IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TEXARKANA DIVISION

HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY,	)	
Plaintiff,	)	Civil Action No. 5:25-cv-00186-RWS
v.	)	
ZOTEC PARTNERS, LLC,	)	
Defendant.	)	

AMICUS CURIAE BRIEF OF THE
EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOCIATION
IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Federal Cases

Federal Statutes

State Statutes

Regulations

Other Authorities

INTRODUCTION

Scrutiny of out-of-network ("OON") disputes has not waned in the five years since Congress passed the No Surprises Act, Pub. L. 116-260, div. BB, tit. I, 134 Stat. 1182, 2757-890 (2020) ("NSA" or "Act"), and nearly four years since implementing regulations were first introduced. Through Congressional hearings and protracted litigation (centered in this Court and the Fifth Circuit), special attention has been paid to the NSA's independent dispute resolution ("IDR") process. One of the major disputes resolved by this Court has been the role of the qualifying payment amount ("QPA") in IDR cases, which is a figure calculated exclusively by health insurers to represent the median contract rate as of January 1, 2019, of the same or similar item or service, adjusted for inflation. Through three lawsuits, this Court determined (over the opposition of the health insurance industry) that the plain text of the NSA prohibits the QPA from being elevated or given undue influence over other factors that must be considered in IDR.[1]

Congressional members have pithily averred what this Court unequivocally confirmed in its rulings. Immediately after passage of the NSA, a large bipartisan group of Congress lauded the NSA as a "free-market solution that takes patients out of the middle and fairly resolves disputes between plans and providers," while emphasizing that the NSA's "text includes NO benchmarking or rate-setting."[2] (emphasis in original). Yet, in the opening words of plaintiff

[1] *See Texas Medical Ass'n v. U.S HHS*, 587 F. Supp. 3d 528, 541 (E.D. Tex. 2022) (***TMA I***); *Texas Med. Ass'n v. U.S. HHS et al.*, 654 F. Supp. 3d 575, 580 (E.D. Tex. 2023), *aff'd* 110 F.4th 762 (5th Cir. 2024) (***TMA II***); *Tex. Med. Ass'n v. U.S. HHS et al.*, 2023 WL 5489028, at *4-5 (E.D. Tex., Aug. 24, 2023), *aff'd in part, rev'd in part,* 120 F.4th 494 (5th Cir. 2024), *vac'd and rehr'g granted by en banc* (***TMA III***).

[2] Joint Stmt. of the House Comms. on Ways and Means, Energy and Commerce, and Educ. and Labor, "Protecting Patients from Surprise Medical Bills" (Dec. 21, 2020) <https://waysandmeans.house.gov/2020/12/21/protecting-patients-from-surprise-medical-bills> (visited 3-20-26).

Health Care Services Corp.'s ("HCSC") First Amended Complaint [Dkt. #22] ("FAC"), the largest health insurer in Texas incredibly claims that "Congress directed that [the QPA] be included as a key benchmark for resolving rate disputes" in the IDR process. FAC ¶3 (emphasis added). HCSC then doubles down on its revisionist interpretation of the NSA by claiming that IDR awards must be fraudulent because they overwhelmingly pick, as they must between only two offers, the provider's offer rather than the QPA offer. *See id.*

HCSC's action is a thinly-veiled attempt to circumvent the uniform court precedents and clear Congressional pronouncements that the QPA is just one among many factors equally weighted in resolution of OON payment disputes. HCSC's action additionally is premised on the related false notion that the sheer high volume of IDR awards favoring providers must somehow reflect a broken IDR system. In fact, the IDR process is working exactly as Congress designed, and providers are overwhelmingly prevailing in IDR because arbitrators are following the NSA rules and determining that provider offers are more reasonable over health insurer offers. In this context, there is no credible concern of abuse of the system by providers.

The allegations that defendant Zotec Partners, LLC ("Zotec") has engaged in widespread fraud to somehow manipulate the IDR process are founded on this false rendition of the NSA and the IDR process. While those claims should be dismissed as nonjusticiable and for failure to state legal claims, as explained in Zotec's motion to dismiss [Dkt. #25], the Emergency Department Practice Management Association ("EDPMA") by this *amicus curiae* brief puts HCSC's action in a broader context. The allegations and claims raised by the FAC highly resemble many other lawsuits brought by other large health insurers throughout the nation to

