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 Hon. Mark. A. Kearney

AMICUS CURIAE BRIEF OF
THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS
IN SUPPORT OF NORTHSTAR ANESTHESIA

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CORPORATE DISCLOSURE STATEMENT

The American Society of Anesthesiologists has no parent corporation and is not publicly traded. ASA is not aware of any publicly owned corporation not a party to the action that has a financial interest in the outcome of the litigation.

Dated: March 13, 2026

/s/ *William J. Burton*
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STATEMENT OF AMICUS CURIAE

The American Society of Anesthesiologists[1] is a voluntary, national professional association that advocates for the interests of its members, including on matters concerning the independent-dispute-resolution process established under the No Surprises Act. The ASA is comprised of more than 59,000 anesthesiologists and others involved in the medical specialty of anesthesiology, critical care, and pain medicine.

The ASA submits this brief on behalf of its members who are affected by the eligibility determinations for claims submitted under the independent-dispute-resolution process. The ASA has a demonstrated interest in the IDR process, having participated in public comments about proposed federal rules designed to simplify and clarify which disputes are eligible for the IDR process.

The ASA submits this brief to explain how difficult eligibility determinations have proven to be, which suggests that honest mistakes about eligibility are common: roughly 900,000 of roughly 3.7 million IDR disputes have closed on ineligibility grounds. Recognizing that physicians often lack complete information from the health plans, the Departments of the Treasury, of Labor, and of Health and Human Services (the "Departments") are working together to update regulations governing the process, including by requiring health plans to disclose to physicians the information necessary for determining eligibility. The ASA believes this context will aid the Court in evaluating whether common mistakes about complicated eligibility determinations should be subject to fraud claims or whether addressing eligibility mistakes should be left to the Centers for Medicare and Medicaid Services through their administrative authority over the IDR process.

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[1] No party or party's counsel authored the brief in whole or in part or contributed money that was intended to fund preparing or submitting the brief. No person other than the *amicus curiae* and its members contributed money that was intended to fund preparing or submitting the brief.

Amicus's authority to file this brief is based on the accompanying motion for leave to file.

INTRODUCTION

If the Court accepts United Healthcare's fraud theory, it will open the door to hundreds of thousands of suits about eligibility determinations, as one out of every four disputes—over 24%—submitted to IDR since April 2022 has been closed based on an eligibility determination. This high number of closures shows both that mistakes about eligibility determinations are common (because of the complexity of those determinations) and that the proper remedy should be developed and enforced by the Departments, not through litigation. Common-law-fraud claims are not a good fit for mistakes about eligibility determinations, first because eligibility is a question of law, not of fact, and second because the adjudicators who make eligibility determinations are not relying on the assertions of either side but rather are exercising their own independent judgment as to whether a dispute is eligible for the IDR process. Instead, disputes about eligibility for the IDR process should be addressed through the administrative re-opening process that the Departments created because they recognized that eligibility determinations are complex and frequently disputed.

BACKGROUND

The No Surprises Act addresses two interrelated problems with the private health insurance market. First, insurers demand low payment rates as a condition of physicians participating in their networks, a demand that forces many physicians to stay out-of-network to remain economically viable. Second, patients who unknowingly receive certain care from out-of-network providers were responsible for amounts not paid by their insurance companies, which is known as "surprise billing." No Surprises Act, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 2757-890 (2020) (codified at 42 U.S.C. §§ 300gg-111, 300gg- 131 to 132; 29 U.S.C. § 1185e; 26 U.S.C. § 9816).

To address these problems, Congress limited the amount that patients would pay for certain

non-emergency services performed by out-of-network providers at certain in-network facilities. 42 U.S.C. § 300gg-111(b); *see also Texas Med. Ass'n v. United States Dep't of Health & Hum. Servs.*, 110 F.4th 762, 767–68 (5th Cir. 2024) (providing overview of the No Surprises Act). Congress also created an independent-dispute-resolution process to resolve disputes between out-of-network providers and insurers about out-of-network payments. 42 U.S.C. § 300gg-111(c); *Texas Med. Ass'n*, 110 F.4th at 768. The ASA supports Congress's reforms, which, if properly implemented, will ensure fair reimbursement to providers and facilities and protect patient access to medical care. Properly implementing the independent-dispute-resolution process includes allowing the Departments to address disputes about eligibility determinations, rather than flooding the courts with those disputes.

