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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAI‘I

UNITEDHEALTHCARE INSURANCE COMPANY, Plaintiff, vs.	Case 1:26-cv-00040 WRP **DEFENDANT MAUI MEMORIAL EMERGENCY MEDICAL ASSOCIATES, INC.'S NOTICE OF SUPPLEMENTAL AUTHORITY; EXHIBITS 1 – 4; CERTIFICATE OF SERVICE**

MAUI MEMORIAL EMERGENCY MEDICAL ASSOCIATES, INC.

Defendant.

DEFENDANT MAUI MEMORIAL EMERGENCY MEDICAL ASSOCIATES, INC.'S NOTICE OF SUPPLEMENTAL AUTHORITY

Defendant Maui Memorial Emergency Medical Associates ("MMEMA") respectfully submits this Notice of Supplemental Authority in support of its pending Motion to Dismiss Pursuant to Rules 12(b)(1), (6), and (7) of the Federal Rules of Civil Procedure. *See* Dkt. 27. MMEMA submits this notice to alert the Court to recent decisions from other jurisdictions dismissing substantially similar actions brought by health plans against healthcare providers. These cases confirm that the No Surprises Act ("NSA") and its Independent Dispute Resolution ("IDR") framework preclude the very claims asserted here. Copies of these decisions are attached hereto as Exhibits 1 through 4:

1. *Anthem Blue Cross Life & Health Ins. Co. v. HaloMD LLC*, No. 8:25-cv-01467-KES, 2026 WL 982629 (C.D. Cal. Apr. 9, 2026). (Attached as **Exhibit 1**).

2. *Aetna Health Inc. v. Radiology Partners, Inc.*, No. 3:24-cv-01343-BJD-LLL (M.D. Fla. Apr. 16, 2026). (Attached as **Exhibit 2**).

3. *UnitedHealthcare of Pennsylvania, Inc. v. NorthStar Anesthesia of Pennsylvania, LLC*, No. 2:25-cv-07187-MAK (E.D. Pa. Apr. 28, 2026). (Attached as **Exhibit 3**).

4. *Blue Cross Blue Shield of Tex. v. HaloMD, LLC*, No. 5:25-cv-00132-RWS (E.D. Tex. May 22, 2026). (Attached as **Exhibit 4**).

DATED: Honolulu, Hawai‘i, May 29, 2026.

/s/ Steven E. Tom
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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, et al.,

Plaintiffs,

v.

HALOMD LLC, et al.,

Defendants.

Case No. 8:25-cv-01467-KES

MEMORANDUM OPINION AND ORDER

I.
INTRODUCTION

In July 2025, Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California d/b/a Anthem Blue Cross ("Plaintiffs" or "Anthem") filed this civil lawsuit. (Dkt. 1.) The operative First Amended Complaint ("FAC" at Dkt. 50) names the following Defendants:

(1) HaloMD, LLC ("HaloMD") and its president, Alla LaRoque (collectively, the "HaloMD Defendants");

(2) MPOWERHealth Practice Management, LLC and its CEO, Scott LaRoque (collectively, the "MPOWERHealth Defendants");

(3) Bruin Neurophysiology, P.C.; iNeurology, PC; N Express, PC; and

EXHIBIT 1

North American Neurological Associates, PC (collectively, the "LaRoque Family Providers");

(4) Sound Physicians Emergency Medicine of Southern California, P.C. and Sound Physicians Anesthesiology of California, P.C. (collectively, the "Sound Physicians Providers").

(FAC at 2.)

Plaintiffs' claims arise out of the mandatory, independent dispute resolution ("IDR") process to resolve certain types of billing disputes between health plans and out-of-network providers established by the federal No Suprises Act ("NSA"). The FAC provides this overview of the NSA's IDR process:

> [T]he NSA created a separate framework outside the judicial process for health plans and providers to resolve specific types of eligible surprise billing disputes. See 42 U.S.C. § 300gg-111(c). The framework consists of (1) open negotiations—a required 30-business-day period to try resolving the dispute informally; (2) an IDR process for "qualified IDR items and services" if no agreement is reached; and (3) if applicable, a payment determination from private parties called certified IDR entities ("IDREs").

(FAC at 12, ¶ 43.)

Most of the Defendants are healthcare providers. HaloMD "initiates and administers IDR proceedings on behalf of healthcare providers" like the other Defendants. (Id. at 4, ¶ 6.)

The FAC asserts the following federal claims:

Count One: Violations of the Racketeering Influenced and Corruption Organizations Act ("RICO"), 18 U.S.C. § 1962(d), against the LaRoque Family Providers, the HaloMD Defendants, and the MPOWERHealth Defendants (alleged to be the "LaRoque Family Enterprise"), based on allegations that these Defendants engaged in mail and wire fraud, or conspired in such fraud, by submitting billing disputes to the IDR process that they knew were ineligible, accompanied by false attestations of eligibility. (Id. at 3, ¶ 3; id. at 24, ¶ 93.)

Count Two: Similar violations of RICO, 18 U.S.C. § 1962(d), against the Sound Physicians Providers and HaloMD (alleged to be the "Sound Physicians Enterprise").

Count Three: Similar violations of RICO, 18 U.S.C. § 1962(c), against the LaRoque Family Enterprise.

Count Four: Similar violations of RICO, 18 U.S.C. § 1962(c), against the Sound Physicians Enterprise.

Count Eleven: Vacatur of IDR determinations under the NSA, 42 U.S.C. § 300gg-111(c)(5)(E), against all Defendants.

Count Twelve: Equitable relief under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(3).

Count Thirteen: Declaratory and injunctive relief.

The FAC asserts the following state law claims:

Count Five: Fraudulent misrepresentation against all members of the LaRoque Family Enterprise.

Count Six: Fraudulent misrepresentation against all members of the Sound Physicians Enterprise.

Count Seven: Negligent misrepresentation against all members of the LaRoque Family Enterprise.

Count Eight: Negligent misrepresentation against all members of the Sound Physicians Enterprise.

Count Nine: Violations of the Unfair Competition Law ("UCL") at California Business & Professions Code §§ 17200 et seq. against all members of the LaRoque Family Enterprise.

Count Ten: Violations of the UCL against all members of the Sound Physicians Enterprise.

Defendants responded to the FAC by filing the following motions:

/ / /

Dkt.	Motion	Movants	Briefs[1]
69	Motion to Dismiss FRCP 12(b)(1) & (6)	Sound Physicians Providers	Oppo: 93 Reply: 117
72	Motion to Dismiss FRCP 12(b)(2)	MPOWERHealth Practice Management, LLC	Oppo: 93 Reply: 123
73	Motion to Dismiss FRCP 12(b)(6)	MPOWERHealth Practice Management, LLC and LaRoque Family Providers	Oppo: 93 Reply: 124
76	Motion to Dismiss FRCP 12(b)(1), (2) & (6)	HaloMD	Oppo: 93 Reply: 120
77	Motion to Dismiss FRCP 12(b)(1), (2) & (6)	Alla & Scott Laroque	Oppo: 93 Reply: 121
68	Special Motion to Strike (Anti-SLAPP)	Sound Physicians Providers	Oppo: 92 Reply: 118
78	Special Motion to Strike (Anti-SLAPP)	HaloMD Defendants	Oppo: 92 Reply: 122
74	Joinder in Dkt. 68 & 78	MPOWERHealth Practice Management, LLC and LaRoque Family Providers	See above

On March 10, 2026, the Court held oral argument. (Dkt. 127 (minutes); Dkt. 132 (hearing transcript); Dkt. 134 (presentation decks).) For reasons explained in detail below, the Court:

(1) GRANTS, without leave to amend, the motions to dismiss brought under Federal Rule of Civil Procedure 12(b)(6) challenging Count Eleven for vacatur (Dkt. 69, 73, 76, 77), because the facts alleged in the FAC establish no authorized basis for the district court to vacate any IDR determinations;

(2) GRANTS, without leave to amend, the motions to dismiss brought under Federal Rule of Civil Procedure 12(b)(1) asserting lack of subject matter jurisdiction over the remaining federal claims (Dkt. 69, 76, 77)

[1] In addition to the briefs listed in the chart, the Court reviewed amicus briefs filed at Dkt. 80-1, 99, and 101.

because, aside from vacatur authorized by 42 U.S.C. § 300gg111(c)(5)(E)(i)(II), the NSA precludes judicial review of IDR determinations, regardless of the legal theory under which judicial review is sought;

(3) DECLINES to exercise supplemental jurisdiction over the FAC's state law claims and DISMISSES them without prejudice (see 28 U.S.C. § 1367(c)); and

(4) DENIES, without prejudice, the anti-SLAPP motions to strike the state law claims (Dkt. 68, 74, 78) as moot because the Court dismissed the state law claims rather than exercising supplemental jurisdiction.

II.

SUMMARY OF THE FAC'S FACTUAL ALLEGATIONS

A. The NSA's IDR Process.

"Effective January 1, 2022, the NSA banned surprise billing for three categories of out-of-network care: (1) emergency services; (2) non-emergency services at in-network facilities; and (3) air ambulance services. See 42 U.S.C. §§ 300gg-131, 300gg-132, 300gg-135." (FAC at 12, ¶ 42.) When a health plan like Anthem receives a claim for out-of-network services subject to the NSA …, the health plan is supposed to make "an initial payment or issue a notice of denial of payment within 30 days. See 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I)." (Id. ¶ 44.)

"If the provider is dissatisfied with the initial payment, then the provider or its designee may initiate open negotiations with the health plan by providing formal written notice to the health plan within 30 business days of the initial payment or notice of denial. 42 U.S.C. § 300gg-111(c)(1)(A)." (Id. ¶ 45.) "After initiating open negotiations, the provider must attempt in good faith to negotiate a resolution with the health plan over the 30-business-day open negotiations period." (Id. at 12-13, ¶ 45.) "If the provider initiates and exhausts the 30-day open negotiations period, and 'the open negotiations … do not result in a determination

of an amount of payment for [the] item or service,' then the provider may initiate the IDR process. See 42 U.S.C. § 300gg-111(c)(1)(B); 45 C.F.R. § 149.510(b)(2)(i)." (Id. at 13, ¶ 46.) Providers must initiate the IDR process within four business days after exhausting the open negotiations period. (Id.)

"When initiating the IDR process, providers must, among other things, submit an attestation that the items and services in dispute are qualified IDR items or services within the scope of the IDR process." (Id. at 15, ¶ 53.) To be qualified, the following conditions must be met:

a. The underlying services are within the NSA's scope, meaning they are out-of-network emergency services, non-emergency services at participating facilities, or air ambulance services;

b. The services involve a patient with healthcare coverage through a group plan or health insurer subject to the NSA (e.g., not coverage through government programs like Medicare or Medicaid);

c. A state surprise billing law (referred to as a "specified state law" in the NSA) does not apply to the dispute;

d. The underlying services were covered by the patient's health benefit plan (i.e., payment was not denied);

e. The patient did not waive the NSA's balance billing protections;

f. The provider initiated and exhausted open negotiations;

g. The provider initiated the IDR process within 4 business days after the open negotiations period was exhausted; and

h. The provider has not had a previous IDR determination on the same services and against the same payor in the previous 90 calendar days.

(Id. at 13-14, ¶ 48 (citing 42 U.S.C. § 300gg-111(c)(1)(B); 45 C.F.R. § 149.510(a)(2)(xi), (b)(2)).)

