDULENTLY SUBMITTED AN INELIGIBLE MEDICAID CLAIM TO THE NSA IDR PROCESS

54. The following example is emblematic of NorthStar's fraudulent abuse of the NSA IDR process.

55. On January 29, 2025, a 32 year-old patient gave birth at St. Mary Medical Center, in Langhorne, Pennsylvania ("St. Mary's"). This patient was insured through the UnitedHealthcare Community Plan, a managed Medicaid plan.

56. When a Medicaid recipient receives medical care, they have to show the medical provider their insurance card. The card for the patient enrolled in United's Pennsylvania managed Medicaid plan would have looked substantially similar to the following, with a line identifying the patient's Medicaid identification number:

57. While at St. Mary's, the patient received services from a NorthStar-affiliated anesthesiologist.

58. Upon information and belief, NorthStar handles its own billing and submits claims for reimbursement on its own behalf to United. Because NorthStar has a relationship with St. Mary's to provide anesthesia services to admitted patients, NorthStar should have received the patient's insurance information from St. Mary's and, therefore, should have known that the patient was insured under Pennsylvania's Medicaid program.

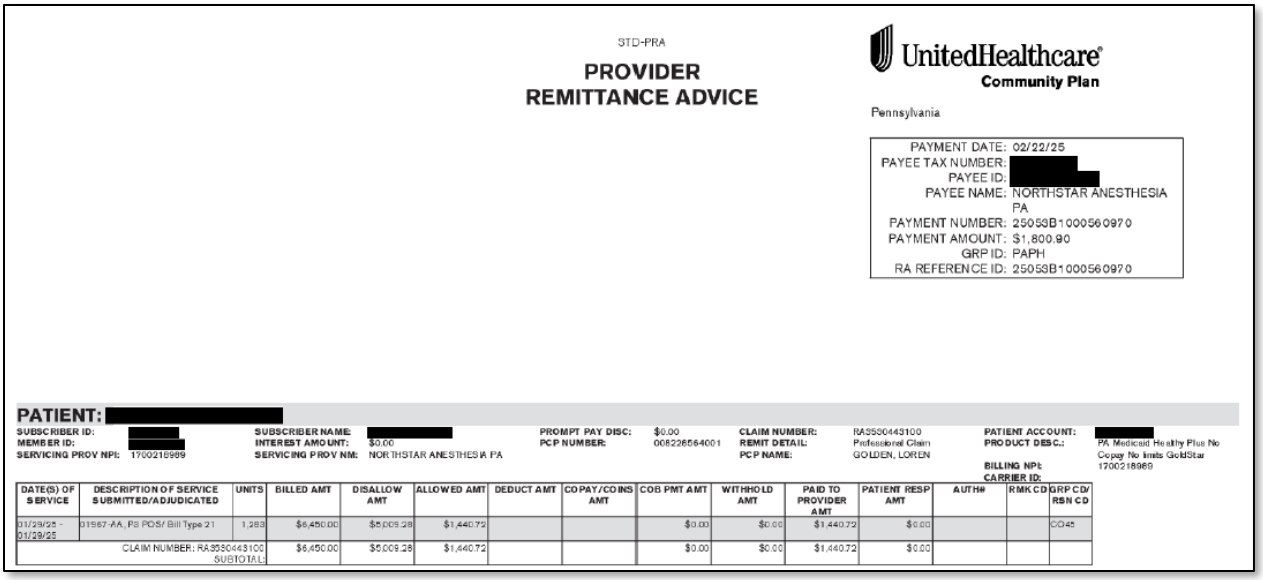
59. On February 7, 2025, NorthStar submitted a claim to United for the anesthesia services provided to the patient.[33] The total charged amount for the anesthesia services was $6,450.00.

60. Upon receiving the claim, United determined that the patient was a member of its Pennsylvania managed Medicaid plan. Accordingly, United calculated the government-mandated reimbursement amount for the anesthesia care provided to patients covered by the Pennsylvania Medicaid program, which was $1,440.72. Specifically, United calculated the appropriate payment for this claim according to the Pennsylvania Department of Human Services fee schedule. Payment for anesthesia claims is calculated by multiplying the number of total anesthesia units by the Pennsylvania Medicaid conversion factor. In this case, 92 total units[34] multiplied by the Pennsylvania Medicaid conversion factor of $15.66 resulted in a proper payment of $1,440.72.

61. On February 22, 2025, United paid NorthStar the government-mandated amount of $1,440.72. With its payment, United sent NorthStar a PRA providing details on the patient, the patient's status as a member of a Medicaid plan, the claim, and United's reimbursement:

[33] For unknown reasons, NorthStar submitted the claim to United using "UHC Choice Plus" as the patient's insurance plan (UHC Choice Plus is a commercial PPO plan). Whether this was in error or intentionally fraudulent is of no import here, as NorthStar certainly must have known that the patient was a Medicaid recipient no later than when United sent its PRA, as described below.

[34] Total units are primarily made up of base units, which are a fixed number of units assigned to a particular procedure, and timed units, which are calculated based on fifteen-minute increments of anesthesia time. For the relevant claim, there were 5 base units and 86 timed units. One additional unit was added because of the physical location of the anesthesia services, bringing the total to 92 units.