ARGUMENT

I. Determining whether a claim is eligible for independent dispute resolution is complex and difficult.

A. The Departments acknowledge confusion over eligibility determinations, with one of every four disputes being closed on ineligibility grounds.

In April 2022, the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (previously defined as the "Departments") launched a portal to accept disputes regarding the appropriate out-of-network rate for claims subject to the surprise billing protections of the No Surprises Act. Federal Independent Dispute Resolution Operations, 88 Fed. Reg. 75,744, 75,753 (Nov. 3, 2023). When the Departments later reviewed how the process had been operating, the Departments observed that resolving disputes submitted to the portal was taking "longer than the timeframes established under the No Surprises Act" and by interim rules. The Departments concluded that the delays were occurring not just because of the high volume of disputes, but also because of "the complexity of determining disputes' eligibility for the Federal IDR process . . . ." *Id.* at 75,753; *see also id.* at 75,755 ("[E]ligibility

reviews have proven to be complex and time consuming."). Based on their review of disputes that had been submitted and of feedback from interested parties, the Departments concluded there was "a pattern of initiating parties submitting ineligible disputes to the Federal IDR process due to miscommunication or a lack of communication between the disputing parties." *Id.* at 75,754.

Data compiled by the Centers for Medicare and Medicaid Services confirmed that eligibility determinations are complex and confusing. Of the 3,696,802 disputes that were closed by independent-dispute-resolution entities from April 15, 2022, through January 31, 2026, ***over 24%*** of the disputes (***899,309*** disputes) were closed because they were found ineligible for the IDR process. CMS, *Independent Resolution Reports*, https://www.cms.gov/nosurprises/policies-and-resources/Reports, (under the heading "Federal IDR bi-monthly reports," expand "As of January 31, 2026," and review "Table 2: Reasons for Closure of Disputes"). In other words, nearly one out of every four disputes submitted for independent dispute resolution was closed because it was ineligible, leading to around 900,000 disputes to be closed as ineligible during the last four years.

As a result of the complexity of eligibility determinations, "certified IDR entities"—that is, the entities tasked with resolving the disputes between providers and payors—"report spending 50 to 80 percent of their time working on eligibility determinations." 88 Fed. Reg. at 75,753.

The complexity of eligibility determinations often stems, as the Departments explained, from "miscommunication or a lack of communication between the disputing parties." 88 Fed. Reg. at 75,754. And the complexity also arises from a lack of clarity as to whether an item or service provided to a patient "is covered by a health plan or coverage that is not subject to the surprise billing protections of the No Surprises Act, such as Medicare or Medicaid, or because the item or service is subject to a specified State law or an All-Payer Model Agreement." 88 Fed. Reg. 75,753. Evaluating the eligibility of a health plan operating under Medicare Advantage can be

particularly confusing, because those plans fall under the names of commercial plans (such as Blue Cross/Blue Shield), and so it may not be readily apparent from the name of a plan that it is a Medicare Advantage plan. This lack of clarity is especially difficult for anesthesiologists, who may not even see the insurance card, as they often rely on information received from the primary care doctor that handles the administrative intake of the patients. Determining whether disputes are properly bundled together for resolution has been another cause of confusion about eligibility. *Id.* ("many batched disputes were found ineligible due to the initiating party incorrectly batching items or services in a manner that did not comply with the regulations, such as batching claims paid by different plans or issuers"). And timing requirements that affect dispute eligibility have also proven to be complex and confusing. 88 Fed. Reg. 75,753–54 (""Disputes are also ineligible when the disputing parties have failed to satisfy the 30-business-day open negotiation period requirements specified under 26 CFR 54.9816–8T(b)(1), 29 CFR 2590.716–8(b)(1), and 45 CFR 149.510(b)(1) or have failed to initiate the Federal IDR process within 4 business days after the end of the 30-business-day open negotiation period as specified under 26 CFR 54.9816–8T(b)(2)(i), 29 CFR 2590.716–8(b)(2)(i), and 45 CFR 149.510(b)(2)(i).").