collaterally challenge IDR awards favoring providers.[3] It is apparent that health insurers are engaged in a national strategy to rehash the arguments that Congress rejected to try to elevate the QPA and tilt the IDR process in insurers' favor. Indeed, one of the largest national insurers is openly lobbying Congress and federal regulators to "fix" the IDR process by, among other things, "requiring arbitrators to reject ineligible claims and justify unusually high awards" and "anchoring arbitration decisions to the QPA and requiring justification for any deviation."[4] Despite resoundingly losing this battle before Congress and this Court, health insurers can certainly try to change the text of the NSA through redoubled lobbying efforts, but this Court is not the proper forum to revisit the debate, much less to modify the NSA. EDPMA respectfully urges the Court to recognize HCSC's action as part and parcel of a greater lobbying effort, not as a proper lawsuit that meets justiciability requirements.

INTERESTS OF THE AMICUS CURIAE

EDPMA is a physician trade association focused on the delivery of high-quality, cost-effective care to patients in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes, as well as billing, coding, and other professional support organizations that assist physicians in our nation's emergency departments.

[3] *See Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. v. HaloMD, LLC et al.*, case no. 2025-cv-02919-TWT (N.D. Ga.); *Community Insurance Co. et al. v. HaloMD, LLC et al.*, case no. 2025-cv-00388-MWM (S.D. Ohio); *Anthem Blue Cross Life and Health Insurance Company et al. v. HaloMD LLC et al.*, case no. 25-cv-1467-KES (C.D. Cal.); and *Health Care Service Corporation v. HaloMD, LLC, et al.*, case no. 2025cv00132-RWS (E.D. Tex.).

[4] *See* Elevance Health, "No Surprises Act Intended to Protect Patients, but Loopholes Drive Up Health Costs" (Dec. 19, 2025) <https://www.elevancehealth.com/our-approach-to-health/consumer-centered-health-system/curbing-misuse-of-the-no-surprises-act> (visited 3-20-26).

EDPMA's members provide direct patient care and/or support the provision of care for approximately half of the 146 million patients that visit emergency departments each year.

For more than 25 years, EDPMA has advocated for the rights of emergency physicians and their patients at the federal and state levels. Among other things, EDPMA advanced the voice of emergency medicine providers in debates and public comments around the NSA and its implementing regulations. EDPMA filed *amicus curiae* briefs in support of plaintiff providers and provider associations in this court and in the Fifth Circuit to ensure that the NSA is carried out in conformity with Congressional intent.[5] EDPMA's members have been active participants in the IDR process under the NSA. EDPMA draws on all these experiences and knowledge to lend assistance to the Court in this matter, which involves an effort by a health insurer to thwart the functions and goals of the NSA's IDR process.

DISCUSSION

A. THE NO SURPRISES ACT IS FOUNDED ON A BIPARTISAN BALANCE OF COMPETING INTERESTS TO RELIABLY RESOLVE OUT-OF-NETWORK PAYMENT DISPUTES.

The No Surprises Act is widely lauded as a significant, bipartisan achievement for patients. The Republican co-sponsor, Senator Bill Cassidy, MD (R-LA), heralded the Act as "a milestone in our effort to lower health care costs"; and the Democratic co-sponsor, Senator Maggie Hassan (D-NH), called it "groundbreaking legislation to help ensure that Americans aren't left on the hook for [] outrageous [surprise medical] bills."[6]

[5] EDPMA filed amicus briefs in *TMA I*, *TMA II*, and *TMA III*, supra, footnote 1.

[6] Press release, "Cassidy, Hassan Legislation Ending Surprise Medical Bills Goes into Effect Today," Office of Sen. Bill Cassidy, MD (Jan. 1, 2022) <https://www.cassidy.senate.gov/newsroom/press-releases/cassidy-hassan-legislation-ending-surprise-medical-bills-goes-into-effect-today/> (visited 3/19/26).

Throughout the legislative debates and regulatory rulemaking process for the NSA, providers supported policies to hold patients "harmless" from balance billing while emphasizing the need for broader protections against insurer practices that leave patients with few or difficult to access options for in-network services. These protections include more rigorous network adequacy oversight, transparent and accurate plan and benefit information, especially regarding in-network and OON payment and cost-sharing policies, and accurate provider directories.

Congress believed that a legitimate and reliable dispute resolution process to resolve out-of-network payment disputes was critical to the NSA scheme of restricting balance billing of patients. If providers could no longer balance bill, they must have a productive means to pursue fair compensation from insurers. A defective dispute resolution process that favored insurers or established a de facto, pre-determined out-of-network rate would ill-serve the NSA's goals.

