No. 26-2355

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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

Plaintiffs-Appellants,

v.

HALOMD, LLC, *et al.*,

Defendants-Appellees.

On Appeal from the United States District Court for the
Central District of California,
No. 8:25-cv-01467-KES
The Honorable Karen E. Scott, Magistrate Judge

APPELLANTS' OPENING BRIEF

Martin J. Bishop
Jason T. Mayer
Alexandra M. Lucas
CROWELL & MORING LLP
300 N. LaSalle Drive. Suite 2500
Chicago, IL 60654
Telephone: 312-321-4200

Jared Levine
CROWELL & MORING LLP
Two Manhattan West
375 Ninth Ave.
New York, NY, 10001
Telephone: 212-223-4000

Emily T. Kuwahara (SB# 252411)
CROWELL & MORING LLP
EKuwahara@crowell.com
515 S. Flower St., 41st Floor
Los Angeles, CA 90071
Telephone: 213-622-4750
Facsimile: 213-622-2690

Attorneys for Plaintiffs and Appellants Anthem Blue Cross Life and Health Insurance Company, and Blue Cross of California d/b/a Anthem Blue Cross

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INTRODUCTION

As part of a complex fraud and racketeering scheme, Defendants-Appellees[1] extract millions of dollars in unauthorized payments by submitting fraudulent disputes through the independent dispute resolution ("IDR") process created by the No Surprises Act ("NSA"). Their scheme targets Anthem,[2] the employer-sponsored health plans it administers, and thousands of California employees and consumers covered by Anthem health plans. Seeking to enjoin Defendants' scheme and recover damages, Anthem sued Defendants under the Racketeer Influenced and Corrupt Organizations ("RICO") Act and the Employee Retirement Income Security Act ("ERISA"). The District Court dismissed Anthem's suit after erroneously holding that the NSA stripped federal courts of jurisdiction to hear Anthem's claims. That conclusion defies the text and structure of the NSA and disregards controlling Supreme Court precedent. This Court should reverse.

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[1] Defendants-Appellees are HaloMD, LLC and its principal Alla LaRoque; MPOWERHealth Practice Management, LLC and its principal Scott LaRoque; affiliated out-of-network intraoperative neuromonitoring providers (Bruin Neurophysiology, PC; iNeurology, PC; N Express, PC; and North American Neurological Associates, PC), and out-of-network Sound Physicians entities (Sound Physicians Emergency Medicine of Southern California, PC; Sound Physicians Anesthesiology of California, PC) providing emergency medicine and anesthesiology services (collectively, "Defendants", with out-of-network providers collectively, "Provider Defendants"). 3-ER-384, 3-ER-387 (p.1 & ¶¶ 6-8).

[2] Plaintiffs-Appellants are Anthem Blue Cross Life and Health Insurance Company, and Blue Cross of California (collectively, "Plaintiffs" or "Anthem").

Congress enacted the NSA to end a predatory practice: out-of-network providers imposing surprise medical bills on patients who have no meaningful ability to treat with an in-network provider. *See* H.R. Rep. No. 116-615 (2020), at 52-53. Surprise bills charge "inflated," "non-market-based rates," with "devastating financial impacts on Americans and their ability to afford needed health care." *Id.* at 52, 57. The NSA eliminated surprise billing in many contexts, but the attack on Americans' ability to afford needed health care has continued.

Unable to directly exploit patients with surprise medical bills, out-of-network providers now seek to recover grossly inflated rates through the NSA's IDR process. In the cursory, "baseball-style" IDR process, the provider and the patient's health plan each submit blind "offers" to private companies known as certified IDR entities ("IDREs"), and the IDRE selects one party's offer as the payment determination. Defendants have seized on that process to engage in widespread fraud. By statute, the IDR process is available only for "a qualified IDR item or service," subject to strict eligibility criteria. Congress designed the process to handle 22,000 disputes per year assuming, among other things, that providers would act in good faith and submit only eligible disputes for resolution. But IDR has proven extraordinarily lucrative: providers prevail in nearly 9 out of 10 payment determinations, with median recoveries for some services at 25 times the median in-network rates. This creates a powerful incentive to submit as many

disputes as possible, regardless of eligibility.

Defendants have seized on the IDR process to engage in widespread fraud, exploiting structural features of the IDR system that make it uniquely susceptible to fraud. To initiate IDR, parties self-certify eligibility by providing attestations through an online screening tool (the "IDR Portal"). Defendants deliberately game the IDR system at industrial scale by (1) submitting knowingly false attestations to unlock the IDR process for ineligible disputes, (2) weaponizing artificial intelligence ("AI") to flood a system designed for 22,000 disputes per year with claims faster than anyone can police them, and (3) cashing in on their fraudulent disputes at rates far beyond what any competitive market would bear. For example, on a single day in May 2024, Defendants initiated 126 IDR proceedings against Anthem. Ninety-seven were ineligible. Yet Anthem was ordered to pay $204,000 in additional reimbursement on 65 of those ineligible disputes, plus over $30,000 in IDR fees. The result is devastating: millions of dollars siphoned from Anthem, the employer-sponsored health plans it administers, and ultimately from the Californians whose rising healthcare costs fund Defendants' scheme.

Congress expressly granted Anthem a right to judicial relief for this misconduct. The RICO Act provides that "[a]ny person injured in his business or property by reason of" racketeering activities involving wire fraud and other unlawful conduct "may sue therefor in any appropriate United States district court

and shall recover threefold the damages he sustains and the cost of the suit[.]" 18 U.S.C. § 1964(c). Congress enacted the RICO Act to combat precisely the kind of systematic, enterprise-driven fraud at issue in this case. And Congress further incorporated the NSA into ERISA, an act that expressly authorizes fiduciaries like Anthem to bring "[a] civil action . . . to enjoin any act or practice which violates any provision of this subchapter." 29 U.S.C. § 1132(a)(3). Anthem brought RICO, ERISA, and state law claims to recover damages and enjoin Defendants' scheme.

The District Court dismissed the entire Amended Complaint without leave to amend, holding that the NSA implicitly stripped it of jurisdiction. Its conclusion was grounded in the Departments'[3] post-legislative regulations and policy concerns rather than the NSA's text or controlling Supreme Court precedent.

The District Court erred. The NSA's narrow "Judicial Review Provision," relied upon by the District Court, limits review only of "*[a] determination of a certified IDR entity under subparagraph (A)*." 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II) (emphasis added). Subparagraph (A) addresses a single task: the IDRE shall "select one of the offers submitted [by the parties] to be the amount of payment for such item or service[.]" 42 U.S.C. § 300gg-111(c)(5)(A). Congress

[3] The "Departments" responsible for implementing the NSA include the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and Treasury.

thus limited judicial review to the IDRE's payment determination; that is the only "determination of a certified IDR entity" identified in subparagraph (A), and the only IDRE determination contemplated anywhere in the broader statutory scheme. 42 U.S.C. § 300gg-111(c)(5)(E)(ii). Defendants' fraud and racketeering scheme involves the mass submission of false eligibility attestations, which are distinct from and precede IDRE payment determinations. Congress did not clearly and convincingly bar judicial review of Defendants' scheme.

The District Court noted that the Departments—not Congress—delegated eligibility reviews to IDREs through post-legislative regulations. Those decisions are neither covered in "subparagraph (A)" nor assigned to IDREs by the statute. Because Congress never delegated eligibility reviews to IDREs, IDRE eligibility decisions cannot possibly fall within the NSA's Judicial Review Provision. The District Court erred by concluding otherwise, improperly treating a regulatory assignment of duties as equivalent to a congressionally enacted limitation on judicial review. *Kucana v. Holder*, 558 U.S. 233, 248, 252 (2010), forecloses that approach: agencies cannot, through regulation, limit the jurisdiction of the federal courts.

This Court should reverse the judgment and allow this case to proceed.

JURISDICTIONAL STATEMENT

The District Court had subject matter jurisdiction over Anthem's federal RICO and ERISA claims under 28 U.S.C. § 1331 and supplemental jurisdiction over Anthem's state law claims under 28 U.S.C. § 1367.

This Court has jurisdiction under 28 U.S.C. § 1291 and 28 U.S.C. § 636(c)(3). Anthem appeals from the final judgment of the United States District Court, entered by a magistrate judge before whom the parties did not object to proceed under 28 U.S.C. § 636. 3-ER-479; 3-ER-569 (Text of Dkt. No. 37).

Judgment was entered on April 9, 2026, following a final order dismissing Anthem's First Amended Complaint in its entirety without leave to amend. 1-ER-002-024. Anthem timely filed a Notice of Appeal on April 13, 2026. 3-ER-550.

ISSUES PRESENTED

1. Whether the District Court erred in holding that the NSA strips federal courts of jurisdiction over RICO and ERISA claims challenging a large-scale fraud scheme built on the mass submission of statutorily ineligible IDR disputes, where there is a strong presumption of judicial review that can only be overcome by clear and convincing indications that Congress meant to foreclose review.

2. Whether, in the alternative, the District Court erred in dismissing Anthem's claims because the NSA permits judicial review of IDR payment determinations in a "case described in" FAA § 10(a)(1) and (4), and Anthem's

claims fall within (i) § 10(a)(4) because the IDREs exceeded their authority by deciding payment disputes that were statutorily ineligible for the IDR process, and (ii) FAA § 10(a)(1) because the IDR awards were procured through Defendants' fraudulent eligibility attestations.

3. Whether, in the alternative to the first two assignments of error, the District Court erred in dismissing Anthem's vacatur claim, which falls within the types of cases that the court may review under the Judicial Review Provision.

4. Whether Anthem should be permitted to amend its complaint.

5. Whether the alternative arguments for dismissal raised by Defendants lack merit.

STATUTORY AND REGULATORY PROVISIONS

Pursuant to Ninth Circuit Rule 28-2.7, copies of pertinent statutes and regulations appear in the attached addendum.

STATEMENT OF THE CASE[4]

A. Defendants' Fraudulent Scheme Relies on False Attestations to Access a Highly Lucrative Dispute Resolution Process.

The NSA created an IDR process through which out-of-network providers could dispute payments from the patient's health plan for a limited number of

[4] As this appeal is taken from a judgment following a motion to dismiss, the allegations in the Amended Complaint are presented as true and must be construed in the light most favorable to Anthem. *See Knievel v. ESPN*, 393 F.3d 1068, 1072 (9th Cir. 2005).

qualifying medical services. 3-ER-385-386 (¶ 2). Congress expected the IDR process "to tether payment rates for surprise out-of-network bills directly to market-based prices" and "curb[ ] cost growth relative to the status quo." H.R. Rep. No. 116-615 at 57. But due to several factors,[5] the IDR process has had the opposite effect, producing results that overwhelmingly favor providers; they prevail in nearly 9 out of every 10 payment determinations, with median awards that are 459% of market rates. 3-ER-405-407 (¶¶ 82-90). The success rate and magnitude of IDR awards creates a powerful financial incentive for providers to stay out-of-network and channel as many disputes as possible into the IDR system, regardless of whether the dispute is eligible for IDR. *See id.*

Defendants did exactly that. 3-ER-406-407 (¶¶ 86, 90). Beginning no later than January 2024, they launched a three-part scheme to defraud Anthem and the

[5] For example, because IDREs are compensated on a per dispute basis, and "nearly all of the cases are initiated by providers," "[i]t is within reason to suspect that [IDREs] are inducing more cases by ruling generously for providers." Benjamin Chartock and Christopher Whaley, *Arbitration and Negotiated Prices: Evidence from Insurer-Doctor Disputes* at 4, Brown Univ. (Jan. 22, 2026), https://bit.ly/4uuaRnq. IDREs also claim that the benchmark rate Congress directed they use when selecting out-of-network payment determinations is not actually relevant to determining out-of-network rates. *See Independent Dispute Resolution Program Performance: An Evidence-Based Review of Volume, Eligibility, and Payment Outcomes*, Coalition of Independent Dispute Resolution Entities, at 7, available at https://bit.ly/4wzpM1i. The reasons for exorbitant IDRE payment determinations are not at issue in this case; they merely provide an incentive for Defendants to submit fraudulent IDR process disputes.

employer-sponsored plans it administers using the interstate wires. 3-ER-392, 406, 469 (¶¶ 33, 86, 364-65). First, Defendants submit thousands of knowingly false eligibility attestations to unlock the IDR process for their ineligible disputes. 3-ER-408-410 (¶¶ 96, 98-102). Second, they conceal their scheme, deploying AI to flood the IDR system with massive volumes of disputes so that health plans cannot identify and object to their ineligible disputes within the process's narrow timeframes. 3-ER-387, 407-408, 411-413 (¶¶ 6, 92-93, 105-118). Third, they cash in, demanding grossly inflated payments on their ineligible disputes and obtaining awards at rates far exceeding what Defendants could command in a competitive market. 3-ER-414-415 (¶¶ 119, 124). Through this scheme, Defendants extract millions of dollars in unauthorized payments and impose enormous costs on Anthem, the employer-sponsored plans that it administers, and ultimately California patients. 3-ER-385-388 (¶¶ 1-11).

