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IN THE UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, a California corporation; BLUE CROSS OF CALIFORNIA DBA ANTHEM BLUE CROSS, a California corporation,

Plaintiffs,

v.

HALOMD, LLC; ALLA LAROQUE; SCOTT LAROQUE; MPOWERHEALTH PRACTICE MANAGEMENT, LLC; BRUIN NEUROPHYSIOLOGY, P.C.; iNEUROLOGY, PC; N EXPRESS, PC; NORTH AMERICAN NEUROLOGICAL ASSOCIATES, PC; SOUND PHYSICIANS EMERGENCY MEDICINE OF SOUTHERN CALIFORNIA, P.C.; and SOUND

Case No. 8:25-cv-1467-KES

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS AMICUS CURIAE IN SUPPORT OF PLAINTIFFS' OPPOSITIONS TO DEFENDANTS' MOTIONS TO DISMISS AND SPECIAL MOTIONS TO STRIKE

Judge: Hon. Karen E. Scott

PHYSICIANS ANESTHESIOLOGY OF CALIFORNIA, P.C.,

Defendants.

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INTEREST OF AMICUS CURIAE[1]

America's Health Insurance Plans, Inc. (AHIP) is the national trade association representing the health insurance industry. AHIP is committed to market-based solutions and public-private partnerships that make high-quality coverage and care more affordable, accessible and equitable for everyone. AHIP's members provide health care coverage, services and solutions to more than 200 million Americans. That experience gives AHIP broad first-hand knowledge and a deep understanding of how the nation's health care and health insurance systems work.

AHIP writes here to explain the broader context surrounding this lawsuit. Specifically, Congress designed the dispute resolution process at issue to be efficient, rarely used, and cost saving for taxpayers and health care consumers. Most health care providers appear to have approached the Act in good faith and have been fairly compensated. Yet Congress's intended cost savings have not materialized. Instead, costs have ballooned. Why? A handful of entities are exploiting the system to obtain windfall profits on ineligible claims. This abuse includes misrepresenting material facts, submitting inflated claim amounts, and submitting claims in large waves to avoid detection. The IDR process lacks procedural safeguards to protect against fraud and abuse. If this abuse continues unchecked, the result will be spiraling health care costs for everyone.

INTRODUCTION AND SUMMARY OF ARGUMENT

AHIP's members strive to reach agreements with health care providers to offer consumers affordable networks that provide choices in the delivery of quality medical care. When unable to secure network agreements before treatment is rendered, health plans seek to negotiate reasonable out-of-network payments to prevent surprise medical bills and reduce costs for patients. But before the No Surprises Act, some

[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than amicus, its members, or its counsel made a monetary contribution intended to fund the brief's preparation or submission. *See* Fed. R. App. P. 29(a)(4).

providers refused to participate in networks. Instead, they sent patients excessive surprise bills to extract payments of the above-market, unilaterally set billed charges initially sought from the patients' health plans. This dynamic was particularly strong for private-equity-backed provider groups in specialties where patients could not choose providers in advance, like emergency care and anesthesiology.

Congress ultimately arrived at a bipartisan solution in the No Surprises Act. The Act bars providers from billing patients for the balance of their out-of-network charges for certain services, including emergency services and services at in-network health care facilities where the patient did not agree in advance to the out-of-network provider. The Act encourages health plans and providers to resolve out-of-network payments through negotiations centered around reasonable negotiated market rates. If disputes persist, Congress established the Independent Dispute Resolution (IDR) process to resolve them. In IDR, the parties submit confidential offers to the IDR entity, which then selects one of the two offers in a black-box process governed by short statutory deadlines with limited opportunity for further review. Congress selected this "baseball-style" format to incentivize parties to submit reasonable offers, and Congress expected that parties would rarely resort to IDR.

When providers approach the Act in good faith, the system can work as Congress intended to protect patients from surprise bills, reduce excessive costs for out-of-network care, and minimize administrative costs. The lion's share of providers accept health plans' initial payments without dispute, reflecting the reasonableness of payments centered on negotiated market rates. Most of the remainder resolve any disputes through negotiation, consistent with statutory design.