STD-PRA

PROVIDER REMITTANCE ADVICE

UnitedHealthcare Community Plan

Pennsylvania

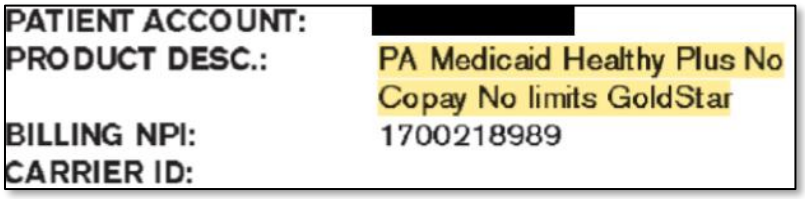
PAYMENT DATE: 02/22/25
PAYEE TAX NUMBER: [redacted]
PAYEE ID: [redacted]
PAYEE NAME: NORTHSTAR ANESTHESIA PA
PAYMENT NUMBER: 25053B1000560970
PAYMENT AMOUNT: $1,800.90
GRP ID: PAPH
RA REFERENCE ID: 25053B1000560970

PATIENT: [redacted]

SUBSCRIBER ID: [redacted]
MEMBER ID: [redacted]
SERVICING PROV NPI: 1700218989
SUBSCRIBER NAME: [redacted]
INTEREST AMOUNT: $0.00
SERVICING PROV NM: NORTHSTAR ANESTHESIA PA
PROMPT PAY DISC: $0.00
PCP NUMBER: 00822664001
CLAIM NUMBER: RA3590443100
REMIT DETAIL: Professional Claim
PCP NAME: GOLDEN, LOREN
PATIENT ACCOUNT: [redacted]
PRODUCT DESC.: PA Medicaid Healthy Plus No Copay No limits GoldStar
BILLING NPI: 1700218989
CARRIER ID:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE SUBMITTED/ADJUDICATED	UNITS	BILLED AMT	DISALLOW AMT	ALLOWED AMT	DEDUCT AMT	COPAY/COINS AMT	COB PMT AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/ RSN CD
01/29/25 - 01/29/25	01967-AA, PS POS/ Bill Type 21	1.283	$6,450.00	$5,009.28	$1,440.72			$0.00	$0.00	$1,440.72	$0.00			CO45
CLAIM NUMBER: RA3590443100 SUBTOTAL			$6,450.00	$5,009.28	$1,440.72			$0.00	$0.00	$1,440.72	$0.00			

62. The PRA was printed on the letterhead of the UnitedHealthcare Community Plan, a managed Medicaid plan. And the PRA noted that NorthStar had made a claim against a "PA Medicaid" plan:



PATIENT ACCOUNT: [redacted]
PRODUCT DESC.: PA Medicaid Healthy Plus No Copay No limits GoldStar
BILLING NPI: 1700218989
CARRIER ID:

63. The PRA also informed NorthStar that "[b]illing or balance billing UnitedHealthcare Community Plan Medicaid members is prohibited and may violate federal and state medical assistance rules and regulations."

64. The PRA also noted that "UnitedHealthcare enrolls members through the Medicare, Medicaid or Medicaid-expansion programs and payment for the services our members receive is payment in full – balance billing, other than co-pays and deductibles, is prohibited. By accepting payment from UnitedHealthcare, the provider agrees to abide by the laws, regulations and agency policies that govern such programs, including the prohibitions on fraud, waste and abuse." As detailed below, the Commonwealth of Pennsylvania's Medicaid program explicitly prohibits

fraud, waste and abuse, and its contracts with MCOs like United contain various provisions designed to prevent payment for fraudulent, abusive and wasteful claims.

65. The PRA also provided detailed procedures to appeal United's payment. These procedures provided, in part, that "Disputes from participating providers must be made within forty-five (45) days of the date of the UnitedHealthcare Community Plan Remittance Advice and must be submitted [on the stated website.] . . . The appeal must include a letter detailing the dispute, a copy of the Remittance Advice, and related medical records and/or other supporting information. Non-participating providers may appeal within one hundred eighty (180) days in [prescribed format and submitted in the prescribed manner]."

66. NorthStar never appealed United's payment on the claim.

67. Even though the insurance cards and PRA clearly showed that the patient was a member of a managed-Medicaid plan and therefore ineligible for the NSA IDR process, on April 15, 2025, NorthStar initiated an IDR dispute, through its agent HaloMD, LLC ("HaloMD").

68. HaloMD is a medical management company based in Texas specializing in NSA disputes. HaloMD's website characterizes HaloMD as "[a] [p]ioneering [f]orce" in IDR, managing IDR for "thousands of healthcare providers across the country" and leveraging "proprietary technology, advanced analytics, and deep specialty expertise" to achieve success in the IDR process for providers.[35] HaloMD works for providers like NorthStar for a contingent fee. Providers, like NorthStar, using HaloMD's services submit the dispute in the IDR process through HaloMD's portal. As part of that process, HaloMD represents that it "gathers and organizes the

[35] *See Home*, https://halomd.com/ (last visited Dec. 8, 2025); *About Us*, https://halomd.com/about-us/ (last visited Dec. 8, 2025).