B. The NSA's Statutory Scheme Creates a Framework for Resolving Surprise Billing Disputes over a "Qualified IDR Item or Service."

1. Congress passed the NSA to protect patients from exploitative, surprise medical bills.

Before the NSA, out-of-network providers exploited patients who had no choice of provider (*e.g.*, in emergencies, or when receiving ancillary services like anesthesiology at an in-network facility) by hitting them with "surprise bills." *See* H.R. Rep. No. 116-615, at 47, 51-53, 57; 3-ER-394 (¶ 39). These surprise medical

bills demanded payment at "inflated," "non-market-based rates" known as "billed charges," with "devastating financial impacts on Americans and their ability to afford needed health care." H.R. Rep. No. 116-615, at 52, 57; 3-ER-394 (¶ 39).

Congress enacted the NSA to protect consumers from these surprise medical bills. H.R. Rep. No. 116-615, at 47, 51-52; 3-ER-394 (¶ 41). Effective January 1, 2022, the NSA bans providers from issuing surprise medical bills to patients for three categories of out-of-network care: (1) emergency services; (2) non-emergency services by out-of-network providers at in-network facilities; and (3) air ambulance services. *See* 42 U.S.C. §§ 300gg-131, 300gg-132, 300gg-135; 3-ER-395 (¶ 42).

2. In the NSA, Congress created a framework for resolving surprise billing disputes over a "Qualified IDR Item or Service."

With patients out of the picture for collections, Congress created a dispute resolution framework for out-of-network providers and health plans to dispute the amount of money health plans remit to providers. *See* H.R. Rep. No. 116-615, at 56-58; 3-ER-395 (¶ 43). Congress intended for this framework "to tether payment rates for surprise out-of-network bills directly to market-based prices, curbing cost growth relative to the status quo." H.R. Rep. No. 116-615, at 57.

Under this framework, prior to initiating IDR, the provider submits a bill for its services charging a rate of its choosing, and the health plan pays the amount

covered by and consistent with the patient's plan. 3-ER-395 (¶ 44). If the provider is dissatisfied and disputes the health plan's reimbursement rate for NSA-covered services, it initiates a thirty-day open negotiation period. 42 U.S.C. § 300gg-111(c)(1)(A); 3-ER-392-396 (¶ 45). If negotiations fail, the provider may initiate the IDR process within four business days by submitting a form through the online IDR Portal. 42 U.S.C. § 300gg-111(c)(1)(A)-(B);[6] 3-ER-395-396 (¶¶ 45-46).

Congress limited IDR to only "qualified IDR item[s] or service[s]," subject to strict eligibility criteria. 42 U.S.C. § 300gg-111(a)(1), (b)(1), (c)(1), (2), (5); 3-ER-396-397 (¶ 48). Among other requirements, the patient must have group or individual health insurance coverage; government plans like Medicare or Medicaid are ineligible. 42 U.S.C. § 300gg-111(a)(1), (b)(1); 3-ER-396-397 (¶ 48). The dispute must not be governed by a state surprise billing law known as a "specified state law." 42 U.S.C. § 300gg-111(a)(3)(H)-(K), (c)(1); 3-ER-396-397 (¶¶ 48-49). And the provider must have initiated and exhausted open negotiations within prescribed timeframes before invoking IDR. 42 U.S.C. § 300gg-111(c)(1), (2), (5); 3-ER-396-397 (¶¶ 48-49). If any requirement is unmet, the dispute is statutorily ineligible for the IDR process. 42 U.S.C. § 300gg-111(c); *see* Federal Independent Dispute Resolution Operations, 91 Fed. Reg. 33900-01, 33933, 33943, 33945

[6] The Portal and Notice of IDR Initiation is available at https://nsa-idr.cms.gov/paymentdisputes/s/.

(June 4, 2026) ("[C]ertified IDR entities are statutorily prohibited from making payment determinations for items and services that are not subject to the No Surprises Act . . . ."); 3-ER-396-397 (¶ 48).

3. The NSA specifies that IDREs are selected to make a payment determination.

Once IDR is initiated, a private company known as an IDRE is selected or appointed to make a payment determination for disputes over "a qualified IDR item or service." 42 U.S.C. § 300gg-111(c)(4), (c)(5)(A); 3-ER-402-403 (¶ 72). Although sometimes called arbitration, the IDR process bears no resemblance to traditional arbitration; there are no evidentiary rules, no discovery, no hearings, no testimony under penalty of perjury, and no procedures by which either party may view (let alone cross-examine or rebut) the other side's evidence or arguments. *See* 42 U.S.C. § 300gg-111(c)(5); 3-ER-403-404 (¶¶ 74-77). Instead, the IDR process follows a "baseball-style" or "final offer" format: each side submits a single blind payment "offer"—without seeing the other side's offer—and the IDRE must select one party's offer as the payment determination; it cannot split the difference or fashion its own award. *Id.* § 300gg-111(c)(5)(A)-(B); 3-ER-403 (¶¶ 74-76). The process is conducted privately, without the public transparency mechanisms that may facilitate the detection of fraud or other misconduct. 3-ER-402-406 (¶ 84).

In the NSA, Congress specified that the IDRE's task is to "select one of the offers submitted" as "the amount of payment" for the dispute, as described under the subparagraph titled "Payment determination":

> **(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. § 300gg-111(c)(5)(A).

In choosing between offers, the NSA requires IDREs to consider a benchmark called the Qualifying Payment Amount ("QPA"), which approximates the plan's median in-network rate for that service, and several "additional circumstances," such as the provider's quality, market share, case mix, and scope of services. 3-ER-403 (¶ 76); 42 U.S.C. § 300gg-111(c)(5)(C). The IDRE cannot consider, among other things, the provider's billed charges. 42 U.S.C. § 300gg-111(c)(5)(D) (IDREs "shall not consider . . . the amount that would have been billed by such provider or facility . . . ."); 3-ER-403 (¶ 76).

Through the text of the NSA, Congress assigned IDREs the singular task of making these payment determinations. *See* 42 U.S.C. § 300gg-111(c)(5)(A). When directing the Departments to promulgate regulations,[7] Congress specified that IDREs "determine[] . . . the amount of payment"—nothing more. 42 U.S.C. § 300gg-111(c)(2)(A). The NSA's IDRE certification requirements likewise focus exclusively on the capacity to evaluate and select payment offers—not to adjudicate eligibility. *See* 42 U.S.C. § 300gg-111(c)(4).

Moreover, through the text of the NSA, Congress provided that an IDRE collects a fee only when it issues a payment determination "under subparagraph (A)" (paid by the losing party) or when the parties settle after IDRE selection (split equally).[8] 42 U.S.C. § 300gg-111(c)(5)(F); 3-ER-404-405 (¶¶ 79-80, 116). By statute, IDREs are not compensated for performing any other function. 3-ER-404-405, 413 (¶¶ 79-80, 116); 42 U.S.C. § 300gg-111(c)(5)(F).

4. The NSA provides for limited judicial review of individual IDRE payment determinations.

The NSA states that in the absence of a fraudulent claim or misrepresentation of facts to the IDRE, an IDRE's payment determination is

[7] The Departments implement and enforce the NSA. *See* 3-ER-398, 401-02 (¶¶ 53 n.9, 67).

[8] The only other authorized fee is a non-refundable "administrative fee" paid to the government, not to IDREs, for "carrying out the IDR process." 42 U.S.C. § 300gg-111(c)(8).

"binding" and not subject to judicial review, with an exception for cases described in certain paragraphs of the FAA:

> 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* [the Federal Arbitration Act ("FAA")].

42 U.S.C. § 300gg-111(c)(5)(E)(i) (the "Judicial Review Provision") (emphasis added); 3-ER-404 (¶¶ 77-78).

Subparagraphs (1) through (4) of section 10(a) of the FAA in turn describe four types of cases:

> **(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); 3-ER-403 (¶ 78).

C. The Departments' Regulatory Scheme Relies on Provider Self-Certification and Limited IDRE Review to Police Eligibility.

Although the NSA limits the IDR process to disputes over a "qualified IDR item or service," the statute itself does not specify how the Departments enforce this statutory limitation. *Cf.* 91 Fed. Reg. at 33942 (The NSA "does not contemplate an eligibility determination process[.]"). The Departments estimated that the IDR process would adjudicate about 22,000 disputes per year between good faith participants. 3-ER-411 (¶ 107) (citing 86 Fed. Reg. 55980, 56068, 56070 (Oct. 7, 2021)). With that assumption, the Departments promulgated regulations to police eligibility that rely on (1) self-certification by initiating parties, and (2) the IDRE's review of the initiating party's notice of IDR initiation (which includes its self-certification of eligibility) to determine whether the IDR process applies. *See* 45 C.F.R. § 149.510(b)(2)(iii) (2024)[9]; 3-ER-398 (¶ 53).

To initiate IDR, providers submit the dispute through the federal IDR Portal, where they answer "Qualification Questions" and submit a signed eligibility attestation confirming that "to the best of my knowledge . . . the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) within the scope of the Federal IDR process." 3-ER-398-401 (¶¶ 53-64); *see* 45 C.F.R. §

[9] The regulations were revised effective August 3, 2026, resulting in the renumbering of certain subparagraphs. *See* 91 Fed. Reg. at 34070. This brief cites the 2024 version of the regulations in effect at the time the District Court rendered its decision, unless otherwise noted.

149.510(b)(2)(iii)(A)(6). This attestation is provided under oath to multiple government agencies, including HHS. *See id.* Throughout this process, the IDR Portal reminds providers of all eligibility criteria; if a provider enters an answer rendering the dispute ineligible, the portal immediately blocks submission. 3-ER-399-401 (¶¶ 55-62). While the Portal and attestation requirement may prevent parties from inadvertently submitting ineligible disputes, the system cannot prevent a provider from knowingly submitting false attestations. 3-ER-409-410 (¶¶ 100, 102). Once a provider attests that its dispute is eligible, the Departments automatically transmit the dispute to the IDRE. 3-ER-413 (¶ 116).

Upon receipt, the IDRE reviews the notice of IDR initiation, which includes the initiating party's self-certification, to determine whether the Federal IDR process applies. 45 C.F.R. § 149.510(c)(1)(v); 3-ER-403 (¶ 73). The NSA only compensates IDREs for their role in selecting a payment determination; IDREs receive no compensation for time spent evaluating eligibility, and they do not receive any compensation at all for disputes they conclude are ineligible for IDR. 3-ER-404-405, 413 (¶¶ 79-80, 116); 42 U.S.C. § 300gg-111(c)(5)(F); *see* Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act, CMS ("[C]ertified IDR entities may not collect fees for those cases that they ultimately determine are ineligible for the Federal IDR process.").

The regulations state the non-initiating party must assert eligibility objections to HHS through the IDR Portal within three business days. 45 C.F.R. § 149.510(c)(1)(iii). But the regulations do not require IDREs to consider those objections while reviewing eligibility. *See id.* § 149.510(c)(1)(v).[10] Nor do they provide for hearings, written decisions addressing eligibility, or any adversarial process by which the non-initiating party may present evidence or challenge the initiating party's attestation. *See id.*

D. The IDR Process Overwhelmingly Favors Providers, Incentivizes Payment Determinations on Ineligible Disputes, and Has Been Exploited by a Concentrated Minority of Filers at Enormous Cost to Health Plans.

IDR payment determinations overwhelmingly favor providers. *See supra* at n.5. At the time the Amended Complaint was filed, providers were prevailing in 85% of all payment determinations, at a median rate exceeding 459% of in-network market rates for identical services. 3-ER-405 (¶¶ 82-84).

Responding to this financial incentive, Defendants and a small number of other providers and IDR middlemen have flooded the IDR system with a volume of disputes that vastly exceeds the Departments' original estimate of 22,000 IDR disputes per year. 3-ER-411 (¶ 107) (citing 86 Fed. Reg. at 56068, 56070). By 2024, actual volume exceeded 2.6 million annually—nearly 120 times that

[10] New regulations, effective August 3, 2026, now require IDREs to consider the IDR initiation response. 45 C.F.R. § 149.510(c)(2)(i) (2026).

projection—and has increased approximately sevenfold from the second half of 2022 to the end of 2025. 2-ER-168 (AHIP Amicus Brief).

A handful of entities drive this explosive volume of disputes. In the last six months of 2024, the top ten initiating parties accounted for approximately 71% of all disputes, and the top three accounted for 43%. 3-ER-411 (¶ 109). Defendant HaloMD—the key operator through which Defendants flood the IDR system—alone initiated 134,318 disputes in that period, averaging 764 per day. 3-ER-411, 421, 433 (¶¶ 110, 151, 210).