Only a small share of providers thus initiate most IDR proceedings. But that small fraction has an outsized impact. The problem is not just the extremely high volume of IDR disputes—though that is a problem. It is also the concentrated exploitation of the IDR system by a few provider groups and third-party intermediaries, many of them backed by private equity firms. These entities, some of

which were created after the federal IDR process was established as a means of leveraging IDR to obtain higher payments for providers, are manipulating the system by submitting ineligible and grossly excessive claims.

As the Complaint documents, a few provider entities and intermediaries have adopted IDR exploitation as a business strategy. They submit claims to the federal IDR process that don't belong there, seeking a windfall when ineligible claims invariably go undetected, and are then accepted, by the IDR entity. This strategy often works. The sheer quantity of ineligible claims—which are often submitted in waves—overwhelms IDR entities' limited capacity to identify misstatements and screen out ineligible disputes, especially when the filer includes false information. Because IDR entities are paid per eligible dispute and collect nothing for disputes deemed ineligible, they have little incentive to find disputes ineligible. And because the IDR process lacks standard adversarial procedures and is largely non-transparent, health plans are hampered from meaningfully responding to misstatements, inflated rates, or fraud.

The result of this concentrated exploitation of the IDR system is billions of dollars in administrative costs and excessive payments for services that never qualified for IDR in the first place. These payments are not only many times higher than negotiated market rates, but may also substantially exceed the amount the provider originally billed. Allowing just a few entities to abuse the system at scale without having to answer for their conduct would be devastating. It not only harms health plans. It also raises costs for American families. And it would create perverse incentives that would encourage even more manipulation of the system.

ARGUMENT

I. The No Surprises Act Was Designed to Foster Good-Faith, Voluntary Dispute Resolution Centered on Reasonable, Negotiated Market Rates and Limited Use of Arbitration.

The Act establishes a dispute resolution process that encourages prompt,

voluntary resolution of out-of-network payment disputes. To begin, the plan makes an initial payment, which is often based on the Qualifying Payment Amount (QPA).[2] The QPA is generally the plan's median in-network contract rate for the same service in the same area.[3] Either party can then start a 30-day open negotiation period.[4] If negotiations fail, then a party may initiate IDR within 4 days.[5]

IDR procedures are limited to foster speed and efficiency. Each party must submit an offer within 10 days after an IDR entity is selected.[6] Neither party sees or responds to the other party's offer.[7] The IDR entity must select one of the two offers within 30 days; it cannot set any other payment amount.[8] These limited "baseball-style" procedures are intended to encourage reasonable offers, foster settlement, and minimize administrative costs.[9]

When providers approach the process in good faith, payment disputes are generally resolved quickly through market-rate payments and negotiation. In 2024, the Act protected patients from nearly 20 million surprise bills. AHIP & Blue Cross Blue Shield Ass'n (BCBSA), *New AHIP/BCBSA Survey Finds Providers are Flooding IDR System with Ineligible Disputes*, at 3 (Oct. 2025), https://tinyurl.com/5hdb63te (AHIP/BCBSA Survey). Per AHIP/BCBSA research, for more than three-quarters (76%) of qualified items or services, providers accepted initial payments without dispute. *See id.* Payments for about an additional fifth of services (18%) were resolved during the negotiation period. *Id.* Collectively, about

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[2] 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I), (b)(1)(C).
[3] *Id.* § 300gg-111(a)(3)(E)(i)(I).
[4] *Id.* § 300gg-111(c)(1)(A).
[5] *Id.* § 300gg-111(c)(1)(B).
[6] *Id.* § 300gg-111(c)(5)(B).
[7] *Id.*; *see also* CMS, *Federal [IDR] Process Guidance for Disputing Parties*, at 18-19 (Dec. 2023), https://tinyurl.com/mr2xvdrk (Disputing Party Guidance).
[8] 42 U.S.C. § 300gg-111(c)(5)(A)(i).
[9] *See Tex. Med. Ass'n v. U.S. HHS*, 110 F.4th 762, 768 n.8 (5th Cir. 2024); 42 U.S.C. § 300gg-111(c)(3)(A).