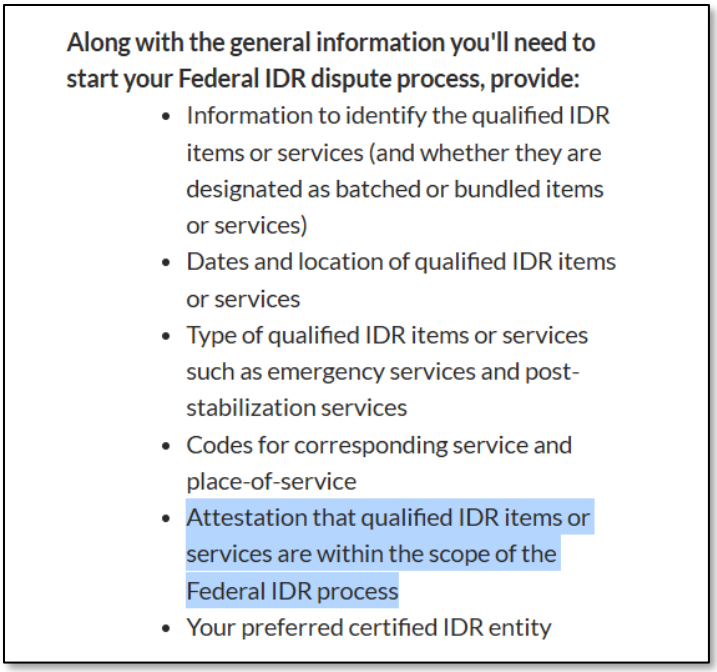
necessary documentation [from the provider], [and] prepar[es] a compelling case that highlights the provider's position, ensuring nothing is overlooked."[36]

69. The Notice of IDR Initiation stated that the QPA for the disputed claim was $1,440.72—i.e., the exact amount United had already paid in accordance with Pennsylvania's Medicaid fee schedule.

70. Shockingly, however, NorthStar sought $7,075.00 for the disputed claim, which was nearly ***five times*** what NorthStar itself identified as the QPA and ***$625.00 more*** than the $6,450.00 NorthStar had initially billed to United. Upon information and belief, NorthStar added $625.00 to its original billed amount as a way to help it cover HaloMD's contingent fee.

71. NorthStar, through HaloMD, initiated the IDR proceeding via an online federal web portal that includes a notice that providers must submit an "[a]ttestation that qualified IDR items or services are within the scope of the Federal IDR process."

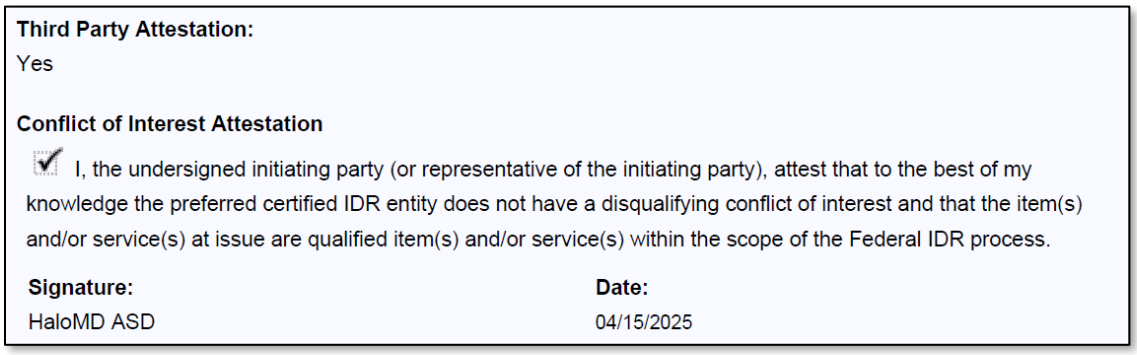
[36] *Id.* HaloMD is among the three most prolific filers of IDR process disputes. During the last six months of 2024, HaloMD initiated 134,318 disputes through the IDR process—which by itself exceeded the government's original estimate for total annual disputes ***more than sixfold***. *See Federal IDR Supplemental Tables for Q3 2024*, Centers for Medicare & Medicaid Services (May 28, 2025), https://www.cms.gov/files/document/federal-idr-supplemental-tables-2024-q3.xlsx; *Federal IDR Supplemental Tables for Q4 2024*, Centers for Medicare & Medicaid Services (May 28, 2025), available at https://www.cms.gov/files/document/federal-idr-supplemental-tables-2024-q4-may-28-2025.xlsx. That means HaloMD initiates an average of more than ***733 disputes*** against health plans per day. *Id*.



Along with the general information you'll need to start your Federal IDR dispute process, provide:

- Information to identify the qualified IDR items or services (and whether they are designated as batched or bundled items or services)
- Dates and location of qualified IDR items or services
- Type of qualified IDR items or services such as emergency services and post-stabilization services
- Codes for corresponding service and place-of-service
- Attestation that qualified IDR items or services are within the scope of the Federal IDR process
- Your preferred certified IDR entity

72. In initiating the dispute at issue here, NorthStar fraudulently attested, through its agent HaloMD, that the "the item(s) and/or services at issue [we]re qualified item(s) and/or service(s) ***within the scope of the Federal IDR process***." (emphasis added).