The IDRE compensation structure compounds these problems by directly incentivizing IDREs to reach payment determinations on ineligible disputes. 3-ER-405 (¶ 80). Unlike a judge, who is paid on salary, or an arbitrator, who is compensated for his or her time regardless of outcome, the Departments delegated the task of reviewing eligibility questions to IDREs, which are *only compensated* if they find a dispute is eligible for IDR and proceed to a payment determination. 3-ER-404-405, 413 (¶¶ 79-80, 116); 42 U.S.C. § 300gg-111(c)(5)(F); *see* Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act, CMS.

As a predictable result of these financial incentives, IDREs *routinely* issue payment determinations for ineligible disputes—approximately 15% of all disputes, amounting to several hundred thousand annually. 2-ER-171 (AHIP

Amicus Brief). The Departments acknowledge that erroneous eligibility decisions are systemic, urging IDREs to "reduce errors" and institute "robust quality assurance programs to verify dispute eligibility and review payment determinations." 2-ER-268 (Federal IDR Technical Assistance for Certified IDR Entities and Disputing Parties (June 2025)). But the Departments designed IDR regulations for good faith participants, not those willing to commit fraud and game the system for access to the lucrative IDR process.

E. Anthem's Lawsuit Seeks to Obtain Damages from and Enjoin Defendants' Large-Scale Racketeering Scheme.

On July 7, 2025, Anthem filed its action against Defendants. 3-ER-480. The parties stipulated to Anthem's filing of an Amended Complaint (3-ER-473-478), and on October 17, 2025, Anthem filed its operative Amended Complaint (3-ER-384).

As detailed in the Amended Complaint, Defendants executed their scheme through two overlapping RICO enterprises—the "LaRoque Family Enterprise" and the "Sound Physicians Enterprise"—both sharing HaloMD as their common submission agent. 3-ER-406-408 (¶¶ 86-89, 92-93). The Provider Defendants perform services to generate claims that HaloMD uses to flood the IDR system with ineligible disputes. *E.g.*, 3-ER-421, 424-425 (¶¶ 148-150,164, 168-209). By using AI and other automated tools, HaloMD submits a massive number of disputes and profits by taking a commission on the amounts recovered through the

IDR process. 3-ER-421-423 (¶¶ 151-154, 157).

Through their scheme, Defendants submit disputes they know are ineligible, including services governed by California's state surprise billing laws, services for which no open negotiation was conducted, services involving Medicaid or Medicare beneficiaries, and services for which coverage was denied. 3-ER-407 (¶ 91). Approximately 47% of Defendants' disputes that reached a payment determination were categorically ineligible for IDR. 3-ER-416 (¶ 128). Defendants know these disputes are ineligible from patients' insurance cards, Anthem's explanations of payment, Anthem's responses during open negotiations, the IDR Portal's own screening questions, and Anthem's direct eligibility objections after IDR initiation. 3-ER-409-410 (¶¶ 98-101). Yet Defendants falsely attest that each dispute involves "qualified item(s) and/or service(s) within the scope of the Federal IDR process." 3-ER-408, 410 (¶¶ 96, 102). And Defendants misrepresent that mandatory open negotiations took place when, in fact, they did not. 3-ER-409-410, 427-429 (¶¶ 100-102; 173-182); 2-ER-109-110.

By submitting massive numbers of these ineligible disputes simultaneously, Defendants exploit the narrow procedural windows—three business days for Anthem to object, thirty business days for IDREs to issue payment determinations—and strategically overwhelm Anthem and the IDR system to prevent timely objections and push ineligible disputes through to payment

determinations. 3-ER-387, 407-408, 411-413 (¶¶ 6, 92-93, 105-118). In total, from January 2024 to August 2025, Defendants initiated at least 1,500 IDR proceedings comprising more than 2,000 separate services against Anthem. 3-ER-415-416 (¶ 127). On a single day in May 2024, Defendants initiated 126 IDR disputes against Anthem, more than 75% of which were ineligible. 3-ER-412 (¶ 112).

To cash in on these ineligible disputes, Defendants submit grossly inflated payment demands, often exceeding even their own "inflated," "non-market-based" billed charges*, and they frequently prevail.* 3-ER-414-415 (¶ ¶ 119, 124). Across more than 380 disputes, Defendants' payment offers exceeded their own billed charges by more than $1.5 million; in the approximately 240 such disputes where Defendants prevailed, Anthem was ordered to pay over $980,000 above those already-inflated charges. 3-ER-415 (¶ 124). In one proceeding, Anthem was ordered to pay 103 times the qualifying payment amount on a single untimely dispute. 3-ER-427 (¶ 172). In another, Anthem was ordered to pay more than six times the billed amount for a service that the patient's plan did not even cover. 3-ER-432 (¶ 205). And in another, Defendants secured payment on an ineligible Medicaid claim at a rate over 4,200% higher than the applicable Medicaid rate. *See, e.g.*, 3-ER-438 (¶ 235).

The Amended Complaint alleges violations of two federal RICO Act provisions, a claim for equitable relief for ERISA-governed plans, and related state

law claims for fraudulent misrepresentation, negligent misrepresentation, and violation of California's Unfair Competition Law (Bus. & Prof. Code § 17200). 3-ER-440-470 (¶¶ 249-282, 283-354, 360-367). It also seeks declaratory and injunctive relief, and in the alternative, vacatur of IDR determinations on grounds of fraud and that the IDREs exceeded their authority by issuing payment determinations for ineligible disputes. 3-ER-468, 470 (¶¶ 356-359, 368-371).

F. The District Court Grants Defendants' Motions to Dismiss the Amended Complaint.

Defendants each filed motions to dismiss and a motion to strike under California's anti-SLAPP laws. *See* Dkt. Nos. 68, 69, 72, 73, 74, 76, 77, 78.

After holding a hearing, the District Court dismissed Anthem's Amended Complaint in its entirety without leave to amend. 1-ER-024; 2-ER-074. The decision rested on three principal grounds.

The District Court first addressed Anthem's alternative claim for vacatur of individual IDR payment determinations, dismissing the claim under Rule 12(b)(6) on the basis that Anthem's allegations did not satisfy FAA § 10(a)(1) or § 10(a)(4). 1-ER-016-019.

As to § 10(a)(1), which permits judicial review where "the award was procured by . . . fraud," the District Court held that because Anthem knew about and objected to Defendants' false attestations during the IDR proceedings in the examples listed in the Amended Complaint, the fraud was "discovered and brought

to the attention of the arbitrators," foreclosing vacatur. 1-ER-015. The District Court did not address Anthem's arguments that: (1) the FAA presumes the existence of a confrontational, adversarial hearing, which the IDR process does not provide; and (2) Anthem expressly pleaded that Defendants' scheme involves submitting an avalanche of disputes simultaneously to conceal their fraud, overwhelm Anthem, and push ineligible disputes to a payment determination. *See* 2-ER-226-227; 2-ER-038.

As to § 10(a)(4), which permits judicial review where the arbitrators exceeded their powers, the District Court held that because IDREs are authorized *by regulation* to determine eligibility, they did not exceed their *statutory authority* when issuing payment determinations on clearly ineligible disputes. 1-ER-019.

Next, the District Court dismissed Anthem's principal federal claims (RICO, ERISA, and declaratory relief) under Rule 12(b)(1) for lack of subject matter jurisdiction. 1-ER-020-022. The District Court acknowledged that the text of the Judicial Review Provision applies solely to "[a] determination of a certified IDR entity under subparagraph (A)" (*i.e.*, the payment determination). 1-ER-014, 020. But rather than apply that plain language, the District Court held that "an IDRE's payment determination necessarily includes a determination of eligibility" and thus could not be judicially reviewed. 1-ER-020. The District Court acknowledged that the directive for IDREs to review eligibility appears only "by regulation (though

not by the Act itself),” but it dismissed this distinction, declaring that “[i]t makes no difference whether the directive to first determine eligibility is in the NSA’s text or the implementing regulations.” 1-ER-018. It carried over that same logic in deciding the scope of the Judicial Review Provision. 1-ER-020.

To support its conclusion, the District Court also relied on its own policy concerns about allowing claims involving ineligible disputes to proceed in court:

> 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.

1-ER-017; *see also* 1-ER-020 (expressing concerns that “Plaintiffs’ proposed reading of 42 U.S.C. § 300gg-111(c)(5)(E)(i)[ ] would impose *no* limits on judicial review of IDREs’ eligibility determinations . . .”).

Third, having concluded it lacked jurisdiction over Anthem’s federal claims, the District Court declined to exercise supplemental jurisdiction over Anthem’s state law claims and denied the anti-SLAPP motions as moot. 1-ER-021-024.

The District Court then denied leave to amend, finding amendment would be futile—a conclusion that rested entirely on its interpretation of the Judicial Review Provision. 1-ER-24.

This appeal followed.

SUMMARY OF ARGUMENT

The District Court had jurisdiction over Anthem's federal claims. Congress expressly authorized this action in ERISA and RICO. 29 U.S.C. § 1132(a)(3), (e); 18 U.S.C. § 1964(c). The judgment must be reversed.

Anthem's RICO and ERISA claims involve Defendants' mass submission of statutorily ineligible disputes using false attestations of eligibility. These claims cannot be shoehorned and adjudicated in the IDR process itself. Instead, RICO was enacted to combat this kind of a scheme.

The District Court's reliance on the NSA's Judicial Review Provision to opine otherwise was error. Statutes that may limit or preclude review must be read narrowly, and the strong presumption of judicial review can only be overcome by clear and convincing indications that Congress intended such a limit. By its plain terms, the Judicial Review Provision limits judicial review only of "[a] determination of a certified IDR entity under subparagraph (A)." 42 U.S.C. § 300gg-111(c)(5)(E)(i). The only "determination of a certified IDR entity" specified in Subparagraph (A) is the IDRE's the payment determination. *Id.* § 300gg-111(c)(5)(A). The backdrop of existing law further confirms the narrow scope of the Judicial Review Provision; Congress enacted far broader judicial review limitations and preclusions in other legislation but chose a narrow one in

the NSA. *Compare id.*, *with, e.g.*, 5 U.S.C. § 805; 38 U.S.C. § 511(a). Congress did not clearly and convincingly bar judicial review of Defendants' scheme.

To reach its erroneous conclusion, the District Court improperly relied on the Departments' post-legislative regulations and matters of policy rather than the NSA's text and structure, the backdrop of existing law, and controlling Supreme Court precedent. The District Court concluded that "[a]n IDRE's payment determination necessarily includes a determination of eligibility," relying on the Departments' post-legislative regulations that delegated eligibility determinations to the IDREs. *See* 1-ER-018-020. The District Court erred by treating the regulatory decision to delegate eligibility reviews to IDREs as equivalent to a congressional directive that could limit judicial review. *Kucana*, 558 U.S. at 252, holds that only Congress, not agencies, can limit the federal courts' jurisdiction. The District Court then compounded its error by departing from the statutory text based on policy concerns about case volume, despite Congress's clear direction.

Alternatively, even if the Judicial Review Provision applies (it does not), Anthem's claims fall within the statutory exceptions for judicial review as "a case described in" FAA § 10(a)(1) and (4). Under § 10(a)(4), the IDREs exceeded their powers by issuing payment determinations on statutorily ineligible disputes. The NSA limits IDR to "a qualified IDR item or service," and IDREs are "statutorily

prohibited" from making payment determinations on ineligible services. Under § 10(a)(1), the awards were procured by fraud through Defendants' false eligibility attestations and strategic use of AI-driven volume to overwhelm Anthem's ability to identify and object to ineligible disputes. The District Court erred in holding the fraud was "known" during IDR because (1) the discoverability requirement presumes a confrontational, adversarial hearing that IDR does not provide, and (2) the District Court ignored that Defendants strategically submit an avalanche of disputes to conceal their fraud.

Third, the District Court erred in dismissing Anthem's alternative vacatur claim. Because Anthem has adequately pleaded both fraud and excess of authority, its alternative claim for vacatur of individual IDR payment determinations should proceed.

Fourth, should this Court reverse on the threshold issue of jurisdiction, Anthem should be permitted to amend to conform its pleadings to this Court's ruling.

Finally, Defendants' alternative arguments, which the District Court did not reach (and this Court need not reach) uniformly fail. The collateral attack doctrine does not apply because Anthem challenges Defendants' fraudulent scheme (not individual payment determinations), the NSA does not incorporate the FAA's exclusive procedural framework, and the payment determinations are not binding

given Defendants' misrepresentations. *Noerr-Pennington* does not immunize Defendants because intentional misrepresentations are not protected petitioning activity and IDREs are private entities, not government bodies. Collateral estoppel does not apply because IDREs never determined whether Defendants engaged in fraud, the issue was never actually litigated, and Anthem had no full and fair opportunity to contest eligibility in a process lacking adversarial procedures and administered by financially interested decisionmakers. And Anthem states viable RICO claims because the "litigation activities" exemption does not extend to IDR proceedings lacking the procedural safeguards underlying that doctrine, and Anthem pleads all elements of its RICO and ERISA claims with requisite specificity.