Providers initiating the IDR process must do so "online through a federal

'IDR Portal.'" (Id. at 16, ¶ 54.) The initiating party must agree to certain terms and conditions, including a notice that they will need to submit an "[a]ttestation that qualified IDR items or services are within the scope of the Federal IDR process." (Id. ¶ 58.) "After agreeing to the terms and conditions, initiating parties must answer certain 'Qualification Questions' through an online form. If the answers to the Qualification Questions indicate that the dispute is not eligible for IDR, the form will provide an alert and prevent the initiating party from proceeding." (Id. at 17, ¶ 59.) "After successfully completing the Qualification Questions, the initiating party is asked to complete the Notice of IDR Initiation Form," which requires inputting "a variety of relevant information." (Id. at 18, ¶ 63.) At the end of this process, the initiating party must attest, via electronic signature, that the "item(s) and/or service(s) at issue are qualified item(s) and/or services(s) within the scope of the Federal IDR process." (Id. ¶ 64.)

A copy of the Notice of IDR Initiation is sent electronically to "the non-initiating party (i.e., the health plan), the IDRE, and the Departments."[2] (Id. ¶ 65.) "[T]he parties select, or HHS appoints, an IDRE. 42 U.S.C. § 300gg-111(c)(4)(F)." (Id. at 19-20, ¶ 72.) The IDRE is directed by regulation to "'determine whether the Federal IDR process applies.' 45 C.F.R. § 149.510(c)(1)(v)." (Id. at 20, ¶ 73.) Guidance published by the government agencies that oversee the IDR process instruct non-initiating parties who believe that the IDR process does not apply how to submit relevant information through the portal. (Dkt. 76-5 at 18, § 5.5.[3]) The

[2] The FAC defines the "Departments" as the Department of Health and Human Services ("HSS"), the Department of Labor, and the Department of the Treasury. (FAC at 15 n.9.) The Centers for Medicare & Medicaid Services ("CMS") is the federal agency within HSS primarily charged with implementing the IDR process. (Id. ¶ 52.)

[3] The Court GRANTS the request for judicial notice (Dkt. 76-2) and considers the guidance documents as a factual description of how the IDR process is supposed to work, not as evidence of how it actually worked for any particular

IDRE "must determine whether the Federal IDR Process is applicable." (Id.) IDREs can and do reject some disputes as ineligible for IDR. (FAC at 22, ¶ 80 (citing 42 U.S.C. § 300gg-111(c)(5)(F)).)

"[I]f the IDRE determines the IDR process applies, then the IDRE proceeds to a payment determination. 42 U.S.C. § 300gg-111(c)(5)(A)." (Id. at 20, ¶ 74.) "IDR payment determinations resemble a baseball-style dispute resolution where the provider and health plan each submit an offer, and the IDRE selects one party's offer as the out-of-network rate. 42 U.S.C. § 300gg-111(c)(5)(B)." (Id. ¶ 75.) "An IDR determination for a 'qualified IDR item or service' is 'binding' unless there was 'a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim[.]' 42 U.S.C. § 300gg-111(c)(5)(E)(i)." (Id. at 21, ¶ 77.) There is, however, a "process for reopening disputes to correct errors" and rescind payment determinations, including errors in eligibility determinations. (Dkt. 76-8 at 2, 4.) Additionally, the government can revoke an IDRE's certification for submitting false data or exhibiting a "pattern or practice of noncompliance" with the applicable requirements. (Dkt. 76-6 at 37, § 12.)

"Parties to IDR proceedings are responsible for payment of two fees. First, both parties must pay a non-refundable administrative fee—currently $115—when the dispute is initiated. This fee is not recoverable even when the IDRE determines that the dispute does not qualify for IDR, or even when the initiating party later voluntarily withdraws the dispute. Second, both parties must pay an IDRE fee before the IDRE makes the payment determination. The IDRE fee is set by the specific IDRE and depends on the type of IDR submitted, but ranges from $200 to $1,173." (FAC at 21, ¶ 79.) The non-prevailing party is responsible for paying both its administrative fee and the whole IDRE fee. (Id. at 21-22, ¶ 79.)

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billing dispute.

B. Defendants' Alleged Wrongdoing.

Plaintiffs allege that Defendants use three "tactics" to turn the NSA's IDR process "into a vehicle for fraud." (Id. at 25, ¶ 94.) First, "Defendants manipulate the IDR process by strategically submitting massive numbers of open negotiations and IDR initiations—hundreds of which are patently ineligible for IDR—in an attempt to overwhelm the ability of health plans like Anthem to contest claims, confuse and swamp IDREs, and manipulate the IDR process." (Id. at 24, ¶ 93.) The NSA does not impose a numeric limit on IDR claims, but it does have batching rules. (Id. at 53, ¶ 226; Dkt. 76-5 at 22, § 6.1.3.)

Second, "Defendants capitalize on flaws in the IDR process by submitting—and often prevailing with—outrageous payment offers that they could never receive on the open market, including many that exceed the Provider Defendants'[4] own billed charges." (FAC at 24, ¶ 93.) As discussed above, the mandatory IDR process is a baseball-style arbitration where the IDRE must pick the more reasonable number based on certain authorized considerations. (Id. at 20, ¶ 75.)

Third, "Defendants make repeated false statements, representations, and attestations of eligibility to Anthem, the IDREs, and the Departments" via the submission portal. (Id. at 24, ¶ 93.) Plaintiffs allege that between January 2024 and August 2025, Defendants initiated at least 1,500 IDR proceedings against Anthem consisting of more than 2,000 separate services. (Id. at 32-33, ¶ 127.) Plaintiffs "determined that approximately 47 percent of these disputes were ineligible for IDR …." (Id. at 33, ¶ 128.) But in many of those cases, the IDREs found the claim eligibility despite Anthem's evidence, so "Defendants illicitly secured millions of dollars in improper IDR awards." (Id.) Plaintiffs allege that the IDREs routinely make errors in eligibility determinations because (1) they are

[4] The FAC defines "Provider Defendants" to include the LaRoque Family Providers and the Sound Physicians Providers. (FAC at 2.)

only compensated when a dispute reaches a payment determination, and (2) they are overwhelmed by a "staggering volume of disputes" and "cannot complete fulsome reviews [of eligibility evidence] in the timeline provided by the NSA." (Id. at 22, ¶ 80; id. at 28, ¶¶ 105-06.)

The FAC describes the following eleven IDR determinations as examples of outcomes that IDREs wrongly decided because of these tactics:

	No.	**Defendant**	**Ineligibility Reason**
1	DISP-918898	Bruin Neuro-physiology	Plaintiff Anthem Blue Cross Life and Health Insurance Company ("ABCLH") "submitted an objection to eligibility asserting that Bruin had not filed its IDR proceeding within the required time." FAC at 44, ¶ 171.
2	DISP-1455557	North American Neurological Associates ("NANA")	"Anthem Payment Disputes, on behalf of ABCLH, submitted an objection to eligibility" stating that NANA "failed to engage in the 30-business day open negotiation period." Id. at 44-45, ¶ 176.
3	DISP-1455555	NANA	Same as above. Id. at 45-46, ¶ 181.
4	DISP-2193991	N Express	Plaintiff Anthem Blue Cross ("ABC") "submitted an objection to eligibility" stating that the claim was "ineligible for IDR under the NSA because a state surprise billing law applies." Id. at 46-47, ¶ 187.
5	DISP-2193967	N Express	Same as above. Id. at 47, ¶ 193.
6	DISP-945678	N Express	Same as above. Id. at 48, ¶ 199.
7	DISP-937342	iNeurology	ABC told HaloMD that the service was ineligible because it was "a service for which no plan benefits were payable in the first place," but HaloMD still initiated IDR. Id. at 49, ¶¶ 203-05.
8	DISP-932222	Sound Physicians Emergency Medicine of Southern California ("SPEMSC")	"The notice of open negotiation attached a spreadsheet with dozens of claims …." Id. at 53, ¶ 226. The claims were for services "rendered to members of self-funded Anthem plans and non-Anthem plans in addition to the services rendered to a member of a fully insured Anthem plan." Id. at 54, ¶ 227. Plaintiffs

			objected to the IDR initiation, stating, "Batched services include multiple Membership types." Id. ¶ 228.
9	DISP-1289721	SPEMSC	ABC "submitted an objection to eligibility" stating that the claim was "ineligible for IDR under the NSA because it involved a Medicare/ Medicaid claim …." Id. at 55, ¶ 234.
10	DISP-1568233	SPEMSC	ABCLH "submitted an objection to eligibility" stating that the claim was ineligible for IDR under the NSA because "a state surprise billing law applies." Id. at 56, ¶ 240.
11	DISP-2639953	Sound Physicians Anesthesiology of California	ABC "submitted an objection to eligibility" stating that the claim was ineligible for IDR under the NSA because "a state surprise billing law applies." Id. at 57, ¶ 247.

III.

DISCUSSION

A. Count Eleven: Vacatur.

1. Applicable Law.

The NSA's provision for baseball-style arbitration requires the IDRE to select one of the party's offers to resolve qualified IDR billing disputes, as follows:

> (5) Payment Determination
>
> (A) In general
>
> Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the certified IDR entity shall—
>
> (i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such item or service determined under this subsection for purposes of subsection (a)(1) or (b)(1), as applicable; and
>
> (ii) notify the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination of the offer selected under clause (i).

42 U.S.C. § 300gg111(c)(5)(A).

The NSA limits judicial review of IDRE determinations, as follows:

> (E) Effects of determination
> (i) In general
> A determination of a certified IDR entity under subparagraph (A) —
> (I) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and
> (II) ***shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9***.

42 U.S.C. § 300gg111(c)(5)(E)(i) (emphasis added). The reference to "paragraphs (1) through (4) of section 10(a) of title 9" is a reference to the Federal Arbitration Act ("FAA"). Those paragraphs describe the four circumstances under which a district court can vacate an arbitrator's award under the FAA, as follows:

> (a) In any of the following cases the United States court in and for the district wherein the award was made may make an order vacating the award upon the application of any party to the arbitration—
> (1) where the award was procured by corruption, ***fraud***, or ***undue means***;
> (2) where there was evident partiality or corruption in the arbitrators, or either of them;
> (3) where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or
> (4) where ***the arbitrators exceeded their powers***, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made.

9 U.S.C. § 10(a)(1)-(4) (emphasis added to identify the grounds for vacatur alleged in the FAC at 85, ¶¶ 357-58).

While the NSA is a recent law, Congress enacted the FAA years ago. As a result, case law defines what circumstances satisfy subparagraphs (1) and (4). A party moving for vacatur under § 10(a)(1) must establish: (1) fraud, by clear and convincing evidence, (2) which was not discoverable upon the exercise of due

diligence prior to or during the arbitration, and (3) which was materially related to an issue in the arbitration. Pac. & Arctic Ry. & Navigation Co. v. United Transp. Union, 952 F.2d 1144, 1148 (9th Cir. 1991). "[W]here the fraud or undue means is not only discoverable, but discovered and brought to the attention of the arbitrators, a disappointed party will not be given a second bite at the apple." A.G. Edwards & Sons, Inc. v. McCollough, 967 F.2d 1401, 1404 (9th Cir. 1992).