1. Restricting Balance Billing of Patients Goes Hand in Hand with Provider Access to a Binding and Independent Dispute Resolution Process.

A two-pronged approach to resolving inadequate OON reimbursement is apparent on the face of the NSA. The Act provides federal protections for patients against surprise billing by limiting OON cost sharing and prohibiting "balance billing" in the circumstances in which surprise bills arise most frequently. *See* 42 U.S.C. §§300gg-111, 300gg-131, 300gg-132. It also establishes detailed procedures for an IDR process. The Act requires payors to reimburse OON providers at a statutorily calculated "out-of-network rate." *Id.* §300gg-111(a)(1)(C)(iv)(II), (b)(1)(D). In most states, the out-of-network rate is either the amount agreed to by the insurer and the OON provider, or an amount determined through the IDR process. *Id.* Payors must first issue an initial payment or notice of denial of payment for any claim for qualified OON medical services. *Id.* §300gg-111(a)(1)(C)(iv), (b)(1)(C). Providers who disagree with the payor's initial determination may initiate a thirty-day period of open negotiations with the payor to try to

resolve the payment dispute. *Id.* §300gg-111(c)(1)(A). If negotiations fail, the parties may then proceed to baseball-style IDR arbitration. *Id.* §300gg-111(c)(1)(B).

IDR under the NSA follows a "baseball-style" process in which the IDR Entity must pick, without modification, only from competing "offers" submitted by each side "to be the amount of payment for" the OON item or service in dispute. 42 U.S.C. §300gg-111(c)(5)(A). Each side may also submit "any information relating to such offer submitted by either party," which could include information by one party that an item or service under dispute is not eligible for IDR through the NSA. *Id.* at §300gg-111(c)(5)(B)(ii). In choosing among the submitted offers, the NSA specifies the considerations that the IDR Entity "shall" and "shall not" consider. *See id.* at §300gg-111(c)(5)(C) and (D).

The IDR Entity must consider all information submitted by the parties and cannot arbitrarily disregard a party's submission. *Id.* at §300gg-111(c)(5)(C)(i)(II). Factors that the IDR Entity must consider include: the "Qualifying Payment Amount" or "QPA," which is the median contracted rate for a specific health service in a given geographic area, used to set patient cost-sharing and by arbitrators in disputes, essentially acting as the "in-network" cost for OON emergency care or services in in-network facilities, calculated from rates as of January 31, 2019, and adjusted annually for inflation. *Id.* at §300gg-111(a)(3) and (c)(5)(C)(i). Equally important and relevant are numerous factors specific to the provider, including: "[t]he level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service"; "[t]he market share held by the nonparticipating provider . . . or that of the plan or issuer in the geographic region . . ."; "[t]he acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual"; "[t]he teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or

service"; and "[d]emonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider . . . or the plan . . . to enter into network agreements, and, if applicable, contracted rates between the provider . . . and the plan . . . during the previous 4 plan years." *Id.* at §300gg-111(c)(5)(C)(ii)(I)-(V).

Staying true to these clear statutory requirements, courts have struck provisions in the NSA implementing regulations that directly or indirectly elevated one factor over the other or in some way operated to establish any particular rate as a "benchmark." *See TMA II*, *supra*, 110 F. 4th at 776 (striking regulations that effectively elevate the QPA over other statutory factors that arbitrators must consider); *TMA I*, *supra*, 587 F. Supp. 3d at 541 (rejecting regulation that established a rebuttable presumption in favor of QPA in IDR, noting the NSA "nowhere states that the QPA is the 'primary' or 'most important'"). As the courts and Congressional members have made clear, the NSA's detailed requirements for the establishment of the IDR process is intended to serve as the binding mechanism for resolution of OON payment disputes. And it is equally clear under the NSA that the IDR process is to be open-ended, whereby only one of the competing offers is selected without modification.

2. Congress Scrupulously Chose Open-Ended Baseball-Style Arbitration Over a Benchmark and Other Similar Processes.

The thrust of HCSC's complaint in this action, summarized in a section of the FAC entitled "Misuse and Abuse of the NSA IDR Process," are that providers have submitted far more disputes to IDR than initially estimated and that providers overwhelmingly prevail with award amounts that far exceed the QPA amounts submitted by plans. *See* FAC ¶¶49-53. At bottom, HCSC complains that the QPA submitted by plans is not getting preference in the IDR process. HCSC goes as far as to misleadingly claim "Congress directed that [the QPA] be included as a key benchmark for resolving rate disputes . . . . But instead, the IDR process often

results in awards that are many multiples of the [QPA].” *Id.* at ¶3. HCSC thus claims the IDR process is broken and being abused, but in fact this is exactly how Congress designed it.