Accordingly, Anthem respectfully requests that this Court reverse the judgment and remand for further proceedings.

STANDARD OF REVIEW

Dismissals of a complaint for lack of subject matter jurisdiction under Rule 12(b)(1) and for failure to state a claim under Rule 12(b)(6) are reviewed *de novo*. *Doğan v. Barak*, 932 F.3d 888, 892 (9th Cir. 2019); *Prodanova v. H.C. Wainwright & Co., LLC*, 993 F.3d 1097, 1105 (9th Cir. 2021).

Generally, the District Court's dismissal with prejudice without granting leave to amend is reviewed under an abuse of discretion standard. *Reddy v. Litton*

Industries, Inc., 912 F.2d 291, 296 (9th Cir. 1990). But "if a district court denies leave to amend based on the futility of the amendment or inability to allege a valid cause of action, [the Court] review[s] the decision de novo." *Kroessler v. CVS Health Corp.*, 977 F.3d 803, 807 (9th Cir. 2020).

ARGUMENT

I. The District Court Erred in Dismissing the Federal Claims for Lack of Subject Matter Jurisdiction Because Congress Did Not Clearly and Convincingly Bar Judicial Review of Defendants' Fraudulent Scheme.

Congress expressly granted Anthem a right to judicial relief for the misconduct alleged in the Amended Complaint. First, through RICO, Congress specified that "[a]ny person injured in his business or property by reason of a violation of section 1962 of this chapter may sue therefor in any appropriate United States district court and shall recover threefold the damages he sustains and the cost[s] of the suit[.]" 18 U.S.C. § 1964(c).

Congress enacted RICO to combat precisely the kind of systematic, enterprise-driven fraud alleged in the Amended Complaint. For example, the Second Circuit has repeatedly authorized insurers' RICO claims against health care providers who abuse an "expedited, simplified," state-imposed arbitration process for no-fault insurance benefits. *E.g.*, *Gov't Emps. Ins. Co. v. Patel*, 166 F.4th 280, 288 (2d Cir. 2026); *State Farm Mut. Auto. Ins. Co. v. Tri-Borough NY Med. Prac. P.C.*, 120 F.4th 59, 91 (2d Cir. 2024); *Allstate Ins. Co. v. Mun*, 751 F.3d 94, 99 (2d

Cir. 2014). The Second Circuit affirmed multiple preliminary injunctions preventing the provider defendants from filing additional arbitrations and state court collections actions, noting the public's interest in the rulings:

> Insurers, by virtue of their central role in the system, are 'uniquely positioned to combat the depletion of public resources caused by fraudulent claims for No-Fault benefits.' Accordingly, the public interest in detecting and preventing insurance fraud is undermined when insurers, alleging fraud, must defend 'thousands of arbitrations and state-court proceedings for reimbursement of individual claims . . . into which complex fraud and RICO claims cannot be shoehorned.'"

Patel, 166 F.4th at 297-98 (quoting *State Farm*, 120 F.4th at 85-86) (citations omitted).

Apart from RICO, Congress incorporated the NSA into ERISA, an act that authorizes fiduciaries like Anthem to bring "[a] civil action" in U.S. district court "to enjoin any act or practice which violates any provision of this subchapter." 29 U.S.C. § 1132(a)(3), (e). The breadth and mandatory character of this provision leave no doubt that Congress intended plan fiduciaries to have recourse to the federal courts to enjoin pervasive violations of the NSA's requirements, including the systematic submission of fraudulent eligibility attestations alleged here.

The NSA does not bar Anthem's federal claims. In the NSA, Congress only limited judicial review of the IDRE's payment determination. The NSA does not affect—much less override—Anthem's right to judicial relief in RICO and ERISA.

A. The NSA's Judicial Review Provision Does Not Bar Judicial Review of Anthem's RICO and ERISA Claims.

The District Court erred in holding that it lacked subject matter jurisdiction over Anthem's federal claims. The plain text of the NSA, statutory structure, and backdrop of existing law all confirm that the Judicial Review Provision limits judicial review of the IDRE's payment determination and nothing more. It does not strip courts of jurisdiction over a fraud and racketeering scheme built on hundreds of false eligibility attestations in violation of RICO and ERISA.

When evaluating statutes, courts must begin with a "'strong presumption' in favor of judicial review," which can be overcome only by "'clear and convincing indications' that Congress meant to foreclose review." *SAS Inst., Inc. v. Iancu*, 584 U.S. 357, 370 (2018). This presumption applies even when reviewing "statutes that may limit or preclude review," *Cuozzo Speed Techs., LLC v. Lee,* 579 U.S. 261, 273 (2016), and "dictates that such provisions must be read narrowly," *El Paso Natural Gas Co. v. United States*, 632 F.3d 1272, 1276 (D.C. Cir. 2011).

In the Judicial Review Provision, Congress limited judicial review of only *certain* determinations, namely "a determination of a certified IDR entity *under subparagraph (A)*," subject to delineated exceptions. 42 U.S.C. § 300gg-111(c)(5)(E)(ii) (emphasis added). The scope of the Judicial Review Provision thus turns on what IDRE determination falls "under subparagraph (A)."

Subparagraph (A) describes how the IDRE selects a "Payment determination." It states the following:

> (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. § 300gg-111(c)(5)(A) (emphasis added).

The only "determination" that the IDRE makes under subparagraph (A) is to "select one of the offers submitted [by the parties] to be the amount of payment[.]" 42 U.S.C. § 300gg-111(c)(5)(A), (B).

The statutory scheme confirms the scope of subparagraph (A). The NSA certifies, compensates, and directs rulemaking for IDREs to perform a single task: the payment determination. *See* 42 U.S.C. § 300gg-111(c)(2)(A), (c)(4), (c)(5)(F). Nothing in the NSA suggests that IDREs will perform any task beyond "select[ing] one of the offers submitted" by the parties as the payment determination. *See id.*

Critically, subparagraph (A) does not contemplate eligibility decisions, *i.e.*, a threshold decision as to whether the IDR process should have been invoked in the first instance. The initiation of the IDR process is addressed earlier in the statute under 42 U.S.C. § 300gg-111(c)(1)(B), and the statute itself does not specify how to enforce statutory limitations on eligibility for IDR. 91 Fed. Reg. at 33942 ("[T]he statute does not contemplate an eligibility determination process[.]").

Congress's legislation in other contexts confirms the narrow scope of the Judicial Review Provision. Congress "legislates against the backdrop of existing law," *Parker Drilling Mgmt. Servs., Ltd. v. Newton*, 587 U.S. 601, 611 (2019), and when it limits or precludes judicial review of all decisions arising from non-judicial proceedings, it does so explicitly. For example, Congress barred judicial review of all non-Constitutional challenges under the Congressional Review Act with broad language: "No determination, finding, action, or omission under this chapter shall be subject to judicial review." 5 U.S.C. § 805; *Center for Biological Diversity v. Bernhardt*, 946 F.3d 553, 560-61 (9th Cir. 2019). Similarly, in the Veterans Judicial Review Act, Congress specified that (i) the Secretary "shall decide all questions of law and fact necessary to a decision by the Secretary under a law that affects the provision of benefits," and (ii) "the decision of the Secretary as to any such question shall be final and conclusive and may not be reviewed by any other official or by any court[.]" 38 U.S.C. § 511(a).

Congress could have done the same here. It could have barred review of any "determination, finding, action, or omission" related to IDR. *See* 5 U.S.C. § 805. Or it could have specified that (i) IDREs "shall decide all questions of law and fact necessary to" a payment determination, and (ii) "the decision of the" IDRE "as to any such question shall be final and conclusive and may not be reviewed by any other official or by any court[.]" *See* 38 U.S.C. § 511(a). It did neither. Instead, Congress limited the Judicial Review Provision to the IDRE's payment determination, and nothing more. 42 U.S.C. § 300gg-111(c)(5)(E)(i).

The only "determination of a certified IDR entity under subparagraph (A)" is the IDRE's payment determination. 42 U.S.C. § 300gg-111(c)(5)(E)(i). There are no "'clear and convincing indications' that Congress meant to foreclose review" of a fraud and racketeering scheme involving the mass submission statutorily ineligible disputes using false eligibility attestations. *SAS Inst.*, 584 U.S. at 370 (citation omitted). In fact, the opposite is true: Defendants' conduct violates RICO, ERISA, and other laws that expressly grant Anthem a right to judicial relief.

B. The District Court Erred by Relying on the Departments' Regulations Delegating Eligibility Determinations to IDREs to Conclude that Congress Intended to Bar Anthem's Federal Claims.

The District Court did not consider the Supreme Court's rules of interpretation, the NSA's plain text, the statutory structure, or the backdrop of existing law when concluding that it had no jurisdiction. Instead, the District Court

concluded that "[a]n IDRE's payment determination necessarily includes a determination of eligibility." 1-ER-020. But *Congress* never specified that "[a]n IDRE's payment determination necessarily includes a determination of eligibility," much less limited judicial review of "a determination of eligibility." Only Congress can restrict the courts' jurisdiction; agency regulations cannot expand the statute's reach. The District Court's reasoning is reversible error.

1. The Departments—not Congress—delegated eligibility reviews to IDREs, and the District Court improperly read those eligibility reviews into the NSA.

In the NSA, Congress was clear: the IDRE's task is to "select one of the offers submitted [by the parties] to be the amount of payment[.]" 42 U.S.C. § 300gg-111(c)(5)(A). The NSA certifies, compensates, and directs rulemaking for IDREs to perform this task (*i.e.*, the payment determination). *See id*. § 300gg-111(c)(2)(A), (c)(4), (c)(5)(F). Nothing in the NSA suggests that IDREs would perform any task beyond selecting one party's offer as the payment determination. *See* 91 Fed. Reg. at 33942-44 (the NSA "does not contemplate an eligibility determination process" of any kind).

The District Court's order notes that per the NSA, IDREs are directed to make a payment determination "for a qualified IDR item or service." 1-ER-020 (quoting 42 U.S.C. § 300gg-111(c)(5)(A)). That fixes the scope of the IDRE's jurisdiction; it does not suggest that IDREs would review eligibility as part of their

determination in subparagraph (A). According to the plain text, the NSA only limits judicial review of "[a] determination of a certified [IDRE] under subparagraph (A)[,]" and the only "determination" IDREs make in subparagraph (A) is the payment determination. 42 U.S.C. § 300gg-111(c)(5)(A), (c)(5)(E)(i); *see also El Paso Natural Gas Co.*, 632 F.3d at 1276 (courts interpret the statutory judicial review limitations "narrowly"). There are no indications that Congress intended for IDREs to make eligibility reviews, much less "'clear and convincing indications' . . . that Congress intended to bar review" of the IDRE's eligibility reviews. *Cuozzo Speed Techs.*, 579 U.S. at 273 (citation omitted).[11]

The District Court's conclusion that "[a]n IDRE's payment determination necessarily includes a determination of eligibility" relies on duties imposed by regulation, not by statute. 1-ER-020. The District Court acknowledged that "[t]he IDRE is directed by regulation (though not by the Act itself) to 'determine whether the Federal IDR process applies.'" 1-ER-018 (citations and internal quotes omitted); *accord* 1-ER-009. Yet the court declared that "*[i]t makes no difference*

[11] While the statute is clear, even if the Court finds that it is ambiguous, "ambiguity does not suffice to deprive a party of [ ] judicial review." *McLaughlin Chiropractic Assocs., Inc. v. McKesson Corp.*, 606 U.S. 146, 162 (2025). "To the extent there is ambiguity in the [provision,] it must be resolved in [] favor" of judicial review. *Salinas v. United States R.R. Ret. Bd.*, 592 U.S. 188, 196 (2021).

whether the directive to first determine eligibility is in the NSA's text or the implementing regulations." 1-ER-018 (emphasis added).

Under the District Court's reasoning, the Departments' post-legislative regulations can overrule the plain text of the statute enacted by Congress. This untenable logic becomes clear if one considers what would have happened had the Departments chosen a different mechanism to enforce eligibility. For example, the Departments could have relied solely on the IDR Portal and the initiating party's attestation to police eligibility, without any eligibility review. Or the Departments could have conducted eligibility reviews themselves, as they at one point considered doing. *See* 91 Fed. Reg. at 33942-44. In either scenario, IDREs would not be conducting eligibility reviews, and eligibility could not possibly be considered "[a] determination of a certified IDR entity under subparagraph (A)" subject to the Judicial Review Provision, 42 U.S.C. § 300gg-111(c)(5)(E)(i), as it would be neither a determination by an IDRE nor a payment determination under subparagraph (A).

2. The District Court's reliance on regulations to expand the scope of the Judicial Review Provision is contrary to controlling Supreme Court precedent.