94% of claims subject to the Act were resolved voluntarily in QPA-centered negotiations. *Id.*

Anticipating that providers would approach this process in good faith, Congress expected the Act to both protect patients from surprise medical bills and bring down health care costs. And while the IDR process adds new administrative costs, it was expected to be a rarely needed, last-resort process. *See* 86 Fed. Reg. 55980, 56056-57 (Oct. 7, 2021). Any additional administrative costs were projected to be offset by premium reductions, on the expectation that out-of-network payments would move closer to negotiated rates. *See* Cong. Budget Office, *Estimate for Divisions O Through FF, H.R. 133*, at 2-3 (Jan. 14, 2021), https://tinyurl.com/3eec2a4n. At the time, this projection made sense because the Act was designed to rein in the pre-Act practice of extorting above-market payments from health plans by leveraging the threat to surprise bill their beneficiaries. *See* 86 Fed. Reg. 36872, 36874 (July 13, 2021). Unfortunately, the reality has not lived up to expectations, in part because of concentrated exploitation of the IDR system by a handful of private-equity backed provider firms and emergent third-party intermediaries.

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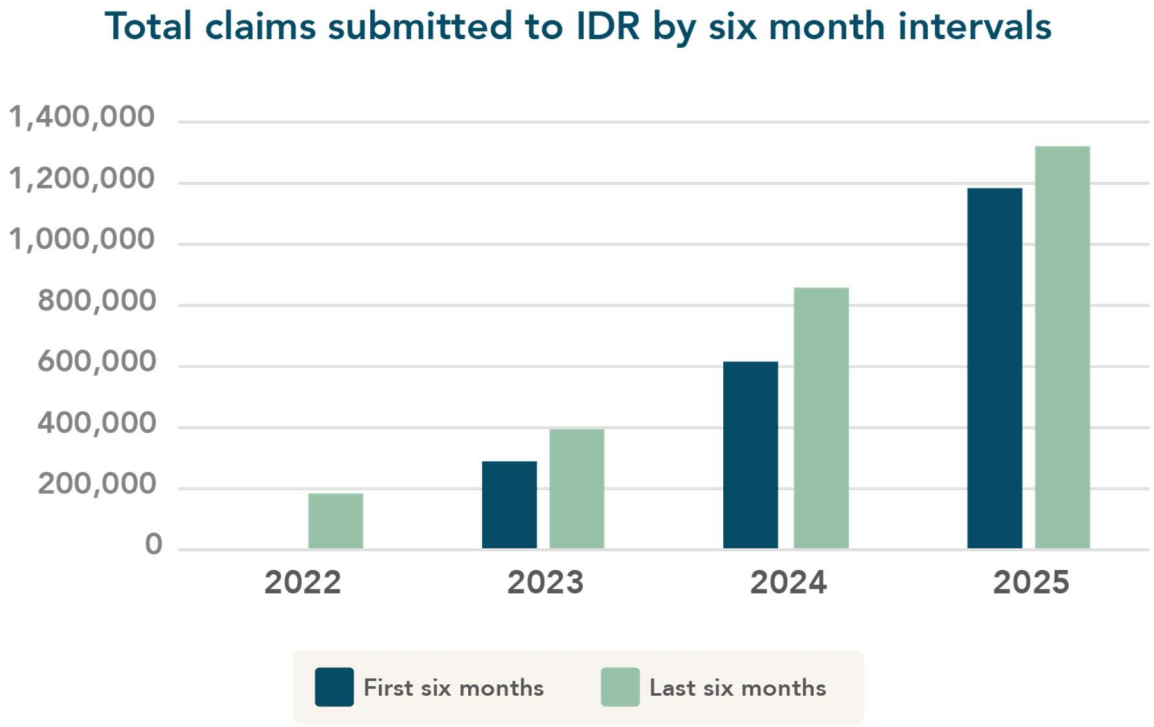
II. Abuse of the IDR Process is Generating Billions in Unwarranted Costs.