"Undue means" in the context of § 10(a)(1) refers to conduct that "is immoral if not illegal." Id. at 1403. Vacatur under this provision "requires a showing of bad faith during the arbitration proceedings, such as bribery, undisclosed bias of the arbitrator, or willfully destroying evidence, and further requires that such evidence of fraud was unavailable to the arbitrator during the course of the proceeding." Dandong Shuguang Axel Corp. v. Brilliance Mach. Co., No. C 00-4480 SC, 2001 WL 637446, at *5, 2001 U.S. Dist. LEXIS 7493, at *18 (N.D. Cal. June 1, 2001) (citation omitted). Like fraud, the undue means must be (1) not discoverable upon the exercise of due diligence prior to or during the arbitration, (2) materially related to an issue in the arbitration, and (3) established by clear and convincing evidence. A.G. Edwards, 967 F.2d at 1404.

For vacatur under § 10(a)(4), arbitrators "exceed their powers when they express a 'manifest disregard of law,' or when they issue an award that is 'completely irrational.'" Bosack v. Soward, 586 F.3d 1096, 1104 (9th Cir. 2009) (citation omitted). "For an arbitrator's award to be in manifest disregard of the law, it must be clear from the record that the arbitrator recognized the applicable law and then ignored it." Id. (citation modified). Mere "misinterpretations of the law" do not justify vacatur. French v. Merrill Lynch, Pierce, Fenner & Smith, Inc., 784 F.2d 902, 906 (9th Cir. 1986).

Sometimes an arbitration agreement delegates the issue of arbitrability to the arbitrator. When that happens, "the arbitrator's interpretation of the scope of his powers is entitled to the same level of deference as his determination on the

merits." See Schoenduve Corp. v. Lucent Techs., Inc., 442 F.3d 727, 733 (9th Cir. 2006).

2. Relevant Allegations.

Plaintiffs seek "vacatur of individual IDR determinations under 42 U.S.C. § 300gg-111(c)(5)(E)" because "[e]ach individual IDR determination at issue" was procured by fraud and undue means in the form of false eligibility attestations, and "the IDREs exceeded their powers by issuing payment determinations on items and services that are not qualified IDR items and services within the scope of the NSA's IDR process." (FAC at 85, ¶¶ 356-58.) Plaintiffs do not list all the IDR determinations they seek to vacate, but they allege that "the list of IDR payment determinations subject to vacatur is expected to increase during the pendency of the case." (Id. ¶ 359.) Plaintiffs pray for "vacatur of the underlying IDR determinations." (Id. at 88 (prayer for relief).)

3. Analysis.

Plaintiffs argue, "Anthem is seeking judicial review of Defendants' NSA Schemes, and not any individual IDRE payment determination." (Dkt. 93 at 48.) But Plaintiffs' claim for vacatur, while pled in the alternative, seeks to vacate "each individual IDR determination at issue." (FAC at 85, ¶ 356.) Plaintiffs' other fraud-based claims, like RICO, could not be litigated without deciding whether Defendants made false eligibility attestations, a decision that would necessarily re-examine eligibility determinations made by IDREs.

a. Fraud.

First, Plaintiffs urge the Court not to follow the above-cited Ninth Circuit cases and instead look to Eleventh Circuit cases. (Dkt. 93 at 49.) But Ninth Circuit cases are binding on this district court.

Next, Plaintiffs argue that the requirements discussed in Pacific & Artic Railway and A.G. Edwards cannot be fairly applied to the NSA IDR process because the Ninth Circuit test "presumes the existence of an opportunity to litigate

the alleged fraud" before the arbitrator. (Id.) Plaintiffs did not allege facts showing that Anthem cannot litigate eligibility within the IDR process. Indeed, the FAC's allegations show that participants in the IDR process can tell the IDRE if they believe a dispute is ineligible and why. (FAC at 30, ¶¶ 115, 118 (describing how Anthem objects to unqualified items).) "The baseball-style dispute resolution process … is premised on the notion that ineligible claims will be weeded out at the outset." (Id. at 30, ¶ 113; see also Dkt. 76-5 at 18, § 5.5 ("If the non-initiating party believes that the Federal IDR Process is not applicable, the non-initiating party must notify the Departments by submitting the relevant information through the Federal IDR portal as part of the certified IDR entity selection process.").

Plaintiffs objected to eligibility for all the sample determinations identified in the FAC and summarized in the chart on pages 10 to 11, above. IDREs are instructed that they "must determine whether the Federal IDR Process is applicable." (Dkt. 76-5 at 18, § 5.5.) IDREs can, and sometimes do, determine that a billing dispute is not eligible. (FAC at 30, ¶ 115 (alleging that most, but not all, of "Defendants' ineligible disputes reach a payment determination" despite "Anthem's objections").)

Plaintiffs point to procedural rules for arbitration in other forums, such as rules providing for in-person hearings, cross-examination, and written decisions explaining the arbitrator's reasoning. (Dkt. 93 at 49.) But such procedures are not necessary to bring allegedly fraudulent eligibility attestations to an IDRE's attention. If the Court were to adopt Plaintiffs' position, then nearly every eligibility determination disputed by an IDR participant would be subject to review in federal court. That would be inconsistent with the NSA's creation of a streamlined IDR process for resolving surprise billing disputes and its limitations on judicial review.

As aptly put by the Sound Physicians Providers, by alleging that Plaintiffs knew about the false eligibility attestations and objected, "Anthem has pleaded itself out of court," at least as to vacatur based on fraud, because the "fraud" was

known during the IDR and disclosed to the IDRE. (Dkt. 69-1 at 22.) As a result, the FAC's allegations, even if accepted as true, do not establish the kind of "fraud" that justifies vacatur under § 10(a)(1). Plaintiffs have not identified even one example of an IDR determination for which they could amend and allege that a Defendant made a false eligibility attestation based on facts that Plaintiffs did not know, and could not reasonably have known, before or during the IDR process.

b. Undue Means.

Plaintiffs argue that the IDREs are "financially incentivized" to disregard objections to eligibility. (Dkt. 93 at 50.) The FAC describes how IDREs only receive fees if they find a dispute eligible. (FAC at 22, ¶ 80; id. at 30, ¶ 116.) But this fee structure is part of the IDR rules established by Congress. See 42 U.S.C. § 300gg-111(c)(5)(F). Such financial incentives are not akin to bad faith or bribery. In any event, the FAC does not allege that improper financial incentives motivated an IDRE's decision-making for any particular award. Plaintiffs have not suggested that they could amend and add such facts.

c. Excess of Authority.

Plaintiffs argue that they are "entitled to judicial review where, as here, the IDREs 'exceeded their powers' by issuing payment determinations on disputes that were ineligible for IDR." (Dkt. 93 at 48.) The FAC alleges that IDREs issued hundreds of payment determinations for services that were not a qualified IDR item or service. (FAC at 33, ¶ 128 (referring to 47% of 1,500 IDR proceedings).)

The IDREs, however, are authorized to decide eligibility. "First, the IDRE is directed by regulation (though not by the Act itself) to 'determine whether the Federal IDR process applies.' 45 C.F.R. § 149.510(c)(1)(v)." (Id. at 20, ¶ 73.) It makes no difference whether the directive to first determine eligibility is in the NSA's text or the implementing regulations.

The moving parties cite Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc., 160 F.4th 1110, 1114 (11th Cir. 2025). In that case, a medical service

provider (an air ambulance) challenged an IDR award in which the IDRE chose Kaiser's number. Reach Air, 160 F.4th at 1114-15. The air ambulance company sued to vacate the award under § 10(a)(4), alleging that the IDRE exceeded its authority "by applying an illegal presumption in favor of Kaiser." Id. at 1119. The Eleventh Circuit noted, "An arbitrator's actual reasoning is of such little importance to our review that it need not be explained …. Our sole question under § 10(a)(4) is whether the arbitrator (even arguably) performed the assigned task, not whether she got the outcome right or wrong." Id. at 1120 (citation modified). The examples given included "awarding relief on a statutory claim when the arbitration agreement allows only for arbitration of contractual claims" or "failing to give preclusive effect to an issue previously decided by a court." Id.

Here, Plaintiffs argue that IDREs have issued awards for ineligible claims and thus strayed from their "assigned task." (Dkt. 93 at 48 n.11.) But movants counter that part of the IDREs' assigned task is to decide eligibility. (Dkt. 117 at 19.) Plaintiffs do not (and cannot) allege that IDREs failed to rule in Anthem's favor in the complete absence of factual support for eligibility, because Plaintiffs allege that Defendants consistently represent (albeit falsely) to the IDREs that the claims are eligible. (FAC at 3, ¶ 3; id. at 23, ¶ 90.) Such allegations collapse the analysis under § 10(a)(4) into the same test as § 10(a)(1). Plaintiffs raised Defendants' allegedly false eligibility attestations to the IDREs, and the IDREs were authorized to determine eligibility. This means that judicial review of the IDREs' eligibility determinations premised on the same allegedly false eligibility attestations is not available. Pac. & Arctic Ry., 952 F.2d at 1148.

Because Plaintiffs' allegations do not meet the substantive requirements for claiming vacatur under 9 U.S.C. § 10(a)(1) or (4), the Court need not decide whether any of the FAA's procedural requirements for seeking vacatur (like timing and

venue) apply to claims seeking vacatur of NSA IDRE determinations.[5]

B. Subject Matter Jurisdiction over Remaining Federal Counts (1-4, 12, 13).

Movants argue that the NSA's above-discussed limitations on judicial review bar the Court from exercising subject matter jurisdiction over Plaintiffs' other federal claims, because those claims seek review of IDRE determinations, regardless of the legal label. (Dkt. 69-1 at 26.) None of Plaintiffs' responses to this argument (discussed below) are persuasive.

1. The Statutory Interpretation Argument.

In a novel argument unsupported by any case law, Plaintiffs contend that the NSA's limitations on judicial review apply only to "[a] determination of a certified IDR entity ***under subparagraph (A)***," and subparagraph (A) refers only to payment determinations, not eligibility determinations. (Dkt. 93 at 43 (emphasis added).) But as set forth in full above, subparagraph (A) refers to "a determination for a qualified IDR item or service." 42 U.S.C. § 300gg111(c)(5)(A). An IDRE's payment determination necessarily includes a determination of eligibility. Plaintiffs' proposed reading of 42 U.S.C. § 300gg111(c)(5)(E)(i), which would impose *no* limits on judicial review of IDREs' eligibility determinations, would be clearly contrary to the streamlined dispute resolution process that Congress intended when it created the NSA's IDR process.

2. The Policy Argument.

Next, Plaintiffs urge the Court not to apply the NSA's limits on judicial review because the IDR process is deeply flawed and there is no readily available remedy for erroneous IDR awards. (Dkt. 93 at 23-27.) But such policy-based arguments would be better directed at Congress which alone has the power to

[5] Count Eleven also fails because the alleged fraud is not pled with specificity as to every challenged IDR determination, as required by Federal Rule of Civil Procedure 9(b). This order does not rely on Rule 9(b), because non-compliance with Rule 9(b) could potentially be cured by amendment.

rewrite the NSA. Moreover, the FAC alleges that false attestations to the federal government can violate 18 U.S.C. § 1001, providing a strong incentive against making false attestations. (FAC at 18-19, ¶ 67.)