The District Court's reliance on the Departments' regulations to expand the scope of the Judicial Review Provision contradicts controlling Supreme Court precedent. Only Congress can limit or foreclose judicial review; "the scope of

judicial review is 'hardly the kind of question that the Court presumes that Congress implicitly delegated to an agency.'" *Salinas v. U.S. RR. Ret. Bd.*, 592 U.S. 188, 201 (quoting *Smith v. Berryhill*, 587 U.S. 471, 486 (2019)). Agency regulations cannot expand the scope of a statutory limitation on judicial review. *Kucana*, 558 U.S. at 248, 252.

In *Kucana*, an immigration statute barred judicial review of determinations "the authority for which is specified under this subchapter to be in the discretion of the Attorney General." 8 U.S.C. § 1252(a)(2)(B)(ii). The government argued that this provision encompassed denials of motions to reopen because *a regulation* declared those denials discretionary. 558 U.S. at 237-38. The Supreme Court unanimously rejected that argument, holding that "[b]y defining the various jurisdictional bars by reference to other provisions in the [statute] itself, Congress ensured that it, and only it, would limit the federal courts' jurisdiction." *Id.* at 252. If Congress had "wanted the jurisdictional bar to encompass decisions specified [by regulation] along with those [specified by statute]," Congress could "easily have said so." *Id.* at 248. And "[s]eparation-of-powers, moreover, caution us against reading legislation, absent clear statement, to place in executive hands authority to remove cases from the Judiciary's domain." *Id*. at 237.

Kucana requires reversal. In the NSA, Congress limited judicial review to "[a] determination of a certified [IDRE] under subparagraph (A)[.]" 42 U.S.C.

§ 300gg-111(c)(5)(E)(i). That provision references the statute, not the Departments' regulations. "By defining the [ ] jurisdictional bar[ ] by reference to other provisions in the [statute] itself, Congress ensured that it, and only it, would limit the federal courts' jurisdiction." *Kucana*, 558 U.S. at 252. Had Congress wanted the jurisdictional bar to reach a possible regulatory delegation of eligibility reviews, it could easily have said so. *Id.* at 248, 252. As discussed above, Congress has enacted broad judicial review limitations in other statutes. *E.g.*, 5 U.S.C. § 805; 38 U.S.C. § 511(a). But in the NSA, Congress narrowly chose to limit judicial review of the IDRE's payment decision, and nothing more.

The District Court did precisely what *Kucana* forbids: it expanded the statutory judicial review limitation beyond payment determinations contemplated "under subparagraph (A)" to encompass eligibility decisions based solely on the Departments' post-legislative regulations. *Kucana*, 558 U.S. at 252; *see Salinas*, 592 U.S. at 201; *Smith*, 587 U.S. at 486. This Court should reverse.

3. The District Court further erred by departing from the statutory text on the basis of policy concerns.

The District Court's policy concerns cannot justify departing from the statutory text. The District Court worried that "Plaintiffs' proposed reading of [the Judicial Review Provision] would impose *no* limits on judicial review of IDREs' eligibility determinations" and "would be inconsistent with the NSA's creation of a

streamlined IDR process[.]" 1-ER-018, 020. Respectfully, such policy concerns are not proper considerations for the courts:

> Policy arguments are properly addressed to Congress, not this Court. It is Congress's job to enact policy and it is this Court's job to follow the policy Congress has prescribed . . . whatever its virtues or vices[.]

SAS Inst., 584 U.S. at 368; *accord Rotkiske v. Klemm*, 589 U.S. 8, 14-15 (2019) ("It is not our role to second-guess Congress' decision . . . We simply enforce the value judgments made by Congress.").

The District Court's role is to interpret the law, not create it based on policy concerns. "[T]he text of a law controls over purported legislative intentions unmoored from any statutory text," and the District Court "may not replace the actual text with speculation as to Congress' intent." *See Corner Post, Inc. v. Bd. of Governors of Fed. Rsrv. Sys*., 603 U.S. 799, 815 (2024) (citation and internal quotes omitted). Congress limited judicial review to the IDRE's payment determination. 42 U.S.C. § 300gg-111(c)(5)(E)(i); *supra*, Section I.A. That ends the Court's inquiry.

Although not relevant, the District Court's policy concerns are also overstated. Unlike payment determinations, which require weighing statutory factors and have no definitive "correct" answer, eligibility is a straightforward inquiry: a dispute is either eligible or ineligible. Anthem's claims do not require courts to second-guess the IDRE's payment determination. Moreover, courts

already have a well-established role deciding eligibility in other dispute resolution contexts. *Cf., e.g.*, *AT&T Technologies, Inc. v. Comm'ns Workers of Am.*, 475 U.S. 643, 649 (1986) (questions of arbitrability are "undeniably" for the courts). A party seeking judicial review must still allege facts supporting a plausible claim to relief (*e.g.*, RICO), and the court system has procedural safeguards to deter frivolous or fraudulent complaints that are unavailable in IDR.

II. Alternatively, the District Court Erred Because Anthem Pleads "a Case Described in" FAA Section 10(a)(1)-(4).

Alternatively, if the Court concludes that Anthem's claims are somehow subject to the NSA's Judicial Review Provision (they are not), the claims would be reviewable because they fall within the cases eligible for judicial review, as "a case described in" FAA § 10(a)(1)-(4). 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). As relevant here, these cases include those where "the arbitrators exceeded their powers," 9 U.S.C. § 10(a)(4), or where "the award was procured by . . . fraud," 9 U.S.C. § 10(a)(1). The District Court erred in concluding that Anthem failed to allege such a case, relying on factual inferences drawn from outside the pleadings and construing disputed facts against Anthem at the motion-to-dismiss stage.

A. Anthem properly pleaded that IDREs exceeded their authority issuing awards based on ineligible claims under FAA § 10(a)(4).

The NSA permits judicial review of IDR payment determinations where "the arbitrators exceeded their powers" by acting beyond their scope of authority.

Congress only authorized IDREs to make a payment determination "for a qualified IDR item or service" eligible for the IDR process. 42 U.S.C. § 300gg-111(c)(5)(A). "[C]ertified IDR entities are statutorily prohibited from making payment determinations for items and services that are not subject to the No Surprises Act . . . ." 91 Fed. Reg. at 33933, 33943, 33945.

An IDRE that issues a payment determination on a non-qualifying dispute has exceeded the powers delegated to it by Congress. Anthem pleads that IDREs issued hundreds of payment determinations on clearly ineligible disputes for which they lacked authority to do so. *See Raymond James Fin. Servs., Inc. v. Bishop*, 596 F.3d 183, 193 (4th Cir. 2010) (affirming vacatur where "the arbitrators lacked the authority to address this 'cause of action[.]'").

In rejecting this argument, the District Court again ignored the text of the NSA and relied instead on the Departments' regulations. It reasoned that because "part of the IDREs' assigned task is to decide eligibility," an IDRE does not exceed its authority by issuing a payment determination on ineligible disputes. 1-ER-019. While acknowledging that "[t]he 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)," the court nonetheless opined that "[i]t makes no difference whether the directive to first determine eligibility is in the NSA's text or the implementing regulations." 1-ER-018.

This was clear error. "It is beyond dispute that a federal regulation cannot empower the Government"—or, in this case, a private company—"to do what a federal statute prohibits it from doing." *Tuan Thai v. Ashcroft*, 366 F.3d 790, 798 (9th Cir. 2004). To be sure, the Departments' regulations direct IDREs to review eligibility before proceeding to a payment determination. But that review does not confer on the IDRE authority to issue a payment determination on ineligible disputes. As the Departments acknowledge, their delegation of eligibility reviews to IDREs does not alter the fact that IDR entities are "statutorily prohibited from making payment determinations for items and services that are not subject to the No Surprises Act[.]" 91 Fed. Reg. at 33933, 33943, 33945. The District Court failed to consider whether an IDRE issuing a "statutorily prohibited" payment determination exceeds its powers under FAA § 10(a)(4); it plainly does.[12]

B. Anthem properly pleaded the issuance of an award procured by fraud under FAA § 10(a)(1).

Anthem may also seek judicial review of the disputes at issue in this case because "the award[s] [were] procured by . . . fraud." 9 U.S.C. § 10(a)(1). If the Judicial Review Provision applies (it does not), then Defendants' scheme to submit

[12] *Reach Air Medical Services LLC v. Kaiser Foundation Health Plan, Inc.*, 160 F.4th 1110 (11th Cir. 2025), cited by the District Court, does not support its conclusion. There, the plaintiff contested the amount of the payment determination, which fell squarely within the IDRE's "assigned task" under the statute. *Id.* at 1117. Eligibility was never disputed. *See id.*

false attestations of eligibility on a mass scale and conceal their fraud by submitting an avalanche of disputes all at once is the type of "perjury materially related to an issue in the arbitration" sufficient to meet this standard. *Cf. Bonar v. Dean Witter Reynolds, Inc.*, 835 F.2d 1378, 1383-84 (11th Cir. 1988).

The District Court's analysis of FAA § 10(a)(1) disregards the Amended Complaint's allegations. The District Court held that Anthem did not allege "a case described in" FAA § 10(a)(1) because in "the sample determinations identified in the [First Amended Complaint]," Anthem "knew about the false eligibility attestations and objected," so the fraud was "known during the IDR and disclosed to the IDRE." 1-ER-17-18 (citation omitted). But Anthem alleges that Defendants' fraud often was not known during IDR or disclosed to the IDRE.

Indeed, Anthem specifically alleges that Defendants deployed "automation and artificial intelligence infrastructure to operate 'at scale,'" 3-ER-387 (¶ 6), initiating massive numbers of fraudulent IDR disputes "all at once to overwhelm the IDR system" and prevent Anthem from timely identifying and objecting to each ineligible submission. 3-ER-407-408, 411-412 (¶¶ 93, 105, 112). This volume was unmanageable by design: on a single day—May 3, 2024—Defendants initiated 126 separate IDR proceedings against Anthem, more than 75% of which were ineligible. 3-ER-412 (¶ 112). Despite Anthem's efforts, "most of Defendants' ineligible disputes reach a payment determination due to Defendants' knowingly

false attestations of eligibility," and "[n]early half of disputes from Defendants that reached a payment determination were ineligible for the IDR process, often [though not always] despite objections from Anthem." 4-ER-413 (¶¶ 115, 118). The District Court erred by ignoring Anthem's allegations that Defendants' designed their fraudulent scheme to conceal their ineligible disputes and prevent Anthem from timely identifying and objecting to them.

In any event, the requirement that the fraud was not discoverable presumes the existence of an opportunity to litigate the alleged fraud "at a confrontational, adversarial hearing[.]" *Pour Le Bebe, Inc. v. Guess? Inc.*, 112 Cal. App. 4th 810, 833 (2003) (cited with approval by *Mohazzabi v. Wells Fargo Bank, N.A.*, No. 22-15357, 2023 WL 4449179, at *1 (9th Cir. July 11, 2023)). Here, there was no such "confrontational, adversarial hearing" on eligibility. In dismissing Anthem's claims, the District Court declined to address these authorities or infer facts in the light most favorable to Anthem.

III. The District Court Erred in Dismissing Anthem's Alternative Request for Vacatur.

Defendants agree that courts may review requests for vacatur of individual IDR payment determinations under FAA § 10(a)(1)-(4). *See* 3-ER-359; 3-ER-326; 2-ER-305. In the alternative to its arguments in Sections I and II, Anthem has adequately pleaded that it is entitled to vacatur on the basis of fraud under

§ 10(a)(1) and excess of authority under § 10(a)(4). *See supra*, Section II.A (excess of authority), II.B (fraud).

IV. Anthem Should Be Granted Leave to Amend to Cure Specific Pleading Deficiencies.

Should this Court reverse, Anthem requests leave to amend to conform its pleadings to this Court's ruling. "It is black-letter law" that a plaintiff should be given at least one opportunity to amend, and here there was only a single motion to dismiss. *Nat'l Council of La Raza v. Cegavske,* 800 F.3d 1032, 1041 (9th Cir. 2015), *overruled on other grounds by Food and Drug Administration v. Alliance for Hippocratic Medicine*, 602 U.S. 367 (2024). The District Court's futility finding rested entirely on its interpretation of the Judicial Review Provision and its disregard of the Amended Complaint's allegations. At a minimum, Anthem should have been granted leave to identify "sample determinations" that meet the District Court's proposed standard for judicial review and/or vacatur. *See* 1-ER-017; 2-ER-134.

V. Defendants' Alternative Arguments for Dismissal of Anthem's Claims Were Not Reached Below and Lack Merit.

Because the District Court resolved this case on threshold jurisdictional grounds, it did not reach Defendants' alternative arguments for dismissal. Should this Court reverse and hold that subject matter jurisdiction exists, it should remand

for the District Court to address these remaining arguments in the first instance. In any event, each argument lacks merit.