A. A Few Entities Have Overwhelmed the IDR System with Ineligible Disputes, Significantly Straining the IDR System.

1. IDR volume is very high and still growing, driven by ineligible claims.

IDR volume has increased about seven-fold from the second half of 2022 to the end of 2025:



Disputes were up more than 10% in the latter half of 2025, belying any notion that IDR volume is stable, *contra* Cal. Med. Ass'n Amicus Br., Dkt. 80-1, at 8 (CMA Br.). Annualized, this means more than 2.6 million IDR disputes are filed a year, nearly 120 times the volume anticipated by the implementing agencies. 86 Fed. Reg. at 56056-57 & nn.187, 199.[10]

[10] Volume data is drawn from the agencies' semiannual and bi-monthly reports, with December 2025 volume estimated based on the per-month average for July to November 2025. *See* CMS, *[IDR] Reports*, https://tinyurl.com/5enjup2e.

This high volume is primarily driven by two related phenomena. First, a handful of firms have engaged in concentrated exploitation of the IDR system. Second, the system has been flooded with disputes that do not qualify for IDR.

a. In 2023 and 2024, a few "[l]arge investor-backed provider groups … accounted for a large and disproportionate share of IDR cases." Matthew Fiedler & Loren Adler, *A first look at outcomes under the No Surprises Act arbitration process*, fig. 1, Brookings Inst. (Mar. 27, 2024), https://tinyurl.com/ub6hutwb (2023 data); Jack Hoadley et al., *[IDR] Process 2024 Data: High Volume, More Provider Wins*, Health Affairs Forefront (June 11, 2025), https://tinyurl.com/436rpfys (2024 data).

By 2025, third-party intermediaries like Defendant HaloMD had joined these firms among the top initiators of IDR. CMS, *Supplemental Background on Federal [IDR] Public Use Files, Jan. 1, 2025 – June 30, 2025*, at 2 (Jan. 21, 2026), https://tinyurl.com/yc35y54r (2025 IDR Report). The top three initiating entities—HaloMD and two private-equity-backed provider firms—generated nearly half of all IDR disputes in the first half of 2025. *Id.*; U.S. Gov't Accountability Office, *Private Health Insurance: Roll Out of [IDR] Process for Out-of-Network Claims Has Been Challenging*, at 43-44 (Dec. 2023), https://tinyurl.com/mrsvxbdr (identifying private-equity-backed firms).

b. The disputes initiated by frequent filers are often ineligible for IDR. About two-fifths of IDR disputes are filed for services that are not eligible for IDR. *See* AHIP/BCBSA Survey, *supra*, at 4 (39%); 2025 IDR Report, *supra*, at 3 (40% challenged as ineligible); CMS, *Supplemental Background on Federal [IDR] Public Use Files, July 1, 2024 – Dec. 31, 2024*, at 3 (May 28, 2025), https://tinyurl.com/yefd33j5 (2024 IDR Report) (43-45% challenged as ineligible). That adds up to more than a million ineligible disputes per year based on the latest IDR volume data.

Because IDR was never intended to be a catch-all forum, there are many criteria that disqualify disputes from IDR:

Reason Why Health Plan Deemed Disputed Claims Ineligible	Share of Ineligible Disputes (%)
Dispute is outside of the allowed timeframe	29%
Incomplete IDR submission	13%
Dispute should be resolved through a state surprise billing process	8%
Claim is for services not covered by NSA	7%
Dispute is submitted by a provider that is in network/already contracted with the health plan	4%
Patient is covered by an ineligible coverage type (e.g., Medicare, Medicaid, or an Excepted Benefit)	3%
Duplicate IDR submission	2%
Resubmitted IDR disputes where a payment determination was already issued	<1%
Patient is not covered by our health plan	1%
Other	32%

AHIP/BCBSA Survey, *supra*, tbl. 4; *see also* 42 U.S.C. § 300gg-111(a)(1), (a)(3)(F)-(K), (b)(1), (c)(1).