3. The "Outside the Scope" Argument.

Next, Plaintiffs argue that the NSA's limits on judicial review apply only to claims seeking to vacate IDR awards, but Plaintiffs' claims for monetary damages for time spent addressing fraudulent submissions and for prospective injunctive relief can be adjudicated without reviewing any IDR awards. (Dkt. 93 at 51-52.) Therefore, Plaintiffs argue that their claims fall outside the scope of the NSA's jurisdiction-stripping provisions. (Id.)

Plaintiffs' federal claims cannot be adjudicated without reviewing the correctness of past IDR awards or inserting the district court in overseeing future IDR awards. The district court could not, for example, award damages measured by time spent addressing a fraudulent eligibility attestation without first deciding that the eligibility attestation was false. Similarly, the district court could not order Defendants to pay damages measured by IDR administrative fees for disputes ineligible for the IDR process without first deciding that the dispute was ineligible for IDR. And if, for example, the district court entered a follow-the-law injunction that prohibited Defendants from making future false eligibility attestations, then Plaintiffs would be able to come back into court to request a contempt remedy for violations of such an injunction, a remedy that would require litigating whether the challenged attestation was false. These theories are all end runs around the NSA's limits on judicial review.

4. The "Other Statutory Basis" Argument.

Plaintiffs argue that jurisdiction to hear its federal claims is conferred by ERISA or the federal Declaratory Judgment Act. (Dkt. 93 at 84.) These laws generally provide that district courts can hear certain kinds of claims, but neither specifically allows claims that require judicial review of IDR awards, as Plaintiffs'

federal claims do. These federal laws' general jurisdictional language does not supplant the NSA's specific limitations on judicial review.

C. Supplemental Jurisdiction over Counts 5-10.

The Court has discretion to exercise supplemental jurisdiction over state law claims that do not, themselves, have a basis for federal subject matter jurisdiction once the Court has dismissed the claims over which it has original jurisdiction. 28 U.S.C. § 1367(c)(3). Here, Plaintiffs' federal claims all fail for the reasons stated above. The Court declines to exercise supplemental jurisdiction over Plaintiffs' remaining state law claims.

D. The Anti-SLAPP Motions.

"California law provides for the pre-trial dismissal of certain actions, known as Strategic Lawsuits Against Public Participation, or SLAPPs, that masquerade as ordinary lawsuits but are intended to deter ordinary people from exercising their political or legal rights or to punish them for doing so." Planet Aid, Inc. v. Reveal, 44 F.4th 918, 923 (9th Cir. 2022) (quoting Makaeff v. Trump Univ., LLC, 715 F.3d 254, 261 (9th Cir. 2013)); see Cal. Civ. Proc. Code § 425.16. The Ninth Circuit has held that California Code of Civil Procedure section 425.16 is, in part, a substantive law that applies in federal court to state law claims. See United States ex rel. Newsham v. Lockheed Missiles & Space Co., 190 F.3d 963, 972-73 (9th Cir. 1999).

To prevail on an anti-SLAPP motion, "the moving defendant must make a prima facie showing that the plaintiff's suit arises from an act in furtherance of the defendant's constitutional right to free speech." Makaeff, 715 F.3d at 261. "Once it is determined that an act in furtherance of protected expression is being challenged, the plaintiff must show a 'reasonable probability' of prevailing in its claims for those claims to survive dismissal." Metabolife Int'l, Inc. v. Wornick, 264 F.3d 832, 840 (9th Cir. 2001) (citation omitted); see also Makaeff, 715 F.3d at 261. Under this standard, "the claim should be dismissed if the plaintiff presents

an insufficient legal basis for it, or if, on the basis of the facts shown by the plaintiff, 'no reasonable jury could find for the plaintiff.'" Makaeff, 715 F.3d at 261 (quoting Metabolife, 264 F.3d at 840).

Here, movants argue (primarily) that all of Plaintiffs' state law claims (1) arise from petitioning activity protected by the First Amendment and (2) are unlikely to succeed because the same limitations on judicial review that deprive the Court of jurisdiction over Plaintiffs' federal claims apply equally to Plaintiffs' state law claims. (Dkt. 68, 78.)

The Court has already dismissed the state law claims, exercising its discretion under 28 U.S.C. § 1367(c)(3) not to assert supplemental jurisdiction. Without any state law claims, district courts may properly decline to address anti-SLAPP motions. See Hilton v. Hallmark Cards, 599 F.3d 894, 901 (9th Cir. 2010) ("[A] federal court can only entertain anti-SLAPP special motions to strike in connection with state law claims …."); McMillan v. Chaker, 791 F. App'x 666, 667 (9th Cir. 2020) (holding that the district court, after dismissing all federal claims, did not abuse its discretion in not exercising supplemental jurisdiction over the remaining state law claims and not addressing the anti-SLAPP motion).

Movants urge the Court to retain jurisdiction to rule on the anti-SLAPP motions. The Court declines to do so. Applying California's anti-SLAPP law requires analysis under the two-part test described above, which goes beyond the analysis needed to dismiss the federal claims. Furthermore, Plaintiffs ask the Court to consider (1) a new Supreme Court decision that Plaintiffs believe limits or eliminates anti-SLAPP motions in federal court, and (2) the timing of the motions, both issues the Court need not reach if it declines to retain jurisdiction. (Dkt. 92 at 13-14, 23.) Finally, the Court has inherent power "to control the disposition of the causes on its docket with economy of time and effort for itself, for counsel, and for litigants." Landis v. N. Am. Co., 299 U.S. 248, 254 (1936). Declining to address the anti-SLAPP motions serves the interest of judicial economy.

E. Leave to Amend.

If a district court finds that a complaint should be dismissed for failure to state a claim, the court has discretion to dismiss with or without leave to amend. Lopez v. Smith, 203 F.3d 1122, 1126-30 (9th Cir. 2000) (en banc). The court may dismiss a complaint without leave to amend if further amendment would be futile. Cahill v. Liberty Mut. Ins. Co., 80 F.3d 336, 339 (9th Cir. 1996). If, after careful consideration, it is clear that a complaint cannot be cured by amendment, then the district court may dismiss without leave to amend. See, e.g., Chaset v. Fleer/Skybox Int'l, 300 F.3d 1083, 1088 (9th Cir. 2002) (holding that "there is no need to prolong the litigation by permitting further amendment" where the "basic flaw" in the pleading cannot be cured by amendment).

Plaintiffs request leave to amend. (Dkt. 93 at 87.) But in neither briefing nor oral argument have Plaintiffs identified any facts that they could add that would (1) qualify a particular IDE determination for vacatur or (2) put its other federal claims beyond the jurisdiction-stripping provisions of 42 U.S.C. § 300gg111(c)(5)(E)(i)(II). Since leave to amend would be futile, the Court declines to grant leave to amend.

V.

CONCLUSION

Based on the foregoing, **IT IS ORDERED** that (1) the motions to dismiss (Dkt. 69, 73, 76, 77) shall be granted for the reasons stated above; (2) all other pending motions (Dkt. 68, 72, 74, 78) shall be denied as moot; and (3) the FAC shall be dismissed in its entirety, without leave to amend.

DATED: April 9, 2026

Karen E. Scott

KAREN E. SCOTT
United States Magistrate Judge

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

AETNA HEALTH INC. et al.,

Plaintiff,

v. Case No. 3:24-cv-1343-BJD-LLL

RADIOLOGY PARTNERS, INC., and MORI, BEAN AND BROOKS, INC.,

Defendants.
_____/

ORDER

THIS CAUSE is before the Court on Defendants' Motion to Dismiss the Amended Complaint (Doc. 84), Plaintiffs' Response in Opposition (Doc. 90), and Defendants' Notice of Supplemental Authority (Doc. 91).

Plaintiffs are a tripartite conglomeration that make up the nationally known Aetna health insurance brand. (Doc. 80 ¶1; AC). Defendant Radiology Partners, Inc., ("RP"), is a "private equity-backed aggregator of radiology practices across" the United States. Id. ¶3. Once RP acquires a practice, it essentially controls and manages all aspects of the practice but conceals the extent of that control to "appear compliant" with state regulations, including potential prohibitions on the "corporate practice of medicine." Id.

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One of the nine practices RP acquired in Florida was Defendant Mori, Bean and Brooks, Inc., ("MBB"), which had the most lucrative reimbursement contact with Aetna within the state. Id. ¶5. After RP acquired MBB, MBB's claim submissions skyrocketed. Id. ¶6. Aetna contends—and for purposes of this Motion, the Court accepts that contention—that RP funneled its other Florida radiology practices' claims through MBB to obtain higher reimbursements. Id. ¶6. Aetna inquired into the increase in the number of claims but MBB "deflected Aetna's inquiries." Id. Aetna responded by terminating MBB's in-network contract, which meant MBB would now be considered an "out-of-network" provider. Id. The other Florida RP radiology providers remained "in-network."[1]

The gravamen of the Amended Complaint is that once Aetna terminated its contract with MBB, RP continued submitting its other practices' claim through MBB forcing Aetna to reimburse MBB at an even higher rate out-of-network rate. Id. ¶8. The other RP entities billing through MBB did so despite not actually being fairly classified as a MBB provider. Id. This allowed RP to collect "significantly more for the same services provided by the same physicians at the same hospitals." Id. ¶9.

[1] The critical difference between an in-network provider and out-of-network provider is the former means there is a predetermined amount negotiated between the provider and insurance company that limits the cost passed on to the patient, while the latter leaves the uncovered amounts uncapped and owed by the patient.

The scheme relied on the recent enactment of the No Surprises Act ("NSA" or the "Act") 42. U.S.C. §§ 300gg-111, which, as its name implies, aims to reduce surprise billing by out-of-network providers to unwitting patients.[2] Id. ¶10; see also Med-Trans Corp. v. Cap. Health Plan, Inc., 700 F. Supp. 3d 1076, 1079 (M.D. Fla. 2023), aff'd sub nom. Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc., 160 F.4th 1110 (11th Cir. 2025) ("Its main purpose was to end surprise medical billing by ensuring that certain out-of-network providers . . . are treated the same as in-network providers."). To that end, the Act requires the out-of-network provider to submit its bill to the patient's insurer, who must offer to settle the claim or refuse to pay the claim altogether. Med-Trans Corp., 700 F. Supp. 3d at 1079.

If the insurer and provider fail to agree, the dispute is forwarded to the Independent Dispute Resolution ("IDR") for "baseball style" arbitration. Id. After an arbitrator is assigned (or mutually agreed upon), the parties submit their best offers to the arbitrator, who must pick just one (no compromises or adjustments can be made) that the arbitrator believes best represents the equivalent in-network reimbursement rate. Id. The decision is "not . . . subject to judicial review except on the same grounds as are available to

[2] An example of this would be a patient receiving emergency services or undergoing a procedure at an in-network hospital who then contracted with an out-of-network anesthesiologist to assist with a patient's surgery.

review awards under the Federal Arbitration Act[,]" such as the existence of a fraudulent claim or evidence of misrepresentation of facts. Id at 1080 (citing § 300gg-111(c)(5)(E)(i)(II) (citing 9 U.S.C. § 10(a)(1)–(4))) (internal quotations omitted).