Third Party Attestation:
Yes

Conflict of Interest Attestation

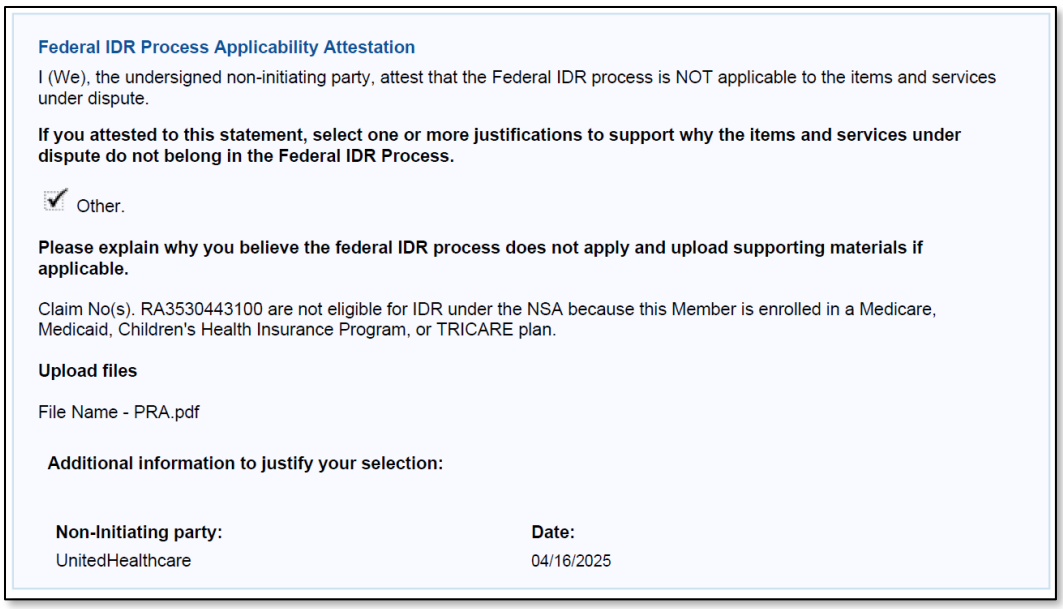
☑ I, the undersigned initiating party (or representative of the initiating party), attest that to the best of my knowledge the preferred certified IDR entity does not have a disqualifying conflict of interest and that the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) within the scope of the Federal IDR process.

Signature: HaloMD ASD

Date: 04/15/2025

A. United Objected to NorthStar's Submission of the Ineligible Medicaid Claim

73. The very next day, on April 16, 2025, United responded by attesting that the claim was "***not eligible for IDR under the NSA*** because this Member is enrolled in a Medicare, Medicaid, Children's Health Insurance Program, or TRICARE plan." (emphasis added).



Federal IDR Process Applicability Attestation

I (We), the undersigned non-initiating party, attest that the Federal IDR process is NOT applicable to the items and services under dispute.

If you attested to this statement, select one or more justifications to support why the items and services under dispute do not belong in the Federal IDR Process.

☑ Other.

Please explain why you believe the federal IDR process does not apply and upload supporting materials if applicable.

Claim No(s). RA3530443100 are not eligible for IDR under the NSA because this Member is enrolled in a Medicare, Medicaid, Children's Health Insurance Program, or TRICARE plan.