Strikingly, the most common reason for ineligibility—submitting disputes outside the allowed timeframe—is entirely within a provider's control and knowledge. The other disqualifiers are also readily identifiable by a provider, especially when plans repeatedly put providers on notice. *See* Anthem Opp'n to Mot. to Dismiss, Dkt. 93, 11-12 (Anthem Br.). Nonetheless, despite increased experience with the system, ineligible disputes keep increasing alongside overall volume.

The incentive to submit ineligible IDR disputes can be particularly strong in States like California that have state surprise billing laws. Services subject to California's surprise billing law are not eligible for IDR. 42 U.S.C. § 300gg-111(a)(3)(K). In California, an out-of-network provider is paid the higher of the average contracted rate or 125% of the Medicare rate. *See* Cal. Health & Safety Code §§ 1371.30, 1371.31(a)(1). Well-developed guardrails mean state arbitration is rare, with just 375 disputes over nearly 7 years. Cal. Dep't of Managed Health Care, *AB 72 Independent Dispute Resolution Process Quarterly Report*, at 1 (2025), https://tinyurl.com/69xf8kfk. However, with federal IDR payment amounts averaging

many times higher than the average contracted rate, *see infra* pp. 11-12, providers have every incentive to file IDR disputes despite knowing they do not qualify for IDR.

2. The IDR system is not well-equipped to self-correct for abuse and manipulation.

a. IDR entities have minimal incentives and limited capability to screen out ineligible claims. Although the statute does not require IDR entities to determine dispute eligibility, 42 U.S.C. § 300gg-111(c)(5), IDR entities do screen out some ineligible disputes. *See* 2025 IDR Report, *supra*, at 3. But a huge number pass through and reach final payment determinations—15% of all disputes, AHIP/BCBSA Survey, *supra*, at 4, meaning several hundred thousand payment determinations are issued annually on ineligible disputes. This is a widespread problem. *See, e.g.*, AHIP Comment Letter, Proposed Rule: Federal [IDR] Operations, at 13 (Jan. 2, 2024), https://tinyurl.com/488wkans (describing "numerous ineligible claims entering the IDR process" leading to "payment determinations without basis in the letter or spirit of the No Surprises Act").

IDR entities have little incentive to closely scrutinize dispute eligibility. They recover fees only when they issue a final payment determination on the merits. CMS, *Calendar Year 2023 Fee Guidance for the Federal [IDR] Process under the No Surprises Act*, at 5 (Oct. 31, 2022), https://tinyurl.com/4r5w97p5. Their assessments are also hampered by an IDR process that lacks adversarial testing of submissions, especially if initiating parties sign false attestations of eligibility criteria and misrepresent critical dates. *See* Anthem Br. 3-6, 11-12. Parties have only a few days to file an eligibility objection. 45 C.F.R. § 149.510(c)(1)(iii). This is precious little time to screen out false dates or other misstatements, especially if initiating parties deliberately bunch their filings into waves. *See* Anthem Br. 12-13.

b. Beyond ineligible claims, IDR lacks a meaningful process that could identify fraud or abuse. IDR proceedings do not involve discovery or adversarial testing of the parties' offers; a party cannot even see the other party's offer. *See* Disputing Party

Guidance, *supra*, at 18-19. This format makes it impossible for plans to identify grossly excessive offers like those exceeding billed charges. *See* Anthem Br. 13.

Worse still, plans often lack notice of an IDR proceeding because providers input the wrong plan information. *See* AHIP/BCBSA Survey, *supra*, at 5 (providers often "entered incorrect health plan or contact information, preventing plans from being informed" about IDR). The startling share of IDR default decisions—more than 20% of decisions, 2025 IDR Report, *supra*, at 4—is not an indicator that health plans are undercutting the system, as CMA supposes (Br. 10). Rather it reflects fundamental process gaps and a system straining under the weight of far too many disputes.