B. The ASA and other providers support the Departments efforts to reduce confusion about eligibility determinations by requiring health plans to provide more complete information.

One factor that contributes to the difficulty is that insurers and payors often do not pass on complete information necessary for eligibility determinations to physicians. The ASA brought concerns about receiving insufficient information from health plans to the attention of the Departments by commenting on the Departments' proposed rule about disclosing information. In a February 2024 letter to the Departments, the ASA observed that "[o]ne of the principal areas of confusion that physician groups, including ASA members, have cited is misunderstanding if a particular service is eligible for the Federal or state IDR process." ASA Letter at 10,

https://www.regulations.gov/comment/CMS-2023-0176-0100 (click the "Download" link for the letter). "In the experience of many of our members, health plans have not provided complete information to physicians, resulting in physicians inadvertently submitting ineligible claims to the Federal IDR process." *Id.* Accordingly, the ASA has supported changes to the IDR process, including the disclosure requirements in the Departments' proposed rule that would "require health plans to communicate information by using claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs), as specified in guidance, when providing any paper or electronic remittance advice to an out-of-network provider." *Id.*

A number of other providers and healthcare management professionals submitted similar comments supporting the Departments' proposed disclosure requirements for health plans. For example, the American Hospital Association explained that "[o]ne of the biggest challenges for providers has been obtaining sufficient information about claims, including whether or not a claim is eligible for the IDR process," and so the AHA supported "mandatory use of the [claim adjustment reasons codes] and [remittance advice remark codes]" by payors "to address concerns that numerous claims filed through the IDR process are proven to be ineligible, wasting IDR entities' time and resources." AHA Letter at 6, https://www.regulations.gov/comment/CMS-2023-0176-0109. Indeed, given that there is a cost to filing (Compl., RE 1, ¶ 86), submitting ineligible disputes wastes physicians' resources too, which shows that physicians have an incentive to avoid filing claims that they know are ineligible. Yet the complexity of the eligibility determinations and the lack of complete information from health plans frequently results in mistakes in submitting disputes to the independent-dispute-resolution process.

A physician-owned practice similarly reported that it has "enormous difficulty for some claims determining whether an out-of-network claim is eligible for the state or federal process."

Vituity Letter at 2, https://www.regulations.gov/ comment/CMS-2023-0176-0120. This practice observed that requiring the use of remittance advice remark codes when providing the initial payment or notice of denial "will clarify state or federal eligibility for out-of-network dispute resolution," will "reduce confusion and unnecessary administrative transactions and delays," and "will reduce 'ineligible' claims being submitted for IDRE." *Id.*

Similarly, the Healthcare Business Management Association reported that "[o]ne of the largest sources of frustration for providers and [revenue cycle management] companies that use the IDR process is the lack of accurate information from health plans." HBMA Letter at 2, https://www.regulations.gov/ comment/CMS-2023-0176-0030. It explained that "[p]roviders have no way of knowing if the patient's plan is regulated by federal or state surprise billing laws" and that "[t]he only way providers can know if the NSA protections apply to a specific item or service is if the health plan notifies the provider." *Id.* The Healthcare Business Management Association further stated that "health plans can make it very difficult to know which specific health plan a patient is enrolled, thus making it impossible to identify the actual payer for dispute initiation." *Id.*; *see also* Manatt Health Report at 12, https://www.regulations.gov/ comment/CMS-2023-0176-0107 (recommending, as part of a 21-page report on the independent-dispute-resolution process, that "more detailed guidance from the Departments, for parties and IDREs, on what is or is not appropriate evidence of eligibility could reduce the number of ineligible claims filed or the amount of follow-up needed from the IDREs").

II. Honest mistakes about complicated eligibility determinations should not be treated as fraud.

Innocent, good-faith billing errors are endemic to modern healthcare, and anesthesiologists are not immune. Anesthesiologists often lack direct access to patient insurance information and physical insurance cards, which are primarily available at intake. As United acknowledges,

NorthStar is one of the largest anesthesia management companies in the country, employing over 4,000 clinicians across more than 280 facilities in over 20 states. (Compl. ¶ 8.) At that scale, NorthStar's clinicians engage with countless insurance plans with different eligibility criteria, billing for large volumes of patients often based on secondhand information. The occasional misidentification of a patient's coverage type under these circumstances is not evidence of fraud, but an unavoidable feature of modern healthcare billing.