Upload files

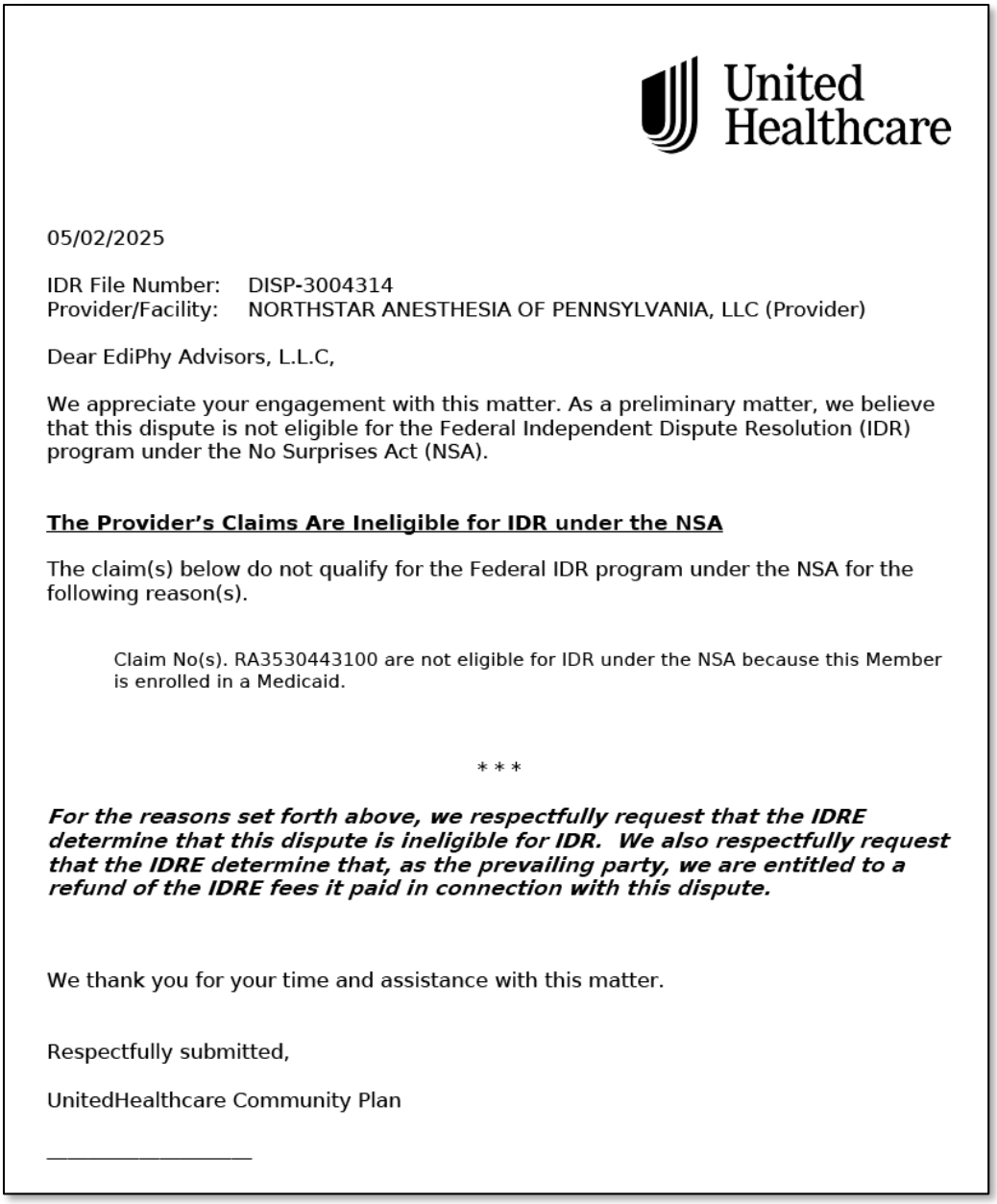
File Name - PRA.pdf

Additional information to justify your selection:

Non-Initiating party:	**Date:**
UnitedHealthcare	04/16/2025

74. United attached the PRA for the claim, which (as discussed in paragraphs 61-65, *supra*) made clear that the services were provided to a patient insured under a Pennsylvania ***Medicaid*** plan.

75. On May 2, 2025, United sent a letter to the selected IDRE, EdiPhy Advisors, L.L.C. ("EdiPhy Advisors"), reiterating that the claim was "not eligible" for IDR adjudication because "this Member is enrolled in [] Medicaid."



United Healthcare

05/02/2025

IDR File Number: DISP-3004314
Provider/Facility: NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC (Provider)

Dear EdiPhy Advisors, L.L.C,

We appreciate your engagement with this matter. As a preliminary matter, we believe that this dispute is not eligible for the Federal Independent Dispute Resolution (IDR) program under the No Surprises Act (NSA).

The Provider's Claims Are Ineligible for IDR under the NSA

The claim(s) below do not qualify for the Federal IDR program under the NSA for the following reason(s).

Claim No(s). RA3530443100 are not eligible for IDR under the NSA because this Member is enrolled in a Medicaid.

* * *

For the reasons set forth above, we respectfully request that the IDRE determine that this dispute is ineligible for IDR. We also respectfully request that the IDRE determine that, as the prevailing party, we are entitled to a refund of the IDRE fees it paid in connection with this dispute.

We thank you for your time and assistance with this matter.

Respectfully submitted,

UnitedHealthcare Community Plan

_____

B. The IDRE (EdiPhy Advisors) Improperly Accepted the Ineligible Medicaid Claim and Entered a Decision in NorthStar's Favor

76. On May 24, 2025, after allegedly "considering all permissible information submitted by both parties," the IDRE inexplicably determined the claim in favor of NorthStar and ordered United to pay NorthStar the full amount sought, ***$7,075.00—$625.00 more than***

NorthStar had originally billed and $5,634.28 more than the Pennsylvania-mandated Medicaid rate that NorthStar was required to accept for treating the Medicaid member at issue.[37]

77. The IDRE made no explicit determination that the claim was eligible for IDR resolution.

78. The IDRE "note[d] that [United] only submitted an objection to the eligibility of the dispute and did not submit any other persuasive argument in its favor." Of course, United had no obligation to submit anything other than an objection because the Medicaid claim at issue was ineligible for NSA IDR and, consequently, the IDRE had no jurisdiction or authority over the dispute.

79. The IDRE's determination made no reference to United's multiple submissions explaining the claim was against a Medicaid plan, including the PRA, which noted that the patient received benefits under "PA Medicaid," evidence that EdiPhy Advisors refused to adequately consider pertinent and material evidence and thereby prejudiced United's rights.

1) The IDRE Never Had Any Jurisdiction Over the Medicaid Claim Submitted by NorthStar

80. IDREs like EdiPhy Advisors must be certified by CMS and, as part of that certification process, must "demonstrate ***expertise*** in …: arbitration and claims administration, managed care, billing and coding, medical, [and] legal (including healthcare law)."[38]

81. HHS, the Department of Labor, and the Department of the Treasury (the "Departments") have issued guidance to IDREs titled "Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities." The most recent December 2023 Guidance

[37] *See* 62 P.S. § 1406(a); 55 Pa. Code § 1101.63.
[38] *Apply to Become a Certified Independent Dispute Resolution Entity*, Centers for Medicare & Medicaid Services, https://www.cms.gov/nosurprises/help-resolve-payment-disputes/apply (last visited Dec. 8, 2025).