As Congress tackled the challenge of protecting patients from surprise OON bills, it very carefully considered how to resolve OON payment disputes. The ultimately successful approach was to resolve disputes through an open-ended dispute resolution process that would focus on the merits of a host of factors to determine the appropriate amount of payment. But a competing alternative was under consideration and supported by the health insurance industry.

In May 2019 a bipartisan group of senators proposed Senate bill S. 1531, which proposed a baseball-style IDR process determined by five factors. The bill attracted significant support, with thirty cosponsors in the Senate, and served as the framework for the NSA. However, the second, prominent competing approach was to establish a legislative “benchmark” payment rate to resolve out-of-network disputes. An early example was S. 1895. It proposed a “benchmark for payment” that would be set at the payor’s “median in-network rate” and would have given providers no ability to negotiate a different rate. The following month, H.R. 3630 was introduced and also proffered a benchmark approach.

Subsequent proposals in 2020 moved closer towards a compromise but continued to diverge on the issue around rate-setting. The Consumer Protections Against Surprise Medical Bills Act of 2020 was introduced in February 2020, representing the persistence of the use of an open-ended IDR process. In the same month, the approach of resolving payment disputes through a legislative benchmark was reintroduced in H.R. 5800.

After multiple proposals and advocacy by health insurers, Congress ultimately rejected the benchmark approach as it enacted the NSA with provisions for an IDR process. *See* 42 U.S.C. §300gg-111(a)(1)(C). As shown below, so long as the parameters and relevant factors

were considered in the IDR, nothing in the NSA mandates a particular result, much less favors any particular amount to resolve OON disputes. These features of the IDR process were integral in the bipartisan support of the NSA, not only with legislators but with stakeholders as well.

The emphasis on the open-ended IDR process continued even after passage of the NSA. The then-Chair and Ranking Member of the House Ways & Means Committee issued a letter strenuously objecting to any regulatory effort to directly or indirectly establish a rebuttable presumption around any particular payment rate. The letter emphasized that "[t]he law Congress enacted directs the arbiter to consider all of the factors without giving preference or priority to any one factor—that is the express result of substantial negotiation and deliberation among those Committees of jurisdiction and reflects Congress' intent to design an IDR process that does not become a de facto benchmark."

In deliberately adopting baseball-style arbitration for the IDR process, Congress rejected the approach that HCSC projects in this action. That is, HCSC complains that the QPA is not being used as a "key benchmark" (FAC, ¶3) and that IDR arbitrators must choose from two greatly divergent offers. HCSC ignores that, in making this choice, the arbitrators presumably determined that the higher offer by providers is more reasonable than the lower offer reflecting the QPA. That is exactly how the IDR is supposed to work under the terms of the NSA.

B. THE EMPIRICAL EVIDENCE SHOWS THAT HEALTH INSURERS, NOT PROVIDERS, HAVE FLOUTED THE SPIRIT AND LETTER OF THE NSA.

HCSC effectively seeks to undercut and terminate providers' past and future access to the IDR process to resolve their disputes with HCSC over underpaid OON claims. That is the point of HCSC requesting in the FAC that "the funds paid by HCSC for improper IDR awards should be returned" as well as its attempt to enjoin Zotec from accessing IDR on behalf of providers. *See* FAC ¶¶ 214, 216. These claims are premised on alleged abuse of the IDR process, but they

are not legally cognizable or justiciable for the many reasons pointed out by Zotec in its moving papers supporting dismissal of the FAC. While the alleged abuses of the IDR process asserted by HCSC are legally if not also factually dubious, there is no denying that health insurers like HCSC have actively, if not also intentionally, thwarted providers from availing themselves of the benefits of the IDR process. As shown below, in spite of federal guidance, health insurers do not provide adequate information in claims payment documentation to inform providers whether a claim is or is not IDR-eligible; and insurers routinely refuse to pay IDR awards in favor of providers. If anyone in this case is gaming the IDR process, it certainly is not Zotec.

1. Insurer QPAs are Artificially Low, Resulting in Certified IDR Entities Choosing the More Reasonable Offer Available from Providers.