A. The Collateral Attack Doctrine Does Not Apply to Anthem's Claims.

Courts apply the collateral attack doctrine to prevent parties from circumventing the FAA's exclusive remedies for challenging final and binding arbitration awards. *E.g.*, *Sander v. Weyerhaeuser Co*., 966 F.2d 501, 503 (9th Cir. 1992) ("[T]he three month limitation [in 9 U.S.C. § 12] is meaningless if a party to the arbitration proceedings may bring an independent direct action asserting such claims outside of the statutory time period."). The doctrine has no application here for four independent reasons.

First, while the Judicial Review Provision limits review of payment determinations, Anthem is not asking the Court to review or second-guess the IDRE's "select[ion of] one of the offers submitted [by the parties] to be the amount of payment for such item or service[.]" 42 U.S.C. § 300gg-111(c)(5)(A). Anthem instead seeks judicial review of Defendants' fraudulent scheme to flood the IDR process with knowingly ineligible disputes.[13] The fact that Defendants' fraud occurred in IDR—which, like the state-imposed arbitration process addressed in

[13] Anthem's vacatur claim, which was brought in the alternative to its principal claims, would be a direct challenge to the IDR payment determination under the FAA and not subject to this argument.

Patel, is "an expedited, simplified affair meant to work as quickly and efficiently as possible"—is inconsequential; the IDR process "cannot readily accommodate '[c]omplex fraud and RICO claims.'" *Patel*, 166 F.4th at 288 (citation omitted). Because nothing limits judicial review of Anthem's claims, and because Anthem could not have asserted these claims in any IDR proceeding, the collateral doctrine does not apply.

Second, even if the Judicial Review Provision applied (it does not), the NSA does not mandate any exclusive remedy for seeking judicial review of the IDRE's payment determination. The collateral attack doctrine requires an "exclusive remedy" for challenging a final and binding award. *See Bachman Sunny Hill Fruit Farms, Inc. v. Producers Agric. Ins. Co.*, 57 F.4th 536, 541 (6th Cir. 2023); *e.g.*, *Sander*, 966 F.2d at 503. The NSA provides no such exclusive remedy. It incorporates only the substantive grounds for challenging an IDRE's payment determination under FAA § 10(a)(1)-(4), not the FAA's procedural framework. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). "Although this explains the grounds upon which a party may challenge an award, it does not discuss how to raise this challenge. . . . The FAA's procedural requirements for vacating an award . . . are not incorporated." *Med-Trans Corp. v. Capital Health Plan*, 700 F. Supp. 3d 1076, 1083 (M.D. Fla. 2023) (internal citations omitted); *see also Guardian Flight, L.L.C. v. Health Care Service Corp.*, 140 F.4th 271, 276 (5th Cir. 2025)

("Congress chose not to incorporate § 9 [governing award confirmation] into the NSA."). Where no exclusive procedures governs challenges to IDRE payment determinations, there is nothing to circumvent, and the collateral attack doctrine's rationale is inapplicable.

Third, the collateral attack doctrine presupposes a binding determination. But the payment determinations at issue here are not binding. Per the NSA, an IDRE's payment determination is only binding "in the absence of 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). Anthem alleges, and the Court must accept, that Defendants presented misrepresentations of fact regarding dispute eligibility to IDREs in each relevant dispute. 3-ER-408, 410 (¶¶ 96, 102). No authority suggests that the collateral attack doctrine applies to claims involving non-binding dispute resolution determinations.

Finally, Anthem seeks forms of relief that are not recoverable in IDR and thus cannot be construed as a collateral attack. Anthem's RICO claims and the treble damages the Act mandates "cannot be shoehorned into" the IDR process. *Mun*, 751 F.3d at 99. Nor could Anthem recover through IDR the damages arising from (1) resources expended addressing Defendants' fraudulent submissions, and (2) non-refundable administrative fees paid to HHS—damages Anthem incurs even when it prevails in the IDR. *See e.g.*, 3-ER-413, 415, 425, 435 (¶¶ 115, 126, 166,

222). Anthem also seeks forward-looking injunctive relief that is unavailable in IDR or through vacatur. 3-ER-470 (¶ 369) (seeking "[i]njuncti[ve relief] prohibiting the Provider Defendants and HaloMD from continuing to submit false attestations and initiate IDR for items or services that are not qualified for IDR"). Because none of this relief seeks to relitigate any prior IDR award, the collateral attack doctrine is inapplicable.

B. The *Noerr-Pennington* Doctrine Does Not Immunize Defendants From Liability for Their Fraudulent NSA Scheme.

Defendants argue that their fraudulent scheme constitutes petitioning activity protected by the First Amendment. It does not. Courts rarely address *Noerr-Pennington* at the motion to dismiss stage because "[w]hether something is a genuine effort to influence governmental action, or a mere sham, is a question of fact." *Clipper Exxpress v. Rocky Mountain Motor Tariff Bureau, Inc.*, 690 F.2d 1240, 1253 (9th Cir. 1982). The argument fails here for at least two additional reasons.

First, "[m]isrepresentations . . . are not immunized when used in the adjudicatory process." *Cal. Motor Transp. Co. v. Trucking Unlimited*, 404 U.S. 508, 513 (1972); *Clipper Exxpress*, 690 F.2d at 1261 ("There is no first amendment protection for furnishing with predatory intent false information to an administrative or adjudicatory body."). A recognized sham litigation exception applies where "allegedly unlawful conduct consists of making intentional

misrepresentations" in an adjudicatory proceeding. *Sosa v. DIRECTV, Inc.*, 437 F.3d 923, 938 (9th Cir. 2006). Defendants' false attestations "deprived the [IDR proceedings] of [their] legitimacy" by enabling statutorily ineligible disputes to proceed to a payment determination. *See id*. (citation omitted). Defendants' misrepresentations are necessary to unlock the IDR process; absent their misrepresentations, no IDR dispute would have occurred.

Second, *Noerr-Pennington* immunity protects only petitioning "aimed at influencing decisionmaking by the government." *Octane Fitness, LLC v. ICON Health & Fitness, Inc.*, 572 U.S. 545, 555-56 (2014)*; see Sosa*, 437 F.3d at 929. The doctrine is rooted in the First Amendment's guarantee of the right "to petition the *Government* for a redress of grievances." *Kottle v. Nw. Kidney Centers*, 146 F.3d 1056, 1059 (9th Cir. 1998) (emphasis added). Defendants submit false attestations in non-public proceedings before private IDREs, not government bodies. Such statements "directed at private organizations" are not protected by the *Noerr-Pennington* doctrine. *Id*. at 1059 n.3 (citing *Allied Tube & Conduit Corp. v. Indian Head, Inc.,* 486 U.S. 492, 499-500 (1988)).[14]

[14] Defendants make false statements to the Departments to access the IDR process, but *Noerr-Pennington* does not apply if "the government acts in a [ ] ministerial or non-discretionary capacity in direct reliance on the representations made by private parties." *In re Buspirone Pat. Litig.*, 185 F. Supp. 2d 363, 369 (S.D.N.Y. 2002).

C. Collateral Estoppel Does Not Apply to Anthem's Claims.

Collateral estoppel does not attach to IDR decisions because IDR procedures are incompatible with the doctrine's requirements. First, the doctrine requires "a sufficient record of the prior proceeding to enable the trial court to pinpoint the exact issues previously litigated." *Clark v. Bear Stearns & Co.*, 966 F.2d 1318, 1321 (9th Cir. 1992) (citation omitted); *Crafty Prods., Inc. v. Fuqing Sanxing Crafts Co.*, 839 F. App'x 95, 98 n.2 (9th Cir. 2020) (doctrine "cannot apply without a record showing the specific issues litigated in arbitration"). Defendants have not and cannot present a record of the IDREs' eligibility "decisions," which are rarely even issued in writing.

Nor could Defendants establish any of the required elements: "(1) the issue at stake was identical in both proceedings; (2) the issue was actually litigated and decided in the prior proceedings; (3) there was a full and fair opportunity to litigate the issue; and (4) the issue was necessary to decide the merits." *Hansen v. Musk*, 122 F.4th 1162, 1172 (9th Cir. 2024), *cert. denied sub nom. Hansen v. Tesla, Inc.*, 145 S. Ct. 2850, 222 L. Ed. 2d 1132 (2025) (citation omitted).

1. The issue at stake is not identical because IDREs did not determine whether Defendants engaged in fraud.

The IDR process and this lawsuit involve different issues that are simply not identical. Under the regulations, IDREs are to "review[] the notice of IDR initiation" with the provider's attestation of eligibility "to determine whether the

Federal IDR process applies" and then make a payment determination for a single payment dispute. 3-ER-403 (¶ 73); 45 C.F.R. § 149.510(c)(1)(v). No IDRE has evaluated, or could evaluate, Defendants' fraud and racketeering scheme to flood the IDR process with knowingly ineligible disputes.

2. Defendants' fraud was neither litigated nor necessary to the IDRE's payment determination.

IDR's "expedited nature," like that of the state-imposed arbitration process addressed by the Second Circuit in *Patel*, "means that it cannot readily accommodate '[c]omplex fraud and RICO claims[.]'" *Patel*, 166 F.4th at 288 (citation omitted). Anthem's claims in this action were "not 'actually litigated' and could not possibly have been 'critical and necessary' to the judgment." *See CSX Transp., Inc. v. Bhd. of Maint. of Way Emps.*, 327 F.3d 1309, 1318 (11th Cir. 2003).

3. Anthem did not have a full and fair opportunity to litigate its claims in the IDR proceedings.

Collateral estoppel does not apply where "there is reason to doubt the quality, extensiveness, or fairness of procedures followed in prior litigation." *Kremer v. Chem. Constr. Corp.*, 456 U.S. 461, 481 (1982) (citation omitted). Due process requires, "[a]t a minimum, ... a hearing before an impartial tribunal." *Clements v. Airport Auth. of Washoe Cnty.*, 69 F.3d 321, 333 (9th Cir. 1995)*; see Caldeira v. Cnty. of Kauai*, 866 F.2d 1175, 1180 (9th Cir. 1989).

IDRE eligibility reviews fail this standard. Unlike judges or arbitrators, an IDRE that concludes a dispute is ineligible for IDR forfeits all compensation. 3-ER-405 (¶ 80). Because IDREs have a direct financial stake in finding disputes are eligible for IDR, they are not impartial decisionmakers to whom collateral estoppel applies. *Alpha Epsilon Phi Tau Chapter Hous. Ass'n v. City of Berkeley*, 114 F.3d 840, 844 (9th Cir. 1997) ("due process is violated if a decisionmaker has a 'direct, personal, substantial pecuniary interest' in the proceedings") (quoting *Tumey v. Ohio*, 273 U.S. 510, 523 (1927)).

Nor can estoppel apply where the prior proceeding "provided [a party] with neither the tools nor the opportunity to fully litigate" the relevant issues. *Littlejohn v. United States*, 321 F.3d 915, 923 (9th Cir. 2003); *see Parklane Hosiery Co. v. Shore*, 439 U.S. 322, 332 (1979) (collateral estoppel should not apply if there are "procedural opportunities available" in the second suit "that were unavailable in the first ... [and] might be likely to cause a different result"); *Maciel v. Comm'r*, 489 F.3d 1018, 1023 (9th Cir. 2007) (same). Anthem's "[c]omplex fraud and RICO claims . . . cannot be shoehorned" into IDR. *Mun*, 751 F.3d at 99. Even for individual eligibility reviews, IDREs need not conduct hearings, consider a health plan's objections, or issue decisions. *See* 45 C.F.R. § 149.510(c)(1)(v). IDR is precisely the kind of "prompt, inexpensive determination of small claims" for

which collateral estoppel is "wholly inappropriate." *See Staub v. Nietzel*, No. 22-5384, 2023 WL 3059081, at *6 (6th Cir. Apr. 24, 2023).

D. Anthem States Claims for Violations of RICO (Counts I-IV).

Defendants committed extensive RICO violations, employing interstate wires to submit hundreds of fraudulent IDR submissions against Anthem. 3-ER-386-388, 406-416, 435 (¶¶ 3-11, 86-129, 221). Defendants' arguments for dismissal of Anthem's RICO claims ignored Anthem's allegations and misconstrued applicable law. There is no merit to either of Defendants' arguments that (1) the litigation activities exemption applies, or (2) that Anthem failed to plead all elements of its RICO claim.

1. The "litigation activities" exemption does not apply.

The RICO "litigation activities" exemption is a policy-based doctrine under which courts generally do not allow litigation filings to serve as RICO predicate acts. *Kim v. Kimm*, 884 F.3d 98, 103-04 (2d Cir. 2018). This Court has not adopted the doctrine. *See United States v. Koziol*, 993 F.3d 1160, 1174 (9th Cir. 2021). Moreover, no court has exempted IDR from RICO liability. There are at least two independent reasons not to apply it here.