directs: "In addition to checking for and submitting an attestation regarding conflicts of interest, the **certified IDR entity must determine whether the Federal IDR Process applies to the items and services that are the subject of the dispute**. The Federal IDR process **does not apply** to items and services payable by Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE." (emphasis in original).[39]

82. Given that their authority and jurisdiction necessarily derives from the NSA and is, therefore, necessarily limited to only eligible disputes related to commercial insurance claims, IDREs are required by regulation to "determine whether the Federal IDR process applies" ***before*** proceeding with a claim.[40]

83. Only after an IDRE satisfies its statutory obligation to determine whether a claim is eligible for the IDR process and within its jurisdiction can an IDRE proceed to a payment determination.[41]

84. Here, there is no doubt that the IDRE (EdiPhy Advisors) was derelict in its duty to determine eligibility of the Medicaid claim submitted by NorthStar. Indeed, given that it is certified by CMS as having expertise in managed care, it defies logic that EdiPhy Advisors could have confused the ineligible Medicaid claim at issue with a commercial insurance claim subject to the NSA.

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[39] *Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities*, Centers for Medicare & Medicaid Services (Dec. 2023), https://www.cms.gov/files/document/federal-idr-guidance-idr-entities-march-2023.pdf.
[40] 45 C.F.R. § 149.510(c)(1)(v).
[41] *See* 42 U.S.C. § 300gg-111(c)(5)(A).

2) The IDRE's Actions and Ultimate Decision Demonstrate Bias Against United

85. EdiPhy Advisors' inability to distinguish between ineligible Medicaid claims and eligible commercial insurance claims raises serious doubts about whether it has the requisite expertise to continue to qualify as a certified IDRE. Beyond that, however, there are reasons to question its objectivity and motives.

86. Pursuant to the NSA, IDREs are compensated on a per-claim basis. The commercial insurance plan and the out-of-network provider must each pay a non-refundable administrative fee of $115 when a dispute is initiated. This amount is typically not recoverable even if the IDRE determines that the dispute is ineligible for IDR. In addition, both parties pay an IDRE fee ***before*** the IDRE accepts a dispute and makes the payment determination. The IDRE fee is set by the specific IDRE and depends on the type of dispute, but in 2025 IDRE fees range from $375 to $1,150.[42] EdiPhy charges the highest fees of any IDRE entity—$800 for single claim determinations and $1,150 for batches of 2 to 25 claims.[43] If the dispute is accepted for IDR and a final decision is entered, the party whose offer is selected by the IDRE is refunded its IDRE fee (meaning it is only responsible for its $115 administrative fee). The non-prevailing party is responsible for both its administrative fee and the IDRE fee. From 2022 to 2024, administrative and IDRE fees totaled $885 million (approximately $228 million in administrative fees and $656 million in IDRE fees).[44]

[42] *See List of Certified Independent Dispute Resolution Entities*, Centers for Medicare & Medicaid Services, https://www.cms.gov/nosurprises/help-resolve-payment-disputes/certified-idre-list (last visited Dec. 8, 2025).
[43] *Id*.
[44] *See* Note 24, *supra*.

87. IDREs are only compensated when they resolve a claim on the merits.[45] If an IDRE rejects a claim because it is ineligible under the NSA, they receive ***no compensation*** on that claim.[46]

88. This compensation structure thus creates an incentive for IDREs to exceed their authority and jurisdiction under the NSA by wrongfully accepting and adjudicating claims that are actually ineligible for NSA IDR.

89. It also incentivizes IDREs to rule in favor of providers because HHS statistics show that providers are responsible for initiating all but an insignificant handful of IDR proceedings. Indeed, providers and facilities initiated 478,799 of 478,849 (99.99%) NSA IDR disputes recorded by CMS during the fourth quarter of 2024 alone.[47] Thus, if IDREs reject a dispute as ineligible for IDR or if they select the health plan's rate proposal, the IDRE is biting the proverbial hand that feeds the IDR pipeline. The fact that IDREs are siding with out-of-network providers in 85% of disputes—and awarding four to five times the QPA when doing so—demonstrates that IDREs are biased in favor of out-of-network providers like NorthStar. The bias becomes clearer once one realizes that, of the fifteen IDREs certified by CMS, five are backed by private equity firms.[48]

90. The fact that EdiPhy Advisors blatantly exceeded its authority and jurisdiction under the NSA in issuing an illegal award purporting to require United to pay $7,075.00 on the ineligible Medicaid claim described herein (for which NorthStar was only entitled to payment of $1,440.72 under Pennsylvania's Medicaid fee schedule) is evidence of EdiPhy Advisors' partiality and corruption.

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[45] *See* 42 U.S.C. § 300gg-111(c)(5)(F).
[46] *See id.*
[47] *Federal IDR Supplemental Tables 2024 Q4*, Centers for Medicare & Medicaid Services, (May 28, 2025) https://www.cms.gov/nosurprises/policies-and-resources/Reports.
[48] *See* Note 26, *supra*.

3) Compliance With the IDRE's Illegal Decision Would Require United to Pay Fraudulent, Abusive and Wasteful Rates That are Inconsistent with the PA Medicaid Fee Schedule and United's Medicaid Contract with the Commonwealth

91. As discussed above, United is contracted as a Medicaid MCO with the Commonwealth of Pennsylvania. The contract governing United's service as a MCO is the Pennsylvania HealthChoices Agreement.