Providers' offers in IDR proceedings are chosen over plans' offers in a great majority of the IDR cases. *See* Jack Hoadley *et al*., "Independent Dispute Resolution Process 2024 Data: High Volume, More Provider Wins," HEALTH AFFAIRS (June 11, 2025)[7] (reporting providers' success rates between 83-88 percent in 2024). Given the design and "baseball-style arbitration" of the IDR, the success rate suggests that plans are not trying as hard as providers to submit evidence to support their offers and, for the most part, providers' offers are the more reasonable as between the two offers presented to an IDR arbitrator.

For instance, a comprehensive analysis by the Congressional Research Service ("CRS") found that the increased overall win rate for providers in 2024 – in which approximately 85% of payment determinations resulted in the selection of a payment offer greater than the QPA – "was attributable to the amount of default determinations in favor of providers/facilities, particularly in Q4 of 2024." CRS, "No Surprises Act IDR Process Data Analysis for 2024" (November 26,

[7] Online at https://www.healthaffairs.org/content/forefront/independent-dispute-resolution-process-2024-data-high-volume-more-provider-wins (visited 3-20-26).

2025). "In Q4 of 2024, 26% of disputes were resolved through a default and approximately 90% of default disputes were decided in favor of providers and facilities." *Id*.

But even when insurers do participate, they have doggedly insisted on submitting offers that are at or near the QPA. In roughly half (47%) of 2024 disputes, insurers offered at *or below* the QPA. *Id*. Insurers have persisted in this behavior even though they lose four-fifths of the time with this strategy.

What is more, there are significant reasons to believe that insurer-calculated QPAs are artificially low. A RAND study published in December 2024 interviewed numerous providers who had encountered unusually low QPAs rates, including at or below Medicare.[8] One emergency medicine group representative was quoted as saying, "I have a very hard time believing that you're paying any meaningful portion of your in-network clinicians below Medicare for a high-acuity [emergency department] service."[9] Similarly, a more recent quantitative study that "matched publicly reported QPA values to insurers' published median in-network contracted rates for the identical CPT code and geographic region," found that "[i]n 65% of disputes subject to the Independent Dispute Resolution (IDR) process, the reported QPA was lower than the median in-network contracted amount."[10] (emphasis added)

---

[8] RAND Health Care, Petra W. Rasmussen *et al.*, "The Implications of the No Surprises Act on Contract Dynamics, Negotiations, and Finances Perspectives from Key Stakeholders" (December 2024) at 28, online at <https://aspe.hhs.gov/sites/default/files/documents/754f61834289cdd719b542035ee36eba/PRA-1820-9.pdf>.

[9] *Id*.

[10] Press release, Americans for Fair Health Care, "Big Surprise for The No Surprises Act: Study Shows Insurer Benchmark Dangerously Lower Than In-Network Rate" (Dec. 18, 2025), https://www.prnewswire.com/news-releases/big-surprise-for-the-no-surprises-act-study-shows-insurer-benchmark-dangerously-lower-than-in-network-rate-302646089.html (visited 3/20/26).

Despite these discrepancies, there are presently no viable checks on the accuracy of payor-calculated QPAs. QPAs are calculated in secret. Payers are not obligated to disclose those calculations to providers during the open negotiations or in connection with IDR proceedings. *See generally* 45 C.F.R. §149.140(d). The NSA requires regulatory audits of up to 25 payors annually to ensure QPAs are calculated accurately. *See* 42 U.S.C. § 300gg-111(a)(2)(A)(i)-(ii); 86 Fed. Reg. 51730, 51747. Yet to date, there has only been one audit, which found that Aetna Health of Texas had calculated air ambulance QPAs in a fundamentally improper manner.[11] Due to pending litigation that has stalled regulatory oversight, health insurers continue to use previously-calculated QPAs that have been revealed to be flawed.[12] In short, health insurers have absolutely no incentive to recalculate or correct existing QPAs.[13] They have every incentive to ensure QPAs as calculated are as low as possible, and thus depress benchmark rates.

[11] CMS.gov, Final Report: Federal Qualifying Payment Amount Audit of Aetna Health Inc. (a Texas corp.) – HIOS ID #58840 State of Texas as of May 29, 2024, <https://www.cms.gov/files/document/qpa-final-report-aetna-tx.pdf> (visited 3/20/26).

[12] *See* CMS.gov, FAQs ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 AND AFFORDABLE CARE ACT IMPLEMENTATION PART 69 (Jan. 14, 2025) (extending enforcement discretion for previously calculated QPAs through August 1, 2025) <https://www.cms.gov/files/document/faqs-part-69.pdf>; CMS.gov, FAQs ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 AND AFFORDABLE CARE ACT IMPLEMENTATION PART 71 (July 30, 2025) (extending enforcement discretion through February 1, 2026, with the potential to extend further through August 1, 2026) <https://www.cms.gov/files/document/faqs-part-71.pdf> (visited 3-20-2026).