First, this Court declined to apply the litigation activities exemption when "the policy concerns asserted in these cases [that have applied it] are not implicated." *Koziol*, 993 F.3d at 1174. That is the case here. The exemption is

rooted in litigation's "time-tested procedures[] to produce reliable results," including rules of evidence, cross-examination, perjury penalties, attorney ethical obligations, and malicious prosecution remedies. *United States v. Pendergraft*, 297 F.3d 1198, 1206-07 (11th Cir. 2002); *see Koziol*, 993 F.3d at 1175. IDR has none of these. Attestations are not filed by attorneys subject to ethical rules or court sanctions; there is no discovery, cross-examination, or perjury exposure; IDREs have a direct financial incentive to find disputes eligible; IDR determinations carry no *res judicata* or collateral estoppel effect; IDR cannot support a malicious prosecution claim; and IDR is a private process with no public accountability of individual IDRE decisions. Unlike courts, which "produce reliable results, separating validity from invalidity," *Pendergraft*, 297 F.3d at 1206, the Departments themselves urged IDREs to "reduce errors" and improve quality assurance. 2-ER-268. Because the policy concerns behind the exemption are not implicated, this Court should not adopt it for this case. *Koziol*, 993 F.3d at 1174.

Second, even courts adopting the exemption reject it where a scheme (1) deceives a third party separate from the adjudicator, or (2) targets other victims beyond the parties to the proceeding. *See United States v. Lee*, 427 F.3d 881, 890 (11th Cir. 2005); *Carroll v. United States Equities Corp.*, No. 1:18-cv-667, 2020 WL 11563716, at *9 (N.D.N.Y. 2020). Here, both conditions are met. Before deceiving the IDREs, Defendants must first deceive HHS with false eligibility

attestations submitted through the Federal IDR Portal, which is the gateway to the entire proceeding. 45 C.F.R. § 149.510(b)(2)(iii)(C). As in *Lee*, where defendants used litigation documents to mislead "the lender and its counsel" rather than simply "influencing the court," 427 F.3d at 890, Defendants use IDR filings to deceive the Departments. Moreover, the scheme involves hundreds of proceedings targeting numerous health plans beyond Anthem. Courts have limited the exemption to "a single frivolous, fraudulent, or baseless lawsuit," *Kim*, 884 F.3d at 105, while expressly leaving "open the door for RICO claims premised on abusive litigation activities involving conduct beyond a single lawsuit." *Carroll*, 2020 WL 11563716, at *9.

2. Anthem pleads all other RICO elements.

Anthem pleads (a) predicate acts of wire fraud, (b) an enterprise, (c) a pattern of racketeering activity, and (d) conspiracy.

Anthem's wire fraud claim identifies the precise misrepresentations required to initiate an ineligible IDR dispute (3-ER-399-402 (¶¶ 54-67)) and sets forth the specific time, date, source, and content of demonstrative misrepresentations. *E.g.*, 3-ER-426-428, 432, 436-440 (¶¶ 171, 175, 180, 204, 227, 233, 240, 246). *See Cooper v. Pickett*, 137 F.3d 616, 627 (9th Cir. 1997) (finding complaint satisfied the who, what, when, and where required of Rule 9(b) despite not pleading the details of specific transactions); *accord Leprino Foods Co. v. Avani Outpatient*

Surgical Ctr., Inc., No. CV 22-7434 DSF (JEMx), 2023 WL 11066072, at *3 (C.D. Cal. 2023) (applying *Cooper* and holding that where a plaintiff alleges "'hundreds' of instances of fraud," Rule 9(b) requires only representative examples pleaded with particularity).

Anthem pleads the three components of a RICO enterprise: "(A) a common purpose, (B) a structure or organization, and (C) longevity necessary to accomplish the purpose." *Eclectic Props. E., LLC v. Marcus & Millichap Co.*, 751 F.3d 990, 997 (9th Cir. 2014). HaloMD submits IDR disputes on behalf of every Provider Defendant and is paid on commission for each recovery, aligning all Defendants' financial interests in the scheme. 3-ER-422-423, 433 (¶¶ 157, 213). *See Odom v. Microsoft Corp.*, 486 F.3d 541, 552 (9th Cir. 2007) (allegations were "more than adequate to establish . . . that [Defendants] had a common purpose of increasing the number of [IDR disputes] through fraudulent means"); *accord Blue Cross & Blue Shield Oklahoma v. S. Coast Behavioral Health LLC*, No. 2:24-cv-10683 MWC (AJRx), 2025 WL 2004500, at *8 (C.D. Cal. June 20, 2025) (finding RICO enterprise where each defendant played distinct role in furthering common objective in fraudulent billing scheme).

RICO's structural requirement demands only a "relationships among those associated with the enterprise," not a "hierarchy, role differentiation . . . [or] a chain of command. *Boyle v. United States*, 556 U.S. 938, 946, 948 (2009). Anthem

far exceeds this threshold by alleging each Defendant's specific role and the precise contractual arrangements binding them together. *E.g.*, 3-ER-386-388, 416-440 (¶¶ 4-11, 130-248). And Anthem pleads the requisite longevity (which Defendants did not dispute) given the scheme extended over a period of years and continues today. 3-ER-406 (¶ 86) (alleging scheme began no later than January 2024).

Anthem also pleaded a pattern of racketeering by identifying two or more predicate acts for each Defendant. A defendant need not personally make the wire transmission; it suffices that Provider Defendants supplied all information and authorized each submission after being expressly advised of ineligibility. *United States v. Johnson*, 297 F.3d 845, 870 (9th Cir. 2002); *see* 3-ER-426-432, 436-440 (¶¶ 168-205, 224-48).

Finally, Anthem pleads a RICO conspiracy under 18 U.S.C. § 1962(d), which requires only "the mere agreement to violate RICO"—not proof of a substantive violation. *Oki Semiconductor Co. v. Wells Fargo Bank, Nat. Ass'n*, 298 F.3d 768, 774-75 (9th Cir. 2002). Such agreement may be "inferred from the words, actions, or interdependence of activities and persons involved," *id*. at 775, and Anthem's allegations of coordinated fraud among Defendants more than satisfy this standard.

E. Anthem States a Claim Under ERISA (Count XII).

The Amended Complaint pleads a claim against Defendants under ERISA § 502(a)(3), which authorizes plan fiduciaries like Anthem to "enjoin any act or practice which violates any provision of this subchapter[.]" *See* 3-ER-469 (¶ 362). At the pleading stage, Anthem need only allege the existence of ERISA plans conferring fiduciary status. Here, Anthem has specifically alleged self-funded plans subject to ERISA. *See* 3-ER-392, 468-469 (¶¶ 33, 361, 365). Anthem has also alleged the terms of those ERISA plans that confer discretionary authority to Anthem. *See* 3-ER-468-469 (¶ 361). This is all that is required. *See Carpenters Health & Welfare Tr. for S. Cal. v. Vonderharr*, 384 F.3d 667, 672 (9th Cir. 2004) ("[T]o state a cause of action under § 1132(a)(3), an ERISA plan must 'demonstrate (1) that it is an ERISA fiduciary, and (2) that it is seeking equitable, rather than legal, relief'"); *e.g.*, *Nutrishare, Inc. v. Connecticut Gen. Life Ins. Co.*, No. 2:13-CV-02378-JAM-AC, 2014 WL 2624981, at *3 (E.D. Cal. June 12, 2014) ("Once the case is allowed to proceed to discovery, CIGNA would be required to specifically identify the plans at issue.").

The incorporation of the NSA's requirements (including the Judicial Review Provision) into ERISA does not negate this claim. Congress enacted 29 U.S.C. § 1185e against the backdrop of ERISA's existing enforcement framework. That framework authorizes plan fiduciaries and the Secretary of Labor to "enjoin any

act or practice which violates any provision of this subchapter," including § 1185e. 29 U.S.C. §§ 1132(a)(3), (a)(5). Had Congress intended the Judicial Review Provision to foreclose § 1132 claims in connection with IDR proceedings, it could have expressly limited § 1132 when it added § 1185e. It did not. Adopting Defendants' contrary interpretation—that § 1185e implicitly prohibits any § 1132 claim to enjoin statutory violations in connection with IDR—would produce an absurd result: simultaneously imposing substantive statutory obligations on ERISA plans and providers while stripping the Department of Labor, plan fiduciaries, and any other authorized party of the mechanism to enforce them.

Moreover, Anthem's ERISA claim does not implicate the Judicial Review Provision at all. Anthem does not ask the Court to review any IDRE payment determination. It seeks only a forward-looking injunction against Defendants' ongoing submission of false information to initiate IDR disputes. An injunction against a party's future conduct cannot be "judicial review of a determination of a certified IDR entity" within the meaning of the statute.

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CONCLUSION

For the foregoing reasons, Anthem respectfully requests that this Court reverse the judgment and remand for further proceedings.

August 5, 2026

Respectfully submitted,

s/ Emily T. Kuwahara

Martin J. Bishop
Jason T. Mayer
Alexandra M. Lucas
Jared Levine
Emily T. Kuwahara

Attorneys for Plaintiffs and Appellants Anthem Blue Cross Life and Health Insurance Company, and Blue Cross of California d/b/a Anthem Blue Cross

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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ADDENDUM

ADDENDUM

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KeyCite Yellow Flag
Proposed Legislation

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 6A. Public Health Service (Refs & Annos)
Subchapter XXV. Requirements Relating to Health Insurance Coverage (Refs & Annos)
Part D. Additional Coverage Provisions

42 U.S.C.A. § 300gg-111

§ 300gg-111. Preventing surprise medical bills

Effective: December 27, 2020
Currentness

(a) Coverage of emergency services

(1) In general

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))--

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating provider or a nonparticipating emergency facility--

(i) such services will be provided without imposing any requirement under the plan or coverage for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

(ii) the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

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(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

(iv) the group health plan or health insurance issuer, respectively--

(I) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or facility, as applicable, an initial payment or notice of denial of payment; and

(II) pays a total plan or coverage payment directly to such provider or facility, respectively (in accordance, if applicable, with the timing requirement described in subsection (c)(6)) that is, with application of any initial payment under subclause (I), equal to the amount by which the out-of-network rate (as defined in paragraph (3)(K)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

(v) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 300gg-3 of this title, including as incorporated pursuant to section 1185d of Title 29 and section 9815 of Title 26, and other than applicable cost-sharing).

(2) Audit process and regulations for qualifying payment amounts

(A) Audit process

(i) In general

Not later than October 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans and health insurance issuers offering group or individual health insurance coverage are audited by the Secretary or applicable State authority to ensure that--

(I) such plans and coverage are in compliance with the requirement of applying a qualifying payment amount under this section; and

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(II) such qualifying payment amount so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan or health insurance issuer described in clause (ii) of such paragraph (3)(E).

(ii) Audit samples

Under the process established pursuant to clause (i), the Secretary--

(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans and health insurance issuers offering group or individual health insurance coverage; and

(II) may audit any group health plan or health insurance issuer offering group or individual health insurance coverage if the Secretary has received any complaint or other information about such plan or coverage, respectively, that involves the compliance of the plan or coverage, respectively, with either of the requirements described in subclauses (I) and (II) of such clause.

(iii) Reports

Beginning for 2022, the Secretary shall annually submit to Congress a report on the number of plans and issuers with respect to which audits were conducted during such year pursuant to this subparagraph.

(B) Rulemaking

Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking--

(i) the methodology the group health plan or health insurance issuer offering group or individual health insurance coverage shall use to determine the qualifying payment amount, differentiating by individual market, large group market, and small group market;

(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 254e of this title; and

(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i) by group health plans and health insurance issuers offering group or individual health insurance coverage.

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Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate, taking into account the findings of the report submitted under section 109(a) of the No Surprises Act.

(3) Definitions

In this part and part E:

(A) Emergency department of a hospital

The term "emergency department of a hospital" includes a hospital outpatient department that provides emergency services (as defined in subparagraph (C)(i)).

(B) Emergency medical condition

The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(C) Emergency services

(i) In general

The term "emergency services", with respect to an emergency medical condition, means--

(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1395dd of this title, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

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(ii) Inclusion of additional services

(I) In general

For purposes of this subsection and section 300gg-131 of this title, in the case of a participant, beneficiary, or enrollee who is enrolled in a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished services described in clause (i) with respect to an emergency medical condition, the term "emergency services" shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services--

(aa) for which benefits are provided or covered under the plan or coverage, respectively; and

(bb) that are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in clause (i) are furnished.

(II) Conditions

For purposes of subclause (I), the conditions described in this subclause, with respect to a participant, beneficiary, or enrollee who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following;

(aa) Such provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 300gg-132(d) of this title with respect to such items and services.

(cc) Such individual is in a condition to receive (as determined in accordance with guidelines issued by the Secretary pursuant to rulemaking) the information described in section 300gg-132 of this title and to provide informed consent under such section, in accordance with applicable State law.

(dd) Such other conditions, as specified by the Secretary, such as conditions relating to coordinating care transitions to participating providers and facilities.

(D) Independent freestanding emergency department

The term "independent freestanding emergency department" means a health care facility that--

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(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

(ii) provides any of the emergency services (as defined in subparagraph (C)(i)).