RP, using MBB, submitted tens of thousands of disputes under the NSA's IDR process that were premised on Defendants' misrepresentations that the services were provided by MBB, when they had been performed by other non-MBB providers. AC ¶11. Defendants knowingly and falsely certified the claims to both Aetna and the IDR administrators and obtained millions in awards from the IDR process. Id. ¶¶12-15. Aetna now seeks to have the IDR awards vacated and to recover damages from the fees associated with having to participate in the IDR process, and further to have disputed claims not yet filed with the IDR to be limited. Defendants responded with their Motion to Dismiss contending that there was no fraud; any fraud was not sufficiently pled, and further, the IDR awards are not reviewable.

Where a complaint alleges acts of fraud, it "must satisfy two pleading requirements [: Fed. R. Civ. P. 8(a)(2) and Rule 9(b)]." U.S. ex rel. Matheny v. Medco Health Solutions, Inc., 671 F.3d 1217, 1225 (11th Cir. 2012). In satisfying Rule 8(a)(2), a complaint needs to allege "enough facts to state a claim to relief that is plausible on its face." Bell Atlantic Corp. v. Twombly,

550 U.S. 544, 570, 127 S.Ct. 1955 (2007). While "detailed factual allegations" are not required, mere "labels and conclusions" or "a formulaic recitation of the elements of a cause of action" are not enough. Ashcroft v. Iqbal, 556 U.S. 662, 678, 129 S.Ct. 1937 (2009). In assessing the factual allegations "[w]e . . . construe them in the light most favorable to the plaintiff." Pereda v. Brookdale Senior Living Communties, Inc., 666 F.3d 1269, 1272 (11th Cir. 2012) (citation and quotations omitted). Pleadings "must" be "a short and plain statement of the claim[s] showing that the pleader is entitled to relief[.]" Fed. R. Civ. P 8(a)(2).

Plaintiff must also meet Rule 9(b)'s heightened standard by "stat[ing] with particularity the circumstances constituting fraud." U.S. ex rel. Schubert v. All Children's Health Sys., Inc., No. 8:11-CV-1687-T-27EAJ, 2013 WL 1651811, at *1 (M.D. Fla. Apr. 16, 2013) (quoting Fed. R. Civ. P. 9(b)). "The particularity requirement of Rule 9(b) is satisfied if the complaint alleges "facts as to time, place, and substance of the defendant's alleged fraud, specifically the details of the defendant's allegedly fraudulent acts, when they occurred, and who engaged in them." Id. (citing Hopper v. Solvay Pharm., Inc., 588 F.3d 1318, 1324 (11th Cir. 2009) (quotations omitted)). However, "knowledge . . . may be alleged generally." Fed. R. Civ. P. 9(b). "The purpose of Rule 9(b) is to alert defendants to the precise misconduct with which they are charged and protect defendants against spurious charges."

Matheny, 671 F.3d at 1222 (citations and quotation omitted). Rule 9(b)'s heightened standard is tempered, however, in situations when the "alleged fraud occurred over an extended period of time and consisted of numerous acts." U.S. ex rel. Butler v. Magellan Health Servs., Inc., 74 F. Supp. 2d 1201, 1215 (M.D. Fla. 1999).

Starting with Rule 8's less demanding standard, the Court finds that the Complaint is anything but short but it does not necessarily violate Rule 8 for that reason alone. The Complaint sets forth the facts in numbered and organized paragraphs, most of which are pertinent to the claims, and clearly states the nature of Plaintiffs' claims. As to Rule 9, in Linville v. Ginn Real Est. Co., LLC 697 F. Supp. 2d 1302, 1309 (M.D. Fla. 2010), the court held that allegations failed to meet Rule 9(b)'s requirements where they failed to specify "which" agents made the statements, "when" the statements were made and "where" the statements were made.

Aetna does not make those same fatal mistakes. For example, Aetna listed a September 18, 2022 claim from Dr. Nouri billed under MBB's provider tax identification number despite Dr. Nouri working for Radiology Associates of South Florida on the opposite end of the state. AC ¶ 69. The location, date, and individual/entity are all specifically identified. Further, Aetna was harmed because it ultimately was ordered by the IDR arbitrator to

pay MBB an out-of-network amount of $752.00 instead of the in-network fee of $78.89. Id. ¶¶69-70.

Outside of stating a claim for fraud, the Court must determine whether the fraud is alleged in a manner to allow for review of the IDR awards. With limited exceptions as described by the Federal Arbitration Act, IDR decisions under the NSA are not reviewable. Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc., 160 F.4th 1110, 1118 (11th Cir. 2025). A plaintiff bears a "heavy burden of demonstrating that vacatur is appropriate . . . by proving the existence of one or more of four statutorily enumerated causes for reversal set forth in 9 U.S.C. § 10(a)(1)-(4)." Wiand v. Schneiderman, 778 F.3d 917, 925 (11th Cir. 2015) (internal citation omitted). Fraud is one of those enumerated causes. Id.; Reach Air Med. Servs. LLC, 160 F.4th at 1121 ("FAA Section 10(a)(1) [ ] permits vacatur of an arbitration award when 'the award was procured by . . . fraud,' 9 U.S.C. § 10(a)(1)[.]").

To establish fraud, the plaintiff must:

> [(1)] establish the fraud by clear and convincing evidence"; (2) "the fraud must not have been discoverable upon the exercise of due diligence prior to or during the arbitration"; and (3) "the person seeking to vacate the award must demonstrate that the fraud materially related to an issue in the arbitration."

Reach Air Med. Servs. LLC, 160 F.4th at 1121 (quoting Bonar v. Dean Witter Reynolds, Inc., 835 F.2d 1378, 1383 (11th Cir. 1988)).

As discussed above, Aetna has sufficiently alleged Defendants fraudulently submitted claims for reimbursement as out-of-network providers. Those claims resulted in IDR awards that injured Aetna by causing Aetna to incur arbitration fees and to pay at a rate higher than it would have if the claims were submitted as being performed by in-network providers.

Defendants strongest defense is that the fraud was discoverable upon the exercise of due diligence prior to or during arbitration. In the Amended Complaint, Aetna states that it terminated its contract with MBB because MBB was submitting in-network claims from providers across the state that were not employees of MBB. This occurred, necessarily, before MBB became an out-of-network provider through which non-MBB providers submitted claims. Though Aetna attempts to describe Defendants' efforts to shield the true origin of the claims, the Court is mindful of Aetna's "heavy burden" to upend administrative decisions on the basis of fraud. While a close call, the allegations presented in the Amended Complaint fail to establish a sufficient basis excusing Aetna from challenging the IDR disputes on the basis that they were wrongfully submitted by in-network providers. Aetna's own admission that it knew RP and MBB were engaged in that very act as the

reason for the termination of the in-network contract is fatal to Aetna's position. While Aetna cites the thousands of claim submissions and Defendants' efforts to conceal the nature of the fraud, it cannot excuse Aetna's failure to raise the issue in the IDR disputes.

As to the remaining claims, they are all premised on the same facts as Aetna's claims of fraud but rely on different legal theories for recovery. Aetna's attempt to end-around the NSA and FAA strictures is preempted. The NSA adopts the ferocity of the FAA in defending arbitration awards. Reach Air Med. Servs. LLC,160 F.4th at 1115 ("We review arbitration decisions very narrowly, and there is a strong legal presumption that arbitration awards will be confirmed[,]" and there is nothing in the "newly codified NSA, which has expressly incorporated some sections of the Federal Arbitration Act [ ], that has altered that limited scope of judicial review [or preference]."). The FAA preempts state law claims that would otherwise frustrate its purpose. See Marmet Health Care Ctr., Inc. v. Brown, 565 U.S. 530, 533 (2012). Allowing Aetna to recover for the IDR awards above what it otherwise would have paid would have the same effect as discarding the administrative process established by Congress. Because the NSA adopted those specific provisions of the FAA, Aetna's remaining claims must also fall—they are both preempted by the NSA and FAA and otherwise inadequate grounds to challenge the IDR awards. Regarding those claims yet

to be submitted to the IDR, the Court is not empowered to take a preliminarily review. Indeed, Aetna possesses more than enough knowledge pertaining to their propriety and can, if appropriate, challenge those claims before the IDR.

Accordingly, after due consideration, it is

ORDERED:

Defendants' Motion to Dismiss the Amended Complaint (Doc. 84) is **GRANTED**. Because amendment would be futile, the Amended Complaint is **DISMISSED with prejudice**. The Clerk of the Court shall close this file and terminate any pending motions.

DONE and **ORDERED** in Jacksonville, Florida this ***16th*** day of April, 2026.

BRIAN J. DAVIS
United States District Judge

Copies furnished to:

Counsel of Record

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

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

MEMORANDUM

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

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

EXHIBIT 3

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

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

I. Alleged Facts

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

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

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

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

The No Surprises Act provides the defined remedy.

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

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

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

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

UnitedHealthcare and NorthStar dispute the insurer's reimbursement obligation.

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

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

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

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

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

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

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

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

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

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

II. Analysis

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Federal Arbitration Act allows us to vacate an award "procured by corruption, fraud, or undue means" and where "the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made."[52] UnitedHealthcare could have, but chose not to, pursue the defined remedy set by Congress under the Act. It instead elected to allege a common law fraud claim and bootstrap the common law claim into declaratory and injunctive relief with no federal jurisdictional basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. Conclusion

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

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

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

[2] ECF 1 ¶¶ 55, 57.

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

[5] *Id.* ¶ 59.

[6] *Id.* ¶ 60.

[7] *Id.* ¶ 66.

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

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

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

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

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

[13] 42 U.S.C. § 300gg-111(c).

[14] *Id.* § 300gg-111(c)(1)(A).

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

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

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

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

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

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

[21] *Id.* ¶ 70.

[22] *Id.* ¶¶ 73–74.

[23] *Id.* ¶ 75.

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

[25] ECF 26-1 at 17–19.

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

[27] ECF 1 ¶ 9; 28 U.S.C. § 1331.

[28] ECF 1 ¶¶ 72, 108–112.

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

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

[31] *Id.* ¶¶ 95–96.

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

[33] *Id.*

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

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

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

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

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

[39] *Id.*

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

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

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

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

[44] ECF 37 at 14.

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

[46] *Id.* at 311.

[47] *Id.*

[48] *Id.* at 314–15.

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

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

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

[52] 9 U.S.C. §§ 10(a)(1), (4).

[53] ECF 37 at 14.

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

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

[56] *Id.* at 3.

[57] ECF 37 at 14.

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

[59] *Id.*

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

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

[62] *Id.*

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

[64] *Id.*

[65] ECF 37 at 16.

[66] *Id.*

[67] ECF 1 ¶ 112.

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

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

[70] *Id.* at *3.

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

[72] *Id.* at *4–5.

[73] *Id.* at *5.

[74] *Id.* at *6.

[75] *Id.* at *6–7.

[76] *Id.* at *8.

[77] *Id.*

[78] *Id.*

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

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

[81] *Id.* at *2.

[82] *Id.* at *6.

[83] *Id.*

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

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

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

[87] *Id.* at *2.

[88] *Id.*

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

[90] *Id.* at *4.

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

[92] *Id.* at *2.

[93] *Id.* at *2–4.

[94] *Id.* at *3.

[95] *Id.*

[96] *Id.*

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

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

[99] *Id.* at *5–9.

[100] *Id.* at *9.

[101] *Id.*

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

[103] *Id.*

[104] *Id.*

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

[106] ECF 40.

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

[108] ECF 1 ¶¶ 95–96.

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

[110] *Id.* at *2.