92. United must adhere to certain explicit "Program Requirements" set forth in the HealthChoices Agreement, including specific obligations requiring United to have adequate policies and procedures for the "prevention, detection and investigation" of "Fraud, Waste and Abuse."[49] In fact, as a contracted Medicaid MCO in Pennsylvania, United has a "primary purpose of preventing, detecting, reducing, investigating, referring and reporting suspected Fraud, Waste and Abuse that may be committed by … Providers … Caregivers … or other third parties[.]"[50]

93. The amount NorthStar requested, and that the IDRE awarded, for the ineligible Medicaid claim submitted to NSA IDR is nearly ***five hundred percent*** higher than the allowed payment rate established in Pennsylvania's Medicaid fee schedule. Simply put, NorthStar's claim is fraudulent, wasteful and abusive per the HealthChoices Agreement.

94. Moreover, Pennsylvania's Medicaid fee schedule is determined in part based on historic Medicaid expenditures. Should United be required to pay higher amounts to providers who submit fraudulent claims to the NSA IDR, over time, those aggregated claims will result in the Commonwealth of Pennsylvania needing to allocate more money to insuring Medicaid

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[49] *HealthChoices Agreement Physical Health Agreement*, 100 (Jan. 1, 2025), https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/providers/documents/managed-care-information/2025-pa-ph-healthchoices-agreement-exhibits-and-non-rate-financial-appendices-final.pdf.

[50] *Id.* at 99.

beneficiaries in the long term.

IV. UNITED HAS NO ADEQUATE RECOURSE UNDER THE NSA

95. As described herein, the NSA IDR system is broken. Providers like NorthStar are intentionally submitting ineligible Medicare and Medicaid-related disputes to IDR in violation of the NSA. And notwithstanding United's objections, IDREs are illegally exercising authority over the ineligible disputes and are issuing awards in favor of providers at indefensibly high amounts that not only exceed the QPA, but also eclipse (oftentimes by many multiples) the established Medicare and Medicaid rates for the services at issue.

96. United has no adequate remedy without judicial relief from this court. The Departments have provided "Technical Assistance" as to how errors in the NSA IDR process, including when IDREs rule that ineligible Medicaid and Medicare claims are eligible for the NSA IDR process, theoretically can be corrected.[51] But that process is objectively insufficient. It requires that the party raising the error first report it to the IDRE (the party who only gets paid if the dispute is eligible for IDR), who then decides if the error reported is of the type that permits reopening the dispute. If so, the IDRE then reports the error to the Departments, who in turn must also determine if the error is redressable by way of this process. If it is, the Departments then reopen the closed dispute to allow ***the same IDRE who made the erroneous eligibility determination in the first place*** to attempt to correct its decision. If the IDRE determines that the claim was not in fact eligible, the IDRE must refund the IDRE fee ***but the administrative fee is never refundable under any circumstances***. Considering the volume of ineligible claims providers like NorthStar are submitting through the NSA IDR process, this multi-step dispute

[51] *Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties*, Centers for Medicare & Medicaid Services (June 2025), https://www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf

resolution process is insufficient, particularly given that the administrative fees cannot be refunded.

CAUSES OF ACTION

COUNT I

DECLARATORY JUDGMENT UNDER 28 U.S.C. §§ 2201, 2202

97. United incorporates by reference as fully set forth herein the allegations in the preceding and succeeding paragraphs.

98. There is an actual, substantial, and present controversy between United and Defendant concerning the amounts owed (if any) on the Pennsylvania Medicaid claim described herein.

99. United and Defendant have adverse legal interests.

100. United seeks judgment declaring that Defendant's conduct in initiating NSA IDR for an ineligible Medicaid claim was unlawful and fraudulent.

101. Without such declaratory judgment, United could be required to pay the award determined by the IDRE for an ineligible Medicaid claim which never should have been submitted through the NSA IDR process in the first instance.

102. United further seeks a declaration that Medicaid and Medicare claims are not eligible for NSA IDR, that IDREs have no authority or jurisdiction over such claims under the NSA, and that United is not obligated to pay illegal NSA IDR awards issued on ineligible Medicare or Medicaid claims, both retroactively and prospectively.

103. Without such declaratory judgment, there is a real and substantial probability that NorthStar will continue to submit ineligible Medicaid and/or Medicare claims through the NSA IDR process and United may be required to pay IDRE awards, as well as IDRE and administrative fees for these ineligible claims.

104. In addition to declaratory judgment, United seeks an injunction to prevent Defendant from continuing to submit false attestations and initiate the NSA IDR process for items or services that are not qualified for NSA IDR, or from seeking to enforce non-binding awards entered on items and services not qualified for the NSA IDR process.

105. United and Defendant's rights related to the submission of Medicare and Medicaid claims through the NSA IDR process will be definitively decided through such declaratory and injunctive relief.

106. Without declaratory and injunctive relief, United faces ongoing hardship in the form of being forced to (a) defend its payment of government-mandated amounts on ineligible Medicare and Medicaid claims through the NSA IDR process, (b) pay IDRE awards for ineligible claims, and (c) pay IDRE and administrative fees for ineligible claims for which no payment obligation rightfully exists under the NSA.