3. The system is buckling under the strain.

The extraordinarily high IDR volume, including rampant ineligible claims, has bogged down the system. Despite increasing capacity, more than a third of the IDR disputes pending in mid-2025 were more than 30 days old. CMS, *Fact Sheet: Clearing the [IDR] Backlog*, at 3 (Sept. 2025), https://tinyurl.com/3kcw4n2a.

What's more, marginally faster timelines may simply mean more errors. In 2025, the implementing agencies recognized that continued clerical, jurisdictional, and procedural errors by IDR entities undermined the program's integrity. CMS, *Federal [IDR] Technical Assistance for Certified IDR Entities and Disputing Parties*, at 1 (June 2025), https://tinyurl.com/2ujrhaxu. The agencies therefore created a process for reopening erroneous IDR determinations. But this process is designed to correct one-off inadvertent errors, not to address widespread false submissions of the type alleged here.

B. IDR System Abuse Causes Billions of Dollars of Wasteful Costs.

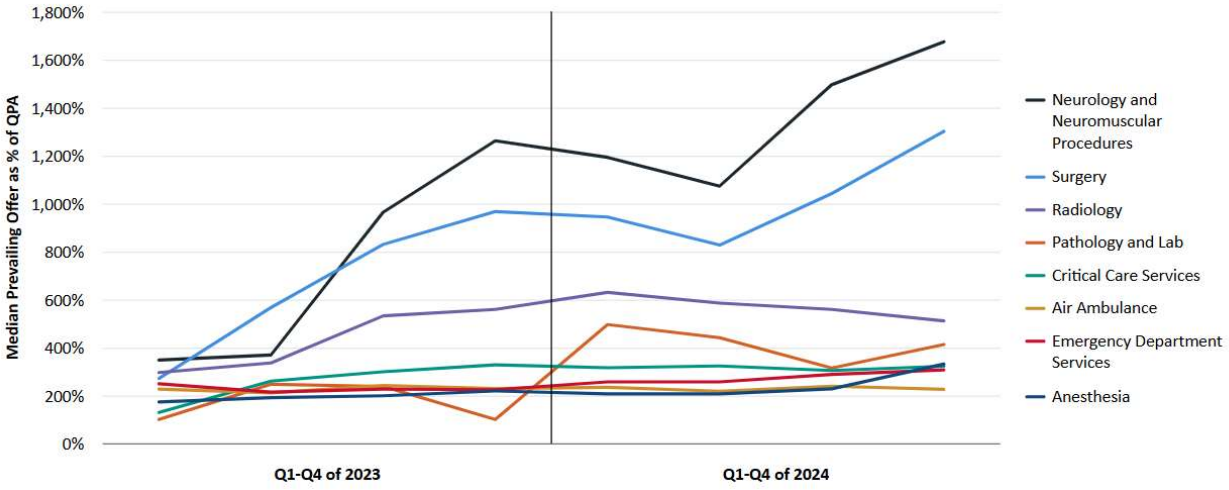
The negative consequences from abuse of the IDR system are immense. IDR is very costly, in terms of both administrative costs and IDR awards that far outpace negotiated market rates.

Both parties must pay an administrative fee (now $115), and the losing party must pay IDR fees that can reach nearly $1,200 or more for a batched claim with

many items. 88 Fed. Reg. 88494, 88523 (Dec. 21, 2023). There are also hefty IDR-related staffing and technology expenses. Using just the agencies' 2021 per-dispute estimate for such costs, which is a substantial understatement, administrative costs alone totaled $2.8 billion over a three-year period (2022-2024) for all IDR parties. Jack Hoadley & Kennah Watts, *The Substantial Costs Of The No Surprises Act Arbitration Process*, Health Affairs Forefront (Aug. 25, 2025), https://tinyurl.com/4za4y38v.