There are many opportunities for innocent errors in IDR eligibility determinations. A provider might fail to recognize that a patient is enrolled in a Medicare Advantage plan rather than a commercial plan, a distinction that can be exceedingly difficult to discern from the face of an insurance card (even if the insurance card is passed on from the primary-care doctor to the anesthesiologist). A provider might miss the 30-business-day open-negotiation requirement or the subsequent four-business-day window to commence IDR, both of which involve precise and technical calendaring obligations. 88 Fed. Reg. 75,753–54. CMS itself has acknowledged the prevalence of such errors, issuing technical guidance identifying five categories of "jurisdictional errors" that arise when "the eligibility of the item or service was incorrectly determined." Ctrs. for Medicare & Medicaid Servs., Fed. Indep. Dispute Resol. (IDR) Tech. Assistance for Certified IDR Entities & Disputing Parties: Errors Identified After Dispute Closure (June 2025) at 3, https://www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf. The five categories include errors based on timing, governing agreements, payor type, provider participation status, or coverage classification. *Id.* The very existence of this guidance and of the multi-step error-correction process that CMS established for closed disputes reflects a regulatory acknowledgment that eligibility errors will inevitably occur.

III. Fraud claims in the context of IDR disputes will often fail to satisfy several elements of common-law fraud.

A. Whether a dispute is eligible for the IDR process is a question of law, not fact.

To satisfy the first element of "common law fraud, a plaintiff must prove: (1) misrepresentation of a material *fact* . . . ." *Boehm v. Riversource Life Ins. Co.*, 117 A.3d 308, 324 (Pa. Super. 2015) (emphasis). This element should bar fraud claims that are based on an eligibility determination, because whether a claim is eligible for the IDR process under governing statutes and regulations is a question of *law*, not of *fact*. United's complaint illustrates this, as it emphasizes that the attestation in the IDR portal is attesting that the items or services are "***within the scope of the Federal IDR process***." (Compl. ¶ 109 (emphasis in original).)

For example, consider what would happen if a provider interpreted the statute (incorrectly) as providing that Medicare Advantage claims were eligible for IDR resolution. If a provider made that mistake and so submitted a Medicare Advantage claim to the IDR process, and if a district court mistakenly agreed that a Medicare Advantage claim was eligible for the IDR process, then there is little doubt that an insurer or health plan would argue on appeal that the eligibility determination is a question of law subject to de novo review, as eligibility determinations are in numerous other areas of law. *E.g.*, *Kiareldeen v. Ashcroft*, 273 F.3d 542, 545 (3d Cir. 2001) ("This court will also 'review an award [of attorneys' fees] *de novo* insofar as it rests on conclusions of law, such as an interpretation of the statutory terms that define eligibility for an award."); *Khan v. Att'y Gen. of United States*, 979 F.3d 193, 197 (3d Cir. 2020) ("we retain jurisdiction over determinations regarding statutory eligibility" and "[w]e review the BIA's legal determination of ineligibility *de novo*"); *Mejia Rodriguez v. U.S. Dep't of Homeland Sec.*, 562 F.3d 1137, 1142 (11th Cir. 2009) (reviewing "*de novo*" whether an alien met "statutory eligibility requirements"). Indeed, even mixed questions of law and fact are often subject to de novo review. *E.g.*, *United*

States ex rel. Int'l Bhd. of Elec. Workers Loc. Union No. 98 v. Farfield Co., 5 F.4th 315, 329 (3d Cir. 2021) ("We review any mixed questions of fact and law de novo insofar as 'the primary facts are undisputed and only ultimate inferences and legal consequences are in contention.'").

Accordingly, attestations as to the legal question whether a dispute is eligible for the IDR process should not be considered to satisfy the "misstatement of material fact" element of common-law fraud.

B. An independent-dispute-resolution entity exercises its own judgment in the face of competing claims about a question of law and so is not relying on either side's assertions.