[13] California Medical Association, No Surprises Act: Agencies extend QPA enforcement discretion into 2026 (August 27, 2025) ("In practice, most QPAs being issued today continue to reflect the 2021 rules") <https://www.cmadocs.org/newsroom/news/view/ArticleId/50958/No-Surprises-Act-Agencies-extend-QPA-enforcement-discretion-into-2026> (visited 3-20-26).

2. Providers Could be Accessing IDR More But for the Actions of Health Insurers to Raise Obstacles to Filing Claims and Taking Advantage of the IDR Process.

It is ironic that HCSC laments the number of IDR filings as some vague indication of a broken system. What is problematic is that providers cannot file more IDR claims or benefit from the process due to the obstreperous actions of health insurers. As a threshold matter, there is no empirical support for HCSC's allegation that the sheer volume of IDR claims is crippling the system and making it susceptible, somehow, to provider manipulation. *See* FAC ¶¶49-51, 74. According to CMS, almost 2.3 million IDR proceedings were initiated between January 1 and November 30, 2025, or an average of 208,326 per month.[14] Rather than complain about excessive volume, CMS has committed to "continue to certify applicants to grow system capacity and [to] continue to enhance and modernize the IDR portal." There is little risk of the system being overwhelmed.

Health insurers appear to be intentionally making it more difficult for providers to determine when an OON payment may be eligible for IDR. Insurers are the only ones with perfect information about whether any given claim is "eligible" or "not eligible" for IDR. When insurers process a reimbursement claim and issue a remittance advice or explanation of benefits ("EOB") form, they know whether a claim relates to a particular "line of business," such as Medicaid, Medicare Advantage, or some form of commercial coverage. But the provider is not typically privy to that information. Many times, the only information available to the provider is that the EOB or remittance advice has been issued by "BlueCross BlueShield of Texas."

[14] CMS.gov, Independent Dispute Resolution Reports, https://www.cms.gov/nosurprises/policies-and-resources/reports.

As Zotec's moving papers note, CMS has proposed a series of CARC and RARC codes that would identify the eligibility of a claim for IDR, but there is presently no mandate for payers to use those codes, and they largely do not. [Dkt. #25 at p. 5 & n.5] But insurers like HCSC would actually prefer not to use codes unless and until the regulators mandate them precisely because it would give providers absolute certainty about what claims are eligible for IDR and which are not.[15] With such certainty, providers could file more IDR claims. For all the sound and fury of the FAC, HCSC and other insurers very much prefer to shift the difficult task of determining eligibility to the IDR entities themselves when the insurers possess the information and can make the process of determining eligibility much more reliable. HCSC, in other words, has created the very problem that it now gripes about.

Not only are health insurers creating obstacles to accessing IDR at the front end, but they are also intentionally flouting the system at the back end when they lose. Members of the House Ways and Means Committee issued a letter to regulators continuing to emphasize the important role of the open-ended IDR process. The Committee stressed the need to "implement the law in alignment with clear congressional intent" but lamented the fact that "multiple bipartisan concerns" have been raised that there was a "lack of timely payment following the [IDR] process," citing a survey that "indicated that 24 percent of settled disputes were not paid or were paid an incorrect amount."[16] Notably, the Committee did not raise concerns about provider abuse

[15] *See* America's Health Insurance Plans (AHIP), January 2, 2024 Letter to the Departments Re: Proposed Rule: "Federal Independent Dispute Resolution Operations" – (REG122319-22) (CMS-9897-P) —AHIP Comments, https://perma.cc/P3WM-35BU at 15-16 (complaining that "the proposed process of implementing new CARCs and RARCs [specific to the NSA] would be expensive and time-consuming for many plans" and "would require plans to set up a new process not currently in place").

[16] *See* Ltr. to Sec'y R. F. Kennedy, Jr. et al. from Members of the House Ways and Means Committee (dated Sept. 5, 2025) < https://waysandmeans.house.gov/wp-content/uploads/2025/09/WM-NSA-Letter-2025-FINAL.pdf> (visited 3/22/26).

of the IDR process even though it highlighted its numerous efforts and hearings to investigate NSA implementation problems. Providers' inability to reap the benefits of a favorable IDR award is exacerbated by a recent court decision holding there is no private right of action to enforce IDR awards, though there remains a split among courts. *See Guardian Flight, L.L.C. v. Health Care Serv. Corp*., 140 F.4th 271, 277 (5th Cir. 2025); *but see Guardian Flight LLC v. Aetna Life Ins. Co*., 789 F. Supp. 3d 214 (D. Conn. 2025).