[111] *Id.* at *2–3.

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

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

BLUE CROSS BLUE SHIELD OF TEXAS, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY, Plaintiff, v. HALOMD, LLC, ALLA LAROQUE, SCOTT LAROQUE, Defendants.	§ § § § § § § § § § § § §	CIVIL ACTION NO. 5:25-CV-132-RWS

ORDER

Before the Court are Defendants HaloMD, LLC, Alla LaRoque, and Scott LaRoque's Joint Motions to Dismiss Pursuant to Rules 12(b)(1) and 12(b)(6) and Related Request for Judicial Notice of Public Documents (Docket No. 15)[1] and Defendants' Motion to Stay Discovery Pending Resolution of Defendants' Rules 12(b)(1) and 12(b)(6) Motions to Dismiss (Docket No. 31). Defendants' motion to dismiss is fully briefed (Docket Nos. 15, 21, 28, 39), and Defendants' motion to stay is briefed through a response (Docket Nos. 31, 35). On March 10, 2026, the Court heard oral argument on the motions. Docket No. 50. For the reasons set forth below, Defendants' motion to dismiss (Docket No. 15) is **GRANTED**, and Defendants' motion to stay (Docket No. 31) is **DENIED-AS-MOOT**.

BACKGROUND

Plaintiff filed this lawsuit on August 28, 2025, alleging that Defendants developed a scheme to abuse the federal and Texas independent dispute resolution ("IDR") processes for

[1] While Defendants styled their briefing as "joint motions," their arguments are contained in a single document, so the Court refers to Docket No. 15 as a "motion to dismiss."

EXHIBIT 4

determining the appropriate reimbursement amounts for certain medical items and services. Docket No. 2 (Complaint) at ¶¶ 89–99. As part of this alleged scheme, Plaintiff complains that HaloMD, LLC initiated IDR proceedings for ineligible items, services, and claims. *Id.* at ¶ 12. Plaintiff contends that, in combination with the submission of ineligible items and services for IDR, Defendants used "delay and dump tactics" by "submit[ting] massive numbers of open negotiations and IDR initiations all at once." *Id.* at ¶¶ 199–201. As a consequence, Plaintiff claims that the alleged scheme has resulted in tens of millions of dollars in ineligible awards for out-of-network providers that are represented by HaloMD in the IDR process. *Id.* at ¶ 331.

Defendants filed the instant motion to dismiss on November 18, 2025, claiming that the Court lacks subject matter jurisdiction, or, alternatively, that Plaintiff has failed to state a claim for relief.[2] *See generally* Docket No. 15. On February 13, 2026, Defendants moved to stay discovery pending the resolution of the motion to dismiss. Docket No. 31.

LEGAL STANDARD

I. Rule 12(b)(1)

Federal Rule of Civil Procedure 12(b)(1) allows a party to challenge the subject-matter jurisdiction of a federal court to hear a claim. A motion to dismiss under Rule 12(b)(1) is properly granted when the court lacks the statutory or constitutional power to adjudicate the case. *Home Builders Ass'n of Mississippi, Inc. v. City of Madison*, 143 F.3d 1006, 1010 (5th Cir. 1998). The

[2] Since the hearing on Defendants' motions, Defendants have filed three notices of supplemental authority. Docket Nos. 58, 60, 62. The notices alert the Court to orders on motions to dismiss in other district courts concerning similar issues presented here. *See generally* Docket Nos. 58-1, 60-1, 62-1. Defendants ask the Court to take judicial notice of these orders. While Plaintiff opposes the applicability of the supplemental authority, it does not challenge judicial notice. *See* Docket Nos. 59, 61, 63. Accordingly, the Court takes judicial notice of the supplemental authority. *See Prescott v. Catoe*, No. 4:20-CV-00169-ALM-CAN, 2021 WL 11486160, at *1 n.1 ("A court may take judicial notice of publicly available documents, including filings, orders, and judgments from other lawsuits.").

party asserting jurisdiction bears the burden of proving that subject-matter jurisdiction exists. *Ramming v. United States*, 281 F.3d 158, 161 (5th Cir. 2001). A motion to dismiss under Rule 12(b)(1) should be granted "if it appears certain that the plaintiff cannot prove any set of facts in support" of his or her claims. *Sureshot Golf Ventures, Inc. v. Topgolf Int'l, Inc.*, 754 Fed. Appx. 235, 239 (5th Cir. 2018) (citing *Wagstaff v. U.S. Dep't of Educ.*, 509 F.3d 661, 663 (5th Cir. 2007)). "When a Rule 12(b)(1) motion is filed in conjunction with other Rule 12 motions, the court should consider the jurisdictional attack before addressing any attack on the merits." *Ramming*, 281 F.3d at 161. In analyzing a motion to dismiss under Rule 12(b)(1), a court may consider: (1) the complaint alone; (2) the complaint supplemented by undisputed facts or evidence in the record; or (3) the complaint supplemented by undisputed facts plus the court's resolution of disputed facts. *Id.*

II. Collateral Attack

A collateral attack is "[a]n attack on a judgment in a proceeding other than a direct appeal." *Collateral Attack*, BLACK'S LAW DICTIONARY (12th ed. 2024). The Fifth Circuit bars collateral attacks on judgments rendered in judicial and quasi-judicial (*e.g.*, arbitration) proceedings. *See Tex. Brine Co. v. Am. Arb. Ass'n*, 955 F.3d 482, 487–90 (5th Cir. 2020); *Gulf Petro Trading Co. v. Nigerian Nat'l Petroleum Corp.*, 512 F.3d 742, 747–50 (5th Cir. 2008). In the context of arbitration, the Fifth Circuit has explained that a plaintiff may "be engaged in collateral attacks even though [he or she] d[oes] not attempt to relitigate the facts and defenses of the underlying disputes that had prompted arbitration, but instead . . . alleg[es] that wrongdoing . . . tainted the arbitration proceedings and caused unfair awards." *Gulf Petro*, 512 F.3d at 750. Thus, "[t]he test for a collateral attack is not merely whether the claims [in the present suit] 'attempt to relitigate the facts and defenses that were raised in the prior arbitration.' " *Tex. Brine*, 955 F.3d at 488 (quoting *Gulf*

Petro, 512 F.3d at 749–59). Instead, courts "look to 'the relationship between the alleged wrongdoing, purported harm, and arbitration award.' " *Id.* (quoting *Gulf Petro*, 512 F.3d at 749).

ANALYSIS

I. Defendants' Joint Motions to Dismiss Pursuant to Rules 12(b)(1) and 12(b)(6) and Related Request for Judicial Notice of Public Documents (Docket No. 15)

Plaintiff complains that Defendants' scheme involved submitting ineligible claims for IDR under both the No Surprises Act ("NSA") and Texas law. The Court first considers Plaintiff's claims in the context of the NSA and federal law before turning to Plaintiff's claims related to the Texas IDR process.

A. The NSA's Statutory Bar to Judicial Review of IDR Awards and Collateral Attack

1. The Federal IDR Process

In 2020, Congress passed the NSA to combat predatory healthcare price billing. Docket No. 2 (Complaint) at ¶¶ 33–34. Among other things, the NSA established an IDR process to resolve claims between out-of-network providers and health plans. *Id.* at ¶ 36. The NSA requires the Departments of Health and Human Services, Labor, and Treasury (the "Departments") to promulgate regulations establishing procedures for IDR. 42 U.S.C. § 300gg-111(c)(2).

To be eligible for IDR, the items and services at issue must fall within the NSA's scope (*e.g.*, services must be rendered by an out-of-network provider). Docket No. 2 (Complaint) at ¶ 37. The party requesting IDR must provide information related to eligibility and attest that the items and services meet the eligibility requirements. *Id.* at ¶ 40. The party responding to the IDR has an opportunity to dispute eligibility. *See* Docket No. 15 at 10 ("If the non-initiating party believes that the Federal IDR Process is not applicable, the non-initiating party must notify the Departments by submitting the relevant information through the Federal IDR portal as part of the certified IDR entity selection process." (quoting Docket No. 15-5 at 7)). According to Defendants,

"[i]n 2024, non-initiating parties objected to IDR eligibility 44% of the time, but only 19% of disputes were determined to be ineligible." *Id.* at 11–12. In fact, Plaintiff acknowledges it challenged the eligibility of at least a portion of the underlying items and services at issue in its IDRs with HaloMD. Docket No. 2 (Complaint) at ¶¶ 109–10, 123, 147.

Within three to six days after an IDR is initiated, the Departments randomly select an IDR entity absent an agreement by the parties. Docket No. 15-4 at 6. Once an IDR entity is selected, the entity has three days to "determine whether the Federal IDR Process is applicable, thereby finalizing the selection." *Id.* The parties then submit their offers and pay the IDR entity and any administrative fees. *Id.* Within 30 days of the selection of the IDR entity, the entity must determine the payment amount for the item or service and select one of the parties' competing offers. *Id.* As Plaintiff explains, the IDR entity's "decision is then binding upon the parties, subject to limited judicial review, and the non-prevailing party is responsible for administrative and IDR [entity] fees." Docket No. 2 (Complaint) at ¶ 38(g) (citing 42 U.S.C. § 300gg-111(c)(5)(F)). Indeed, the NSA provides that IDR decisions "shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a)" of the Federal Arbitration Act. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II).

2. Analysis

Defendants contend that IDR decisions are generally not judicially reviewable and therefore Plaintiff's claims should be dismissed. Docket No. 15 at 15. Specifically, Defendants argue that the NSA's bar on judicial review prevents the Court from considering Plaintiff's claims altogether. *Id.* at 15–16. Defendants also aver that the collateral attack doctrine bars Plaintiff's claims because the claims would require the parties to "re-adjudicat[e] the 'over 42,000' individual IDR disputes [Plaintiff] claims were wrongfully procured and decided." *Id.* at 16.

Plaintiff argues that the NSA's statutory bar against judicial review does not preclude their claims because the NSA only prevents review of "payment determination[s]," not eligibility decisions. Docket No. 21 at 9–10 (citing 42 U.S.C. § 300gg-111(c)(5)(E)). According to Plaintiff, "[t]here is no indication—let alone a 'clear and convincing' one—that Congress intended to foreclose judicial review of Defendants' eligibility scheme in the Federal IDR Process." *Id.* at 10. Plaintiff explains that "[a]lthough the IDR process differ[s] in important respects from arbitration, . . . courts routinely decide whether a dispute is arbitrable." *Id.* at 12. It argues that the same is true with respect to IDR eligibility. *Id.* Plaintiff further contends that it "is not seeking damages that it sought but failed to procure in the underlying IDR proceedings." *Id.* at 13. Instead, Plaintiff claims it "seeks damages related to costs for the overhead and resources necessary for [it] to respond to Federal and Texas IDR Processes and administrative fees and costs imposed on [it] as part of the Federal and Texas IDR Processes," neither of which it could recover in the IDR proceedings. *Id.* at 14. Therefore, according to Plaintiff, its claims are "necessarily not a collateral attack on [the IDR] proceedings." *Id.*

The Court agrees with Defendants that the NSA forecloses judicial review. The NSA expressly states that "[a] determination of a certified IDR entity under subparagraph (A) . . . shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of Title 9 [(FAA § 10 (a)]." 42 U.S.C. § 300gg-111(c)(5)(E)(i). The determination under subparagraph (A) includes selecting "one of the offers submitted under subparagraph (B) to be the amount of payment **for such item or service determined under this subsection for purposes of subsection (a)(1) or (b)(1), as applicable**." *Id.* § 300gg-111(c)(5)(A) (emphasis added). Such a determination "shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the" IDR entity. *Id.* at

300gg-111(c)(5)(E)(i). Thus, the NSA prevents this Court from reviewing the more than 42,000 IDR awards at issue in Plaintiff's suit. *See Guardian Flight, L.L.C v. Health Care Serv. Corp.*, 140 F.4th 271, 275 (5th Cir. 2025) ("The NSA expressly *bars* judicial review of IDR awards *except* as to the specific provisions borrowed from the FAA. . . . The district court correctly reasoned that this bar on judicial review strongly suggests Congress did not insert a private right of action into the statute.").