Under Pennsylvania law, a claim for common-law fraud requires the plaintiff to show that the alleged misrepresentation was a substantial factor in inducing the plaintiff's conduct and that the plaintiff's reliance on it was reasonable under the circumstances. *See Hunt v. U.S. Tobacco Co.*, 538 F.3d 217, 225 (3d Cir. 2008), *as amended* (Nov. 6, 2008); *Fox Int'l Rels. v. Fiserv Sec., Inc.*, 490 F. Supp. 2d 590, 607 (E.D. Pa. 2007), *order corrected* (May 7, 2007).

Here, United's own complaint confirms that it did not rely on NorthStar's attestation. Rather, United affirmatively contested NorthStar's attestation in two ways. First, United sent a provider remittance advice to NorthStar asserting that the claim was not eligible for the IDR process. (Compl. ¶¶ 61–63.) Second, NorthStar contested eligibility before the IDR entity by repeatedly telling the IDR entity that the dispute was not eligible. (Compl. ¶ 73–75.) Under United's own allegations, it did not rely on NorthStar's attestation.

Nor can an insurer argue that an IDRE entity relies on an eligibility attestation. First, "to establish common law fraud, a plaintiff must prove . . . (4) justifiable reliance *by the party defrauded* upon the misrepresentation." *Boehm*, 117 A.3d at 324 (emphasis added). In the context of the IDR process, the IDR entity is not being defrauded, so even if an IDR entity were to rely on an eligibility attestation, reliance by a non-defrauded party would not satisfy the reliance element

of common-law fraud. Second, an IDR entity's job as the adjudicator in an adversarial process means that the IDR entity is not supposed to rely on the assertions of either side when it comes to questions of law. The entity's task in the *independent*-dispute-resolution process is to exercise its own independent judgment, not to rely on one side or the other.

C. As the False Claims Act's scienter framework illustrates, billing errors are not fraud.

Though not directly applicable here to the claim of common-law fraud, safeguards that have developed under the False Claims Act litigation offer instructive guidance on how courts have been reluctant to turn simple billing mistakes into fraud claims. Under the False Claims Act, a plaintiff must establish falsity, causation, scienter, and materiality. *See United States ex rel. Int'l Bhd. of Elec. Workers Local Union No. 98 v. Farfield Co.*, 438 F. Supp. 3d 348, 362 (E.D. Pa. 2020). The scienter element is satisfied if a defendant "(1) has actual knowledge that the claim is false; (2) acts in deliberate ignorance of the truth or falsity of the claim; or (3) acts in reckless disregard of the claim's truth or falsity." *U.S. Dep't of Transp. ex rel. Arnold v. CMC Eng'g, Inc.*, 947 F.Supp.2d 537, 543 (W.D. Pa. 2013). Critically, however, "Congress explicitly expressed its intention that the act not punish honest mistakes or incorrect claims submitted through mere negligence." *Id*. at 544 (quoting *U.S. ex rel. Hefner v. Hackensack Univ. Med. Ctr.*, 495 F.3d 103, 109 (3d Cir. 2007)).

Courts have been careful to cabin the scienter standard. In *Farfield*, the Eastern District of Pennsylvania emphasized that "an honest mistake or even simple negligence is not sufficient to demonstrate reckless disregard[.]" 438 F. Supp. 3d at 363 (citing *United States ex rel. Hill v. Univ. of Med. & Dentistry*, 448 F.App'x 314, 317 (3d Cir. 2011)). Rather, Congress intended "'to hold liable [o]nly those who act in gross negligence, that is, those who failed to make such inquiry as would be reasonable and prudent to conduct under the circumstances.'" *Id*. (*quoting United States*

v. King-Vassel, 728 F.3d 707, 712–13 (7th Cir. 2013) (some internal quotations omitted)).

These principles apply with even greater force here because a false certification under the False Claims Act can result in the direct payment of government funds to an unentitled party, a consequence that strikes at the heart of the federal treasury. An inaccurate IDR attestation, by contrast, merely permits a provider to access the dispute resolution process; it does not directly access government funds. If honest mistakes and simple negligence cannot sustain a claim where the stakes involve direct fraud on the federal treasury, then the same principle should apply with even greater force in the IDR context, where the consequences of an error are just access to an independent adjudicator. The False Claims Act's scienter framework thus illustrates the need to distinguish between the dishonest actor and the merely mistaken one, and that distinction is no less important here.