C. HCSC SEEKS TO RESTORE A SKEWED PROVIDER MARKETPLACE THAT PLACES MORE NEGOTIATING POWER IN THE HANDS OF HEALTH INSURERS.

1. HCSC Seeks to Elevate the QPA as a Benchmark, Directly Contrary to Congressional Intent and Court Precedents.

By surreptitiously seeking to elevate the QPA to the level of a "key benchmark" and thereby claim that IDR awards are defective because they do not hew to the QPA, HCSC hopes to re-argue policy points that Congress resoundingly rejected when it established the IDR process in the NSA. This Court rejected regulations that created a rebuttable presumption in favor of the QPA. *See TMA I*, 587 F. Supp. 3d at 541. The Fifth Circuit in *TMA II* rejected NSA regulations that implemented other means to elevate the QPA, finding that the NSA does not permit requirements that (1) the arbitrators must consider the QPA first and "then" the other factors; (2) the arbitrators must not consider information that is not "credible" or "related to" the issue, or that is already accounted for in the QPA; and (3) the arbitrators must explain their reasons if and only if they depart from the QPA. *TMA II*, 110 F.4th at 776. In so holding, the Court noted the NSA "unambiguously provides that arbitrators deciding which offer to select 'shall consider . . . the qualifying payment amounts . . . and . . . information on any circumstance described in clause (ii).'" *Id.* at 775 (quoting 42 U.S.C. § 300gg-111(c)(5)(C)(i)). But the stricken regulations elevating the QPA "tends to bias outcomes in favor of the offer closest to the

QPA." *Id.* at 778-79. Through its attacks on IDR awards on the basis that they stray too far from what HCSC believes is the QPA "key benchmark," HCSC wishes to elevate the QPA in similar fashion, which the Fifth Circuit has held is contrary to the letter and spirit of the NSA.

2. Skewing the IDR Process Towards the QPA Would Make a Fair Dispute Resolution Process for OON Disputes Illusory and Further Undermine Physician Stability and Access to Care for Patients.

As Congress heard when it rejected efforts to use a benchmark approach for the IDR, anchoring resolution of OON disputes to a numerical factor that is controlled by health insurers (such as the QPA) would result in persistent underpayments to providers and in turn cause the contraction of provider networks and the narrowing of health care choice for patients. Such consequences are at issue if HCSC gets the relief it seeks in this case, which is to elevate the QPA and make access to the IDR process impractical if not improbable for providers. In short, HCSC wishes to restore the unequal provider marketplace that the NSA was designed to redress.

The California experience is illustrative. California's state surprise billing law unintentionally operated like there was a state-set benchmark to determine reasonable payment for OON claims.[17] Insurers recognized that they could force providers out of network by paying the artificially low benchmark rate and then offering take-it-or-leave-it contracts. Shortly after the passage of this law, California's health plan regulator found no anesthesiologists in one of the

[17] California's surprise medical billing law requires insurers to make an interim payment to OON providers who then could initiate independent dispute resolution if they believed the rate to be inadequate. *See* Cal. Health & Safety Code §1371.31. The California Medical Association found that, even though the interim payment rate was not a factor under state law to be considered in the IDR process, arbitrators in over 90 percent of cases chose the interim rate as the "reasonable rate" because it was required by state law. *See* CMA Comments to No Surprises Act: Interim Final Rule: Part I (Sept. 7, 2021) at p. 4 <https://www.cmadocs.org/Portals/CMA/files/public/CMA%20Letter%20on%20Federal%20Surprise%20Billing%20Regs%20(080721).pdf?ver=2021-09-16-125208-947> (visited 3/22/26).

state's largest health plan's networks.[18] A study by the RAND corporation documented that California's law "has changed the negotiation dynamics between hospital-based physicians and payers [whereby] leverage has shifted in favor of payers, and payers have an incentive to lower or cancel contracts with rates higher than their average as a means of suppressing OON prices."[19] Health plans in California carried through with threats to kick providers out of their networks and terminate long-existing contracts, some as long as 25 years, disavowing any agenda to build up their networks.[20] Small, independent providers could not remain financially viable and were forced to consolidate with larger systems to continue to care for their patients. This consolidation substantially increased health care costs.[21]

For emergency medicine physicians such as EDPMA's members, the problem is even more acute. EMTALA causes insurers to be even less inclined to keep emergency providers in-network, because their policyholders can access – in fact, must by law receive – emergency care regardless of insurance status. Insurers have no incentive to enter into fair contract rates with emergency physicians.