Plaintiff offers two reasons why it believes the NSA's bar on judicial review is inapplicable. First, Plaintiff contends that the bar only applies to "payment determination[s]," not eligibility decisions. Docket No. 21 at 9. Second, Plaintiff argues that its claims are not a collateral attack on the IDR awards and the relief they seek is outside the scope of the NSA's bar on judicial review. *Id.* Neither of these arguments is persuasive.

First, inherent in the NSA's bar of judicial review of payment determinations is a limitation on the review of eligibility decisions. If the Court were to conclude that the items and services submitted for payment by Defendants were ineligible under the NSA, then the ultimate payment awards would necessarily be called into question. *See Anthem Blue Cross Life and Health Ins. Co., et al. v. HaloMD, LLC, et al.*, No. 8:25-cv-01467-KES (C.D. Cal. Apr. 9, 2026), ECF No. 135 at 14 (concluding that "Plaintiffs' other fraud-based claims, like RICO, could not be litigated without deciding whether Defendants made false eligibility attestations, a decision that would necessarily re-examine eligibility determinations made by IDREs."). In addition, although Plaintiff argues that the only determination made by the IDR entity is "the amount of payment," its reading of the statute is too narrow because subparagraph (A) also makes clear that the amount of payment is "a determination for a qualified IDR item or service." 42 U.S.C. § 300gg111(c)(5)(A). This suggests

that Congress did not intend to impliedly provide an avenue for challenging eligibility decisions while expressly foreclosing judicial review of the IDR entities' payment determinations.

The cases on which Plaintiff relies to argue that there is no indication that Congress intended to foreclose judicial review of Defendants' eligibility scheme are inapposite. Each of the cases addresses the legal standard for determining whether Congress intended to prevent judicial review of administrative action, but they are not relevant because the dispute between the parties does not involve a federal agency's decision. *See Mach Mining, LLC v. EEOC*, 575 U.S. 480, 486–89 (2015) (judicial review of whether the Equal Employment Opportunity Commission complied with its duty to attempt conciliation of employment discrimination claims); *Guerrero-Lasprilla v. Barr*, 589 U.S. 221, 225–27 (2020) (judicial review of Board of Immigration Appeals' decisions on requests for equitable tolling of deadlines for filing statutory motions to reopen); *Reno v. Cath. Soc. Servs., Inc.*, 509 U.S. 43, 63–64 (1993) (judicial review of Immigration and Naturalization Service determinations respecting illegal aliens' applications for adjustment of status under an alien legalization program). Yet, as Plaintiff points out, "Defendants' misrepresentations in the IDR Processes were not legitimate government petitioning activities. They were made in the course of **'private adjudications' overseen by private companies.**" Docket No. 21 at 35–36 (emphasis added). The cases on which Plaintiff relies are therefore inapplicable since Plaintiff is not challenging administrative actions.

Second, Plaintiff's claims are an impermissible collateral attack on the IDR awards. Plaintiff claims it is "not seeking damages that it sought but failed to procure in the underlying IDR proceedings." And yet, at the hearing on Defendants' motion, Plaintiff explained its requested damages as follows:

> We are not challenging the calculation of th[e] awards. We're saying th[e] awards were obtained through fraud. **So one of our remedies is seeking damages for th[e]**

> **fraudulently obtained awards.** But in addition, we're seeking damages for the administrative fees and also for the costs and expenses we went through in building out an entire team to respond to this ineligible scheme.

Docket No. 53 at 68:19–69:4 (emphasis added). Based on Plaintiff's own interpretation of its request for damages, it seeks payment that is largely co-extensive with the losses it allegedly sustained in the form of IDR awards decided against it.[3] The question then is whether Plaintiff's claims can still constitute a collateral attack on the IDR awards even if it seeks administrative fees, costs, and expenses in "building out an entire team to respond to th[e] ineligible scheme." *Id.* The Court concludes that they can.

The Fifth Circuit's opinion in *Gulf Petro Trading Company, Inc. v. Nigerian National Petroleum Corporation* is instructive. 512 F.3d 742 (5th Cir. 2008). The plaintiff brought suit in the Eastern District of Texas alleging that a final award in an arbitration held in Switzerland was procured by fraud, bribery, and corruption and seeking to vacate award. *Id.* at 745. The plaintiff argued that its "RICO and state law claims [were] not disguised attempts to vacate or attack" the final arbitration award because "the claims it advances and relief it seeks are analytically distinct from vacatur." *Id.* at 747, 750. Relying on Sixth Circuit cases involving collateral attacks on domestic arbitration awards,[4] the Fifth Circuit concluded:

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[3] Indeed, each of Plaintiff's claims refers to the impact of Defendants' alleged actions on the ultimate IDR awards. *See, e.g.*, Docket No. 2 (Complaint) at ¶¶ 222, 242 (explaining regarding Plaintiff's fraud and negligent misrepresentation claims that "[b]ut for [HaloMD's] misrepresentations, HaloMD would not have been able to initiate Federal or Texas IDRs for ineligible claims[.]"); *see also id.* at ¶¶ 226, 243, 262, 287, 307, 322 (explaining regarding each of Plaintiff's claims that Defendants would have been unable to "obtain awards" for ineligible items and services absent Defendants' alleged conduct).

[4] In *Corey v. New York Stock Exchange*, the Sixth Circuit explained that a plaintiff's "claims constitute a collateral attack against the award even though [the plaintiff] is . . . requesting damages for the acts of wrongdoing rather than the vacation, modification or correction of the arbitration award." 691 F.2d 1205, 1213 (6th Cir. 1982). Similarly, in *Decker v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, the Sixth Circuit affirmed a district court's order dismissing the case because the "ultimate objective in this damages suit is to rectify the alleged harm [the plaintiff] suffered by

> The relief Gulf Petro seeks—**the award it believes it should have received, as well as costs, expenses, and consequential damages stemming from the unfavorable award it did receive**—shows that its true objective in this suit is to rectify the harm it suffered in receiving the unfavorable Final Award. . . . Though cloaked in a variety of federal and state law claims, Gulf Petro's complaint amounts to no more than a collateral attack on the Final Award itself.

Id. at 750 (emphasis added). The Fifth Circuit ultimately decided that the case was properly dismissed for lack of subject matter jurisdiction. *Id.* at 753.

So too here. The alleged harm in this case did not result when Defendants submitted items and services for payment under the NSA or when the IDR entities determined that those items or services were eligible for IDR. Rather, the alleged harm resulted from the impact that such submissions and decisions had on the IDR entities' ultimate payment determinations.[5] Plaintiff makes this clear in its sur-reply to Defendants' motion in which it states that Defendants' alleged "scheme has allowed HaloMD to wrongly obtain awards its clients' were never entitled to in the first place, while also causing [Plaintiff] to incur substantial economic harms as a result of the fees, costs, and time that must be (wrongly) allocated to the IDR process for these ineligible submissions." Docket No. 39 at 2 (citing Docket No. 2 (Complaint) at ¶ 12). Plaintiff's attempts to distance its claims and damages from the IDR awards is therefore unpersuasive. Further, the

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receiving a smaller arbitration award than she would have received in the absence of the chairperson's relationship with [the defendant]" and thus the plaintiff "did not follow the proper procedure for challenging her arbitration award under the FAA." 205 F.3d 906, 910–11 (6th Cir. 2000).

[5] The Court also notes that Plaintiff's interpretation of the statute would lead to untenable results. Assuming, *arguendo*, that Plaintiff were to prevail on its claims, the more than 42,000 IDR awards would remain intact. Thus, the predominant source of damages Plaintiff seeks would only serve to cancel out the amounts it would still owe the out-of-network healthcare providers pursuant to the awards. *Cf. Aetna Health Inc, et al. v. Radiology Partners, Inc., et al.*, No. 3:24-CV-1343 (M.D. Fla. Apr. 16, 2026) ("Allowing Aetna to recover for the IDR awards above what it otherwise would have paid would have the same effect as discarding the administrative process established by Congress."), ECF No. 105 at 9. This further demonstrates why the Plaintiff's claims are merely a collateral attack on the IDR awards.

collateral attack doctrine is even more clearly applicable where, as here, Plaintiff *is* attempting to relitigate issues previously decided by the IDR entities (*i.e.*, the eligibility of certain items and claims under the NSA).

Plaintiff's reliance on *Rein v. Providian Financial Corporation* is unpersuasive. Docket No. 39 at 3 (citing 270 F.3d 895, 902 (9th Cir. 2001)). There, the plaintiffs were debtors in separate Chapter 7 bankruptcy proceedings who owed a creditor various amounts in credit card debts. *Id.* at 897. One of the plaintiffs, Frenette, signed an agreement reaffirming the amount he owed the creditor, and the agreement was filed with the bankruptcy court. *Id.* at 898. The plaintiffs later filed suit against the creditor, alleging violations of the automatic stay and discharge provisions of the Bankruptcy Code. *Id.* The district court dismissed the case because, in part, the collateral attack doctrine prevented Frenette from attacking the approval of the reaffirmation agreement in a separate judicial proceeding. *Id.* However, the Ninth Circuit reversed as to Frenette because his "claims were never addressed by a prior order or judgment" and "no adverse proceeding ever was instituted against him." *Id.* at 902.

This case is distinguishable. Plaintiff does not dispute that HaloMD initiated IDR proceedings to resolve payment disputes for certain items and services, nor that the disputes were decided adversely to Plaintiff. In addition, a key issue running through all of Plaintiff's independent causes of action—the eligibility of certain items or services for IDR under the NSA—was decided by the IDR entities, and Plaintiff does not dispute that it had an opportunity to challenge eligibility throughout those proceedings.

Plaintiff also argues that it is "attacking Defendants' [allegedly] fraudulent scheme as a whole," which extends beyond any individual proceeding and is ongoing. Docket No. 39 at 3. However, Plaintiff has not cited any authority suggesting a complaint attacking many IDR or

arbitration awards simultaneously would be immune from the collateral attack doctrine.[6] Further, the Fifth Circuit rejected a similar argument regarding a "scheme" in *Gulf Petro*. 512 F.3d at 747 (rejecting the plaintiff's contention that "it has alleged a pattern of racketeering and conspiratorial conduct that, while arising in the context of arbitration proceedings, constitutes an independent violation of federal and state law and compels relief analytically distinct from vacatur.").