On top of the administrative costs, concentrated exploitation of the IDR system has yielded payment determinations far exceeding market rates. Before the Act, a study found that average rates for a specialty that was historically unable to balance bill were about one and a half times Medicare rates. Zack Cooper et al., *Out-Of-Network Billing and Negotiated Payments for Hospital-Based Physicians*, 39 Health Affairs 24, 26 (Jan. 2020), https://tinyurl.com/bddeyrfj. IDR results quickly surpassed those numbers. Median IDR decisions in the first half of 2023 were often more than double median in-network rates, and nearly four times (or more) the rate that Medicare would pay for the same service. Fiedler & Adler, *supra*.

For most specialties, the median IDR awards only went up from there. By the end of 2024, median IDR awards for some specialties had skyrocketed to more than 16 times median in-network rates.



Cong. Rsch. Serv., *No Surprises Act (NSA) [IDR] Process Data Analysis for 2024*, fig. 7 (Nov. 26, 2025), https://tinyurl.com/ypksct72.

This outcome is extraordinary even without considering ineligible disputes. One analysis indicated that excess payments generated by IDR—*i.e.*, payments exceeding in-network rates—amounted to $2.24 billion. Hoadley & Watts, *supra*. Worse yet, some of these excess payments are due to IDR-exploiting entities obtaining IDR decisions that exceed—sometimes by orders of magnitude—the amount that the provider originally billed for the service. *See, e.g.*, Am. Compl. ¶¶ 124, 172, 182, 188, 200, 205. A scheme to extract payments above billed charges does not merely carry forward the surprise-billing-based market distortion that the Act was designed to ameliorate. It magnifies that distortion.

The problem Congress was trying to solve was providers' surprise efforts to collect from patients the balance of their excessive, above-market billed charges. 86 Fed. Reg. at 36874; 86 Fed. Reg. at 56046-47. Billed charges were understood to be an above-market ceiling for out-of-network payments; that is why Congress barred IDR entities from considering them. *See* 86 Fed. Reg. at 56060. Systemic abuse that allows providers to secure payments above their already excessive billed amounts turns the system on its head.

C. If Left Unchecked, Abusive IDR Practices Will Proliferate, and Patients and Health Care Consumers Will Pay the Price.

When the door is left open for firms to abuse the IDR system, the negative consequences only amplify. With a total cost exceeding $5 billion over three years, and assuming just 15% of those costs are attributable to the ineligible disputes that IDR entities don't screen out, back-of-the-envelope math suggests about a billion dollars so far in unwarranted costs and payments to providers for ineligible claims ($250 million per year from 2022 to 2025). This is almost certainly a gross understatement given how much IDR volume has spiked since 2022, and ineligible disputes along with it.

The billions of dollars in wasteful administrative costs and excessive payments generated by exploitation of the IDR system directly harms consumers who purchase health insurance and indirectly harms taxpayers by increasing expenditures for premium tax credits. *See* 86 Fed. Reg. at 56059. Such an outcome cannot be squared with either the Act's purpose to protect consumers from high out-of-network costs, or the broader legal, commercial, and regulatory imperatives for health plans to limit the amount spent on administrative costs. *See, e.g.*, 42 U.S.C. § 300gg-18(b).

Accepting Defendants' arguments that fraudulent IDR practices are immune from liability would mean increased costs for everyone. If providers can submit false attestations to sneak ineligible disputes into the system, with the prospect of securing payments far above market rates, it will only encourage the submission of ever more ineligible and fraudulent disputes. And the more claims that are submitted—eligible or not, abusive or not—the more likely that the system is further overwhelmed, and that even more ineligible or fraudulent claims pass through. The IDR system was not designed to police the kind of fraud alleged here. The prospect of liability for fraud is essential to forestall a vicious circle of perverse incentives that would abrogate Congress's careful constraints on the IDR system and supercharge the out-of-network costs that the Act was designed to mitigate.

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CONCLUSION

For the foregoing reasons, this Court should deny Defendants' Motions.

Dated: February 6, 2026 SPERTUS, JOSEPHS & MINNICK, LLP

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CERTIFICATE OF COMPLIANCE

The undersigned, counsel of record for America's Health Insurance Plans, Inc., certifies that this brief contains 3,481 words, which complies with the word limit of L.R. 11-6.1 and is less than half of that word limit.

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