COUNT II

COMMON LAW FRAUD

107. United incorporates by reference as fully set forth herein the allegations in the preceding and succeeding paragraphs.

108. In initiating the dispute at issue here, NorthStar fraudulently attested, through its agent HaloMD, that: "I, the undersigned initiating party (or representative of the initiating party), attests that to the best of my knowledge…the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) ***within the scope of the Federal IDR process***." (emphasis added).

109. NorthStar submitted the IDR notice of initiation in the dispute with full knowledge of, or at the very least with reckless disregard to, the falsity of this attestation. From the patient's insurance card, the PRA United submitted to NorthStar, the plain text of federal laws and regulations, CMS publications and resources, NorthStar's preparation of IDR initiation forms and

notices, NorthStar's participation in the IDR process, and the specific objections to eligibility that United submitted to NorthStar and the IDRE, among other sources, NorthStar knew that the dispute it was initiating was ineligible for the IDR process.

110. NorthStar nevertheless submitted these false attestations and did so with the intent that the IDRE and United rely on them. According to federal law, "the certified IDR entity selected must review the information submitted in the notice of IDR initiation" —including NorthStar's false attestations of eligibility— "to determine whether the Federal IDR process applies."[52] Even though United contested eligibility, NorthStar's deliberate misrepresentation to the IDRE, on which the IDRE relied, forced United to rely on the misrepresentation because once the IDRE determined the dispute was eligible, United had no choice but to proceed with the process, submit a final offer, and watch helplessly as the dispute continued to a final payment determination. Any other approach would have resulted in a default award against United for an amount likely to be many times the allowed Pennsylvania Medicaid rate.

111. NorthStar's false attestations of eligibility pertain to material facts in the NSA IDR process because they go to the heart of the IDRE's jurisdiction to even hear the dispute.

112. NorthStar submitted the false attestations to receive a windfall for itself, namely, IDR payment determinations in favor of NorthStar and against United regarding items or services that it knew were ineligible for resolution through the NSA IDR process.

113. As a direct result of these misrepresentations by NorthStar, United has suffered damages in the form of payment of IDRE and administrative fees for a claim that was, at all times, ineligible for resolution through the NSA's IDR process. United will suffer additional harm if it is required to pay the IDR award for this ineligible claim.

[52] 45 C.F.R. § 149.510(c)(1)(v).

114. To date, NorthStar and its affiliated entities have submitted thousands of claims to the NSA IDR process and are continuing to do so, including the ineligible and fraudulent Medicaid claim described herein. United stands to suffer additional ongoing harm if NorthStar is permitted to continue submitting ineligible and fraudulent claims through the NSA IDR process.

115. United seeks damages and injunctive relief to enjoin Defendant from continuing to fraudulently submit false attestations and initiating the NSA IDR process for items or services that are not qualified for NSA IDR, or from seeking to enforce non-binding awards entered on items and services not qualified for the NSA IDR process.

PRAYER FOR RELIEF

Wherefore, Plaintiff United respectfully requests that relief be entered in its favor as follows:

A. Declare that Defendant's conduct in initiating NSA IDR for the ineligible Medicaid claim described herein was unlawful and fraudulent;

B. Declare that Medicare- and Medicaid-related claims are not eligible for NSA IDR;

C. Declare that IDR awards issued on unqualified items or services are non-binding and are not payable;

D. Enjoin Defendant from continuing to submit false attestations and initiate the NSA IDR process for items or services that are not qualified for NSA IDR, or from seeking to enforce non-binding awards entered on items and services not qualified for the NSA IDR process;

E. Award compensatory, punitive, and exemplary damages;

F. Award costs, attorneys' fees, and interest;

G. Grant such other and further relief as the Court deems just and proper.

Dated: December 19, 2025

Respectfully submitted:

/s/ Jordan Hughes
Jordan Hughes (PA Bar No. 330649)
LATHAM & WATKINS LLP
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Telephone: (202) 637-2200
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David C. Tolley (*pro hac vice forthcoming*)
William J. Trach (*pro hac vice forthcoming*)
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200 Clarendon Street
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william.trach@lw.com
gwyn.williams@lw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

COMMUNITY INSURANCE COMPANY D/B/A ANTHEM BLUE CROSS AND BLUE SHIELD, Plaintiff, v. HALOMD, LLC, ALLA LAROQUE, SCOTT LAROQUE, MPOWERHEALTH PRACTICE MANAGEMENT, LLC, EVOKES, LLC, MIDWEST NEUROLOGY, LLC, ONE CARE MONITORING, LLC, and VALUE MONITORING LLC, Defendants.	Civil Action No. 1:25-cv-00388-MWM District Judge: Matthew W. McFarland

[PROPOSED] ORDER GRANTING MOTION FOR LEAVE TO FILE DEFENDANTS' THIRD NOTICE OF SUPPLEMENTAL AUTHORITY

Having considered the Motion for Leave to File Defendants' Third Notice of Supplemental Authority, and any opposition thereto, it is hereby:

ORDERED that the Motion for Leave to File Defendants' Third Notice of Supplemental Authority is GRANTED.

It is FURTHER ORDERED that Defendants shall file their Third Notice of Supplemental Authority.

SO ORDERED on this ___ day of _____, 2026.

_____
Hon. Matthew W. McFarland
United States District Judge