Plaintiff further contends that "IDR proceedings are not true arbitrations, so the collateral attack doctrine should not apply at all in this context." Docket No. 39 at 3. Plaintiff does not provide any authority for this argument. Rather, Plaintiff points to a series of characteristics that it believes distinguish IDR proceedings from arbitration, including that "arbitration is voluntary, pursuant to mutual agreement, and permits parties to define the scope of the proceedings." *Id.* at 6. None of these differences, however, changes the fact that Congress expressly prohibited judicial review of IDR awards and did not provide a private right of action to enforce or challenge such awards. In addition, Plaintiff exaggerates the distinction between IDR proceedings and arbitration. The Fifth Circuit has explained:

> Like judges and arbitrators, [Certified Independent Dispute Resolution Entities] are neutral arbiters of payment disputes with no stake in the underlying controversy.

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[6] Plaintiff's complaint contains numerous discussions of the alleged inefficiency and perceived unfairness of the IDR process. *See, e.g.*, Docket No. 2 (Complaint) at ¶ 3 (explaining that "[t]hese IDR Processes have not worked as intended."); *id.* at ¶ 67 (explaining that "it was estimated that there would be approximately 17,435 disputes submitted to the Federal IDR Process each year," but that "[t]hose estimates turned out to be a drastic underestimate."); *id.* at ¶ 69 (explaining that "providers [are] winning a disproportionate amount of these disputes" and the providers are receiving "unreasonably high rates"); *id.* at ¶ 72 (explaining that "[r]esearchers have commented that 'absent corrective action from policymakers, patients will ultimately bear the cost through higher premiums and the administrative overhead of an increasingly exploited arbitration process.' " (quoting Lawson Mansell & Sage Mehta, Niskanen Center, *New data shows No Surprises Act arbitration is growing healthcare waste*, (June 18, 2025), Available at: https://www.niskanencenter.org/new-data-shows-no-surprises-act-arbitration-is-growing-healthcare-waste/)). However, these complaints are not proper issues for the Court to resolve, and they further demonstrate why Plaintiff's complaints are more appropriately addressed to policymakers in Congress and the Texas legislature.

> They receive competing offers for payment, consider information supporting the offers, and then choose one of the offers, which is binding on the providers and insurers. 42 U.S.C. § 300gg-112(b)(4), (b)(5). CIDREs, in sum, function more or less exactly like arbitrators.

Guardian Flight, LLC v. Med. Evaluators of Tex. ASO, LLC, 140 F.4th 613, 623 (5th Cir. 2025). Thus, the Court is unpersuaded that the collateral attack doctrine applies with any less force to attacks on IDR awards based on the differences Plaintiff has identified.

Plaintiff finally argues that it seeks prospective relief and that it "cannot possibly 'collaterally attack' IDRs that have not yet been commenced." Docket No. 21 at 14; *see also* Docket No. 39 at 5 ("BCBSTX also seeks relief that is entirely different than that available through the IDR Processes, including an injunction prohibiting future misconduct."). While this may be true, Plaintiff's request for an injunction is a remedy rather than an independent cause of action. *See Doe v. Univ. of N. Tex.*, No. 4:18-CV-17, 2018 WL 6495084, at *9 n.10 (E.D. Tex. Nov. 20, 2018), *report and recommendation adopted sub nom. Jon Unt-Rs Doe v. Univ. of N. Tex.*, No. 4:18-CV-17, 2018 WL 6446469 (E.D. Tex. Dec. 10, 2018) (collecting cases and explaining that "Federal courts recognize an injunction is a remedy, not a separate claim or cause of action; a pleading can request injunctive relief in connection with a substantive claim, but a separately plead claim or cause of action for injunctive relief is inappropriate."). This is confirmed by Plaintiff's complaint, which states that Plaintiff "seeks an injunction prohibiting Defendants from continuing to submit false attestations and initiate Federal and State IDR Processes for claims, items, or services that are not eligible for IDR, or from seeking to enforce non-binding awards entered on items and services not eligible for IDR." Docket No. 2 (Complaint) at ¶ 341. Plaintiff's request for an injunction therefore does not constitute an independent cause of action and is inextricably intertwined with its other claims.

Based on the foregoing, Plaintiff's Claims I–VII with respect to Defendants' submission of items and services for Federal IDR are **DISMISSED WITH PREJUDICE** for lack of subject-matter jurisdiction.

B. The Texas Insurance Code's Limit on the Judicial Review of IDR Awards and Collateral Attack

The Court's analysis concerning the NSA and the federal IDR process, *supra* Section I.A.2, also applies to Plaintiff's causes of action related to the Texas IDR process. However, the parties' specific arguments related to the Texas IDR awards are addressed below.

1. The Texas IDR Process

Prior to the adoption of the NSA, the Texas legislature passed Senate Bill 1264 in 2019 to establish an "Out–of–Network Claim Dispute Resolution" process. Docket No. 2 (Complaint) at ¶¶ 51, 53 (citing, for example, Tex. Ins. Code §§ 1467.050 and 1467.081). The statute directs the Texas Commissioner of Insurance to "adopt rules, forms, and procedures necessary for the implementation and administration of the arbitration program." Tex. Ins. Code § 1467.082. The parties to a Texas IDR may agree on an arbitrator; otherwise the Commissioner will select one to preside over the dispute. *Id.* at § 1467.086(a).

The statute provides that "[t]he only issue that an arbitrator may determine under this subchapter is the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider." *Id.* at § 1467.083. The Texas Department of Insurance, rather than the arbitrator, is responsible for determining the eligibility of items and services for IDR. Docket No. 21 at 16 n.8 ("Instead, it is the TDI, not the TDI neutral, who determines eligibility." (citing Tex. Ins. Code § 1467.081)). An arbitrator's determination of the reasonable amount for the health care or medical services or supplies is binding. Tex. Ins. Code § 1467.089(a). "Not later than the 45th day after the date of an arbitrator's decision . . . a party not

satisfied with the decision may file an action to determine the payment due to an out-of-network provider." *Id.* at § 1467.089(b).

Unlike the NSA, Senate Bill 1264 does not limit judicial review of an arbitrator's decision to the mechanisms provided in the Federal Arbitration Act. Instead, the statute limits the reviewing court's determination to "whether the arbitrator's decision is proper based on a substantial evidence standard of review." *Id.* at § 1467.089(a).

2. Analysis

Defendants argue that, similar to federal IDR awards, Texas IDR awards are binding arbitrator decisions and judicial review is strictly limited. Docket No. 15 at 18. Specifically, Defendants note that a dissatisfied party has 45 days from the date of the arbitrator's decision to file a suit for judicial review and that " 'determining the amount that an out-of-network provider should be paid by an insurer is a technical exercise to be performed by a subject-matter expert—not an issue to be decided by a jury of laymen.' " *Id.* (quoting *Tex. Med. Res., LLP v. Molina Healthcare of Tex., Inc.*, 659 S.W.3d 424, 436 (Tex. 2023)). In addition, Defendants contend that "[r]egardless of who decides eligibility, that decision necessarily precedes and leads to the Texas IDR arbitrator's payment decision." Docket No. 28 at 9. According to Defendants, allowing Plaintiff "to seek effective vacatur" of the Texas IDR awards based on eligibility or other grounds would "eviscerate" the statute's limitations on judicial review. *Id.* at 9–10.

Plaintiff argues that "[n]o part of the arbitrator's decision under Section 1467.088 relates to eligibility," Docket No. 21 at 16. Further, Plaintiff contends that, under Defendants' interpretation, "the statute's text restraining the time bar to a[n arbitrator's] 'decision under Section 1467.088' would be rendered superfluous." *Id*. In any event, Plaintiff argues it is "not challenging whether the awarded amount, in any IDR, was 'the closest to the reasonable amount for the services or supplies.' " Docket No. 39 at 7.

The Court agrees with Defendants. The Texas Insurance Code gives a dissatisfied party 45 days to file a suit challenging an arbitrator's determination. Tex. Ins. Code § 1467.089(b). Even if the dissatisfied party files such a case as allowed under Section 1467.089(b), the reviewing court's determination is limited to "whether the arbitrator's decision is proper based on a substantial evidence standard of review." *Id.* at § 1467.089(a). The decision referred to in Section 1467.089(b) is the arbitrator's determination of "the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider." *Id.* at § 1467.083.

As with Plaintiff's claims related to the federal IDR awards, Plaintiff's claims related to Defendants' alleged conduct in the Texas IDR process constitute collateral attacks on the Texas IDR awards. While the Texas Insurance Code does not limit judicial review in the same manner as the NSA, it (1) limits the scope of what the reviewing court may consider (*i.e.*, the arbitrator's decision), and (2) prescribes the standard of review that the court must apply. *Id.* at § 1467.089(c). If the Court were to conclude that the items and services submitted for payment by Defendants were ineligible, then the arbitrators' decisions about the reasonable amounts owed would necessarily be called into question. As explained with regard to the federal IDR process, *supra* Section I.A.2, the Court is unpersuaded that the collateral attack doctrine does not apply simply because Plaintiff's claims indirectly challenge thousands of awards rather than one particular award.

Plaintiff's argument that Defendant's interpretation of the Texas Insurance Code would render the 45-day limit superfluous is unpersuasive. The Texas legislature explicitly provided a limited private right of action for a dissatisfied party to challenge the arbitrator's determination of the reasonable amount for the items and services at issue. It further gave the dissatisfied party 45 days to exercise that right. The logical inference from the Texas legislature's limitation on judicial

review of the Texas IDR awards is that it did not intend to provide a mechanism for a dissatisfied party to challenge the award on other grounds, including eligibility. Indeed, it is Plaintiff's interpretation that would render the Texas legislature's limits on judicial review superfluous because it would allow a dissatisfied party to challenge a Texas IDR award for any reason and without a time constraint so long as the dissatisfied party did not challenge the reasonableness of the award. Plaintiff offers no evidence that this was the Texas legislature's intent.

Based on the foregoing, Plaintiff's Claims I–VII with respect to Defendants' submission of items and services for Texas IDR are **DISMISSED WITH PREJUDICE** for lack of subject-matter jurisdiction.

C. Defendants' Remaining Arguments

Because the Court concludes that it lacks subject matter jurisdiction pursuant to the NSA, SB 1264, and the collateral attack doctrine, it does not reach the merits of Defendants' arguments regarding Article III standing, the *Noerr-Pennington* Doctrine, and Rules 9(b) and 12(b)(6).

II. Defendants' Motion to Stay Discovery Pending Resolution of Defendants' Rules 12(b)(1) and 12(b)(6) Motions to Dismiss (Docket No. 31)

Defendants request that the Court stay discovery pending the resolution of their motion to dismiss. Docket No. 31 at 1. However, because the instant Order disposes of the motion to dismiss (Docket No. 15), Defendants' request is no longer applicable. Thus, the motion to stay (Docket No. 31) is **DENIED-AS-MOOT**.

CONCLUSION

For the foregoing reasons, Defendants HaloMD, LLC, Alla LaRoque, and Scott LaRoque's Joint Motions to Dismiss Pursuant to Rules 12(b)(1) and 12(b)(6) and Related Request for Judicial Notice of Public Documents (Docket No. 15) is **GRANTED**, and Defendants' Motion to Stay

Discovery Pending Resolution of Defendants' Rules 12(b)(1) and 12(b)(6) Motions to Dismiss (Docket No. 31) is **DENIED-AS-MOOT**.

So ORDERED and SIGNED this 22nd day of May, 2026.

ROBERT W. SCHROEDER III
UNITED STATES DISTRICT JUDGE