IV. Allowing health plans to allege fraud for every incorrect eligibility determination will undermine the administrative system created by Congress.

A. The CMS reopen process provides a mechanism to resolve eligibility errors administratively.

The Departments of Health and Human Services, of Labor, and of the Treasury issued Technical Assistance guidance establishing a process for reopening and correcting IDR decisions affected by eligibility errors. Ctrs. for Medicare & Medicaid Servs., *Fed. Indep. Dispute Resol. (IDR) Tech. Assistance for Certified IDR Entities & Disputing Parties: Errors Identified After Dispute Closure* (June 2025), https://www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf. The Departments developed this guidance under their existing regulatory authority under the No Surprises Act based on stakeholder feedback. *Id*. at 1. The guidance identifies three categories of errors—clerical, jurisdictional, and procedural—and provides that jurisdictional errors—that is, errors about whether an eligibility determination is within the scope of the IDR process—should be corrected by reopening the dispute. *Id*. at 1–2. Under this process, a party

that identifies an error reports it to the IDR entity, which evaluates whether the error permits reopening; if so, the IDR entity reports the error to the Departments, which may authorize the dispute to be reopened. *Id*. at 3–4. This administrative correction process is evidence that the implementing agencies recognized that ineligible claims will enter the IDR system, and they chose to address those errors through post-hoc administrative correction rather than federal litigation. *See id*. at 1.

United acknowledges this Technical Assistance process but dismisses it as "objectively insufficient," arguing that it requires reporting the error to the same IDR entity that made the initial eligibility determination. (Compl. ¶ 96.) But whatever United's criticisms, the existence of this process undercuts its assertion that a federal fraud action is the appropriate remedy for eligibility errors. The Departments created a detailed administrative mechanism to address the very issue United complains of, reflecting their considered judgment as to how eligibility errors should be remedied within the IDR system.

B. Courts should be reluctant to impose judicial review where the implementing agencies have created a detailed administrative process to address eligibility errors.

As outlined above, the appropriate remedy for an independent-dispute-resolution entity's erroneous acceptance of an ineligible claim is the administrative correction process that the Departments established through their Technical Assistance guidance, not a federal fraud action against the provider. The Fifth Circuit's recent decision in *Guardian Flight, L.L.C. v. Health Care Service Corp.*, which denied a private right of action to enforce awards by independent-dispute-resolution entities under the No Surprises Act, illustrates this principle. 140 F.4th 271 (5th Cir. 2025), *cert. denied*, No. 25-441, 2026 WL 79855 (U.S. Jan. 12, 2026).

In *Guardian Flight*, the Fifth Circuit held that the No Surprises Act does not create a private right of action. The court reasoned that the statute "expressly bars judicial review of IDR awards"

and instead "empowered HHS to assess penalties against insurers for failure to comply with the NSA." *Id*. at 275, 277 (citing 42 U.S.C. §§ 300gg-111(c)(5)(E)(i)(II), 300gg-22(b)(2)(A)). Because "'[t]he express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others,'" the Fifth Circuit concluded that the statute's "structure conveys Congress's policy choice to enforce the statute through administrative penalties, not a private right of action." *Id*. at 277 (quoting *Alexander v. Sandoval*, 532 U.S. 275, 290 (2001)). As the Fifth Circuit explained, "Congress may have judged it better to have an administrative enforcement mechanism handle most award disputes instead of throwing open the floodgates of litigation." *Id.*

Although *Guardian Flight* addressed whether providers could bring suit to enforce IDR awards, its reasoning applies with equal force to the converse scenario presented here, where an insurer seeks to bring a fraud action concerning the IDR process. The Fifth Circuit's central insight was that Congress designed the No Surprises Act with a comprehensive administrative enforcement framework and deliberately chose to avoid a floodgate of litigation brought by private litigants seeking to resolve IDR-related disputes. Permitting insurers to bypass this framework and to haul providers into federal court whenever an independent-dispute-resolution entity issues an award on a disputed claim would destabilize the IDR system and undermine the balanced dispute-resolution mechanism Congress intended.

CONCLUSION

For these reasons, *Amicus* respectfully asks the Court, when it reaches the merits, to dismiss the complaint.

Dated: March 13, 2026

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