---

[18] *See id.* at 5.

[19] *See* Erin Lindsey Duffy, "Influence of Out-of-Network Payment Standards on Insurer-Provider Bargaining, California's Experience" AMERICAN J. OF MANAGED CARE (Aug. 23, 2019) at 1 <https://www.ajmc.com/view/influence-of-outofnetwork-payment-standards-on-insurer-provider-bargaining-californias-experience> (visited 3/22/26).

[20] *See* CMA Comments to IFR (Dec. 6, 2021) at 11-12 "CMA IFR Comments") <https://www.cmadocs.org/Portals/CMA/files/public/CMA%20Comments%20on%20Federal%20Surprise%20Billing%20Regs%20(120621).pdf?ver=2021-12-07-154335-110> (visited 3/20/26).

[21] "Physicians Decry Unintended Consequences of California's Surprise Billing Laws" (Cal. Med. Ass'n Nov. 1, 2019) <https://www.cmadocs.org/Portals/CMA/files/public/CMA%20Suprise%20Billing%20Survey%20Results%202019.pdf> (visited 3/22/26).

The practice of negotiating over provider payment rates has become a relic of the competitive marketplace of the past, wherein physicians and insurers would work towards a mutually agreeable rate schedule. Under this prior regime, if agreement could not be reached, the physician practice would lose the benefits of being "in-network" (e.g., patient-steering and certainty of payment). Insurers that offered unreasonably low rates or commercially unappealing contract terms risked inadequate provider networks that could not compete in the marketplace. Those incentives and disincentives kept insurers and providers honest in negotiating fair and reasonable contracts, but they were distorted under skewed market conditions that gave too much power to insurers in determining OON payment. For independent physician practices, there is little to no negotiating over fee schedules, but rather a "take it or leave it" approach whereby insurers dictate payment and other contract terms.

Without equal bargaining power and no means to force health insurers to pay reasonable compensation for OON claims, physicians are compelled to be employed in larger health systems and hospital-controlled entities to put themselves in better position to level the playing field. However, such consolidation undermines competition and drives prices higher for patients:

- **Costs rise** – a 2023 study[22] led by researchers at Harvard and the National Bureau of Economic Research found that prices for services from physicians and hospitals within health systems were significantly higher than the prices of services from independent physicians and hospitals. For example, physician services delivered within health systems cost between 12 percent and 26 percent more, compared with independent practices.

[22] *See* Nancy D. Beaulieu, et al., "Organization and Performance of US Health Systems" JAMA 2023:329(f):325-335 (Jan. 24/31, 2023) <https://jamanetwork.com/journals/jama/article-abstract/2800656> (visited 3-22-26).

- **Vulnerable patients suffer** - Without adequate physician payment, physician supply will decrease and patients in rural and urban areas may be cut off from valuable primary care services and lose critical specialty care services.

When practices close or physicians leave independent practice to join larger, more hierarchical hospitals or health systems with a greater emphasis on cost control, patients can lose more than just access to critical care services. Patients also lose valuable patient-physician relationships that are rooted in physician-driven patient-centered care.

CONCLUSION

For the foregoing reasons and the reasons in Zotec's briefing on the motion to dismiss, EDPMA respectfully urges the Court to GRANT the motion to dismiss.

DATED: March 23, 2026.

Respectfully submitted,

/s/ *Long X. Do*

Long X. Do – Lead Attorney
long@athenelaw.com
ATHENE LAW, LLP
5432 Geary Blvd. #200
San Francisco, California 94121
Tel: (415) 680-7419
Fax: (844) 619-8022

Eric D. Chan
eric@athenelaw.com
ATHENE LAW, LLP
10866 Washington Blvd., #142
Culver City, California 90232
Tel: (310) 913-4013
Fax: (844) 619-8022

Attorneys for Amicus Curiae Emergency Department Practice Management Association

CERTIFICATE OF SERVICE

The undersigned certifies that the foregoing document was filed electronically in compliance with Local Rule CV-5(a). This document was also served on all counsel via e-mail service, on this 23rd day of March 2026.

/s/ *Long X. Do*
Long X. Do