(E) Qualifying payment amount

(i) In general

The term "qualifying payment amount" means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering group or individual health insurance coverage--

(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market (specified in subclause (I), (II), (III), or (IV) of clause (iv)) as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

(II) for an item or service furnished during 2023 or a subsequent year, the qualifying payment amount determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(ii) New plans and coverage

The term "qualifying payment amount" means, with respect to a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019--

(I) for the first year in which such group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan or coverage and furnished during such first year; and

(II) for each subsequent year such group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in such region, the qualifying payment amount

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determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(iii) Insufficient information; newly covered items and services

In the case of a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (v)(III)), in the first coverage year (as defined in clause (v)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term "qualifying payment amount"--

(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (v)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term qualifying payment amount in clause (i)(I), except that in applying such clause to such item or service, the reference to "furnished during 2022" shall be treated as a reference to furnished during such first sufficient information year, the reference to "in 2019" [1] shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to "furnished during 2023 or a subsequent year" shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(iv) Insurance market

For purposes of clause (i)(I), a health insurance market specified in this clause is one of the following:

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(I) The individual market.

(II) The large group market (other than plans described in subclause (IV)).

(III) The small group market (other than plans described in subclause (IV)).

(IV) In the case of a self-insured group health plan, other self-insured group health plans.

(v) Definitions

For purposes of this subparagraph:

(I) First coverage year

The term "first coverage year" means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance issuer and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

(II) First sufficient information year

The term "first sufficient information year" means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance issuer--

(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which the sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

(III) Newly covered item or service

The term "newly covered item or service" means, with respect to a group health plan or group or individual health insurance issuer offering health insurance coverage, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

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(F) Nonparticipating emergency facility; participating emergency facility

(i) Nonparticipating emergency facility

The term "nonparticipating emergency facility" means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) Participating emergency facility

The term "participating emergency facility" means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

(G) Nonparticipating providers; participating providers

(i) Nonparticipating provider

The term "nonparticipating provider" means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) Participating provider

The term "participating provider" means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(H) Recognized amount

The term "recognized amount" means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer--

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(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount that is the qualifying payment amount (as defined in subparagraph (E))[2] for such year and determined in accordance with rulemaking described in paragraph (2)(B)) for such item or service; or

(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

(I) Specified State law

The term "specified State law" means, with respect to a State, an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 1144 of Title 29) in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility.

(J) Stabilize

The term "to stabilize", with respect to an emergency medical condition (as defined in subparagraph (B)), has the meaning give[3] in section 1867(e)(3) of the Social Security Act.

(K) Out-of-network rate

The term "out-of-network rate" means, with respect to an item or service furnished in a State during a year to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer receiving such item or service from a nonparticipating provider or nonparticipating emergency facility--

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law;

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(ii) subject to clause (iii), in the case such State does not have in effect such a law with respect to such item or service, plan, and provider or facility--

(I) subject to subclause (II), if the provider or facility (as applicable) and such plan or coverage agree on an amount of payment (including if such agreed on amount is the initial payment sent by the plan under subsection (a)(1)(C)(iv)(I), subsection (b)(1)(C), or section 300gg-112(a)(3)(A) of this title, as applicable, or is agreed on through open negotiations under subsection (c)(1)) with respect to such item or service, such agreed on amount; or

(II) if such provider or facility (as applicable) and such plan or coverage enter the independent dispute resolution process under subsection (c) and do not so agree before the date on which a certified IDR entity (as defined in paragraph (4) of such subsection) makes a determination with respect to such item or service under such subsection, the amount of such determination; or

(iii) in the case such State has an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

(L) Cost-sharing

The term "cost-sharing" includes copayments, coinsurance, and deductibles.

(b) Coverage of non-emergency services performed by nonparticipating providers at certain participating facilities

(1) In general

In the case of items or services (other than emergency services to which subsection (a) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering group or individual health insurance coverage furnished to a participant, beneficiary, or enrollee of such plan or coverage by a nonparticipating provider (as defined in subsection (a)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 300gg-132(d) of this title) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively--

(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing requirement for such items and services so furnished that is greater than the cost-sharing requirement that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (a)(3)(G)(ii));

(B) shall calculate such cost-sharing requirement as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (a)(3)(H)) for such items and services, plan or coverage, and year;

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(C) not later than 30 calendar days after the bill for such services is transmitted by such provider, shall send to the provider an initial payment or notice of denial of payment;

(D) shall pay a total plan or coverage payment directly, in accordance, if applicable, with the timing requirement described in subsection (c)(6), to such provider furnishing such items and services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (C), equal to the amount by which the out-of-network rate (as defined in subsection (a)(3)(K)) for such items and services involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)) and year; and

(E) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant, beneficiary, or enrollee (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

(2) Definitions

In this section:

(A) Participating health care facility

(i) In general

The term "participating health care facility" means, with respect to an item or service and a group health plan or health insurance issuer offering group or individual health insurance coverage, a health care facility described in clause (ii) that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.

(ii) Health care facility described

A health care facility described in this clause, with respect to a group health plan or group or individual health insurance coverage, is each of the following:

(I) A hospital (as defined in section 1861(e) of the Social Security Act).

(II) A hospital outpatient department.

(III) A critical access hospital (as defined in section 1861(mm)(1) of such Act).

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(IV) An ambulatory surgical center described in section 1833(i)(1)(A) of such Act.

(V) Any other facility, specified by the Secretary, that provides items or services for which coverage is provided under the plan or coverage, respectively.

(B) Visit

The term "visit" shall, with respect to items and services furnished to an individual at a health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

(c) Determination of out-of-network rates to be paid by health plans; independent dispute resolution process

(1) Determination through open negotiation

(A) In general

With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, in a State described in subsection (a)(3)(K)(ii) with respect to such plan or coverage and provider or facility, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(1) or (b)(1), the provider or facility (as applicable) or plan or coverage may, during the 30-day period beginning on the day the provider or facility receives an initial payment or a notice of denial of payment from the plan or coverage regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such provider or facility and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider or facility, respectively, and such plan or coverage for payment (including any cost-sharing) for such item or service. For purposes of this subsection, the open negotiation period, with respect to an item or service, is the 30-day period beginning on the date of initiation of the negotiations with respect to such item or service.

(B) Accessing independent dispute resolution process in case of failed negotiations

In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant

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to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

(2) Independent dispute resolution process available in case of failed open negotiations

(A) Establishment

Not later than 1 year after December 27, 2020, the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the "IDR process") under which, in the case of an item or service with respect to which a provider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a "qualified IDR item or service"), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such item or service furnished by such provider or facility.

(B) Authority to continue negotiations

Under the independent dispute resolution process, in the case that the parties to a determination for a qualified IDR item or service agree on a payment amount for such item or service during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of subsection (a)(3)(K)(ii) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

(C) Clarification

A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 300gg-132 of this title with respect to such item or service pursuant to subsection (b) of such section.

(3) Treatment of batching of items and services

(A) In general

Under the IDR process, the Secretary shall specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the IDR process. Such items and services may be so considered only if--

(i) such items and services to be included in such determination are furnished by the same provider or facility;

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(ii) payment for such items and services is required to be made by the same group health plan or health insurance issuer;

(iii) such items and services are related to the treatment of a similar condition; and

(iv) such items and services were furnished during the 30 day[4] period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by the Secretary, for use in limited situations, such as by the consent of the parties or in the case of low-volume items and services, to encourage procedural efficiency and minimize health plan and provider administrative costs.

(B) Treatment of bundled payments

In carrying out subparagraph (A), the Secretary shall provide that, in the case of items and services which are included by a provider or facility as part of a bundled payment, such items and services included in such bundled payment may be part of a single determination under this subsection.

(4) Certification and selection of IDR entities

(A) In general

The Secretary, in consultation with the Secretary of Labor and Secretary of the Treasury, shall establish a process to certify (including to recertify) entities under this paragraph. Such process shall ensure that an entity so certified--

(i) has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to make determinations described in paragraph (5) on a timely basis;

(ii) is not--

(I) a group health plan or health insurance issuer offering group or individual health insurance coverage, provider, or facility;

(II) an affiliate or a subsidiary of such a group health plan or health insurance issuer, provider, or facility; or

(III) an affiliate or subsidiary of a professional or trade association of such group health plans or health insurance issuers or of providers or facilities;

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(iii) carries out the responsibilities of such an entity in accordance with this subsection;

(iv) meets appropriate indicators of fiscal integrity;

(v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations;

(vi) does not under the IDR process carry out any determination with respect to which the entity would not pursuant to subclause (I), (II), or (III) of subparagraph (F)(i) be eligible for selection; and

(vii) meets such other requirements as determined appropriate by the Secretary.

(B) Period of certification

Subject to subparagraph (C), each certification (including a recertification) of an entity under the process described in subparagraph (A) shall be for a 5-year period.

(C) Revocation

A certification of an entity under this paragraph may be revoked under the process described in subparagraph (A) if the entity has a pattern or practice of noncompliance with any of the requirements described in such subparagraph.

(D) Petition for denial or withdrawal

The process described in subparagraph (A) shall ensure that an individual, provider, facility, or group health plan or health insurance issuer offering group or individual health insurance coverage may petition for a denial of a certification or a revocation of a certification with respect to an entity under this paragraph for failure of meeting a requirement of this subsection.

(E) Sufficient number of entities

The process described in subparagraph (A) shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (5).

(F) Selection of certified IDR entity

The Secretary shall, with respect to the determination of the amount of payment under this subsection of an item or service, provide for a method--

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(i) that allows for the group health plan or health insurance issuer offering group or individual health insurance coverage and the nonparticipating provider or the nonparticipating emergency facility (as applicable) involved in a notification under paragraph (1)(B) to jointly select, not later than the last day of the 3-business day period following the date of the initiation of the process with respect to such item or service, for purposes of making such determination, an entity certified under this paragraph that--

(I) is not a party to such determination or an employee or agent of such a party;

(II) does not have a material familial, financial, or professional relationship with such a party; and

(III) does not otherwise have a conflict of interest with such a party (as determined by the Secretary); and

(ii) that requires, in the case such parties do not make such selection by such last day, the Secretary to, not later than 6 business days after such date of initiation--

(I) select such an entity that satisfies subclauses (I) through (III) of clause (i)); and

(II) provide notification of such selection to the provider or facility (as applicable) and the plan or issuer (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the "certified IDR entity" with respect to such determination.

(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).

(B) Submission of offers

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Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination--

(i) shall each submit to the certified IDR entity with respect to such determination--

(I) an offer for a payment amount for such item or service furnished by such provider or facility; and

(II) such information as requested by the certified IDR entity relating to such offer; and

(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

(C) Considerations in determination

(i) In general

In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider--

(I) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

(ii) Additional circumstances

For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer of group or individual health insurance coverage the following:

(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1395aaa of this title).

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(II) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(D) Prohibition on consideration of certain factors

In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges, the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 300gg-131 or 300gg-132 of this title (as applicable) not applied, or the payment or reimbursement rate for such items and services furnished by such provider or facility payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, under the Children's Health Insurance Program under title XXI of such Act, under the TRICARE program under chapter 55 of Title 10, or under chapter 17 of Title 38.

(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.

(ii) Suspension of certain subsequent IDR requests

In the case of a determination of a certified IDR entity under subparagraph (A), with respect to an initial notification submitted under paragraph (1)(B) with respect to qualified IDR items and services and the two

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parties involved with such notification, the party that submitted such notification may not submit during the 90-day period following such determination a subsequent notification under such paragraph involving the same other party to such notification with respect to such an item or service that was the subject of such initial notification.

(iii) Subsequent submission of requests permitted

In the case of a notification that pursuant to clause (ii) is not permitted to be submitted under paragraph (1)(B) during a 90-day period specified in such clause, if the end of the open negotiation period specified in paragraph (1)(A), that but for this clause would otherwise apply with respect to such notification, occurs during such 90-day period, such paragraph (1)(B) shall be applied as if the reference in such paragraph to the 4-day period beginning on the day after such open negotiation period were instead a reference to the 30-day period beginning on the day after the last day of such 90-day period.

(iv) Reports

The Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall examine the impact of the application of clause (ii) and whether the application of such clause delays payment determinations or impacts early, alternative resolution of claims (such as through open negotiations), and shall submit to Congress, not later than 2 years after the date of implementation of such clause an interim report (and not later than 4 years after such date of implementation, a final report) on whether any group health plans or health insurance issuers offering group or individual health insurance coverage or types of such plans or coverage have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day period described in such clause, including recommendations on ways to discourage such a pattern or practice.

(F) Costs of independent dispute resolution process

In the case of a notification under paragraph (1)(B) submitted by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group or individual health insurance coverage and submitted to a certified IDR entity--

(i) if such entity makes a determination with respect to such notification under subparagraph (A), the party whose offer is not chosen under such subparagraph shall be responsible for paying all fees charged by such entity; and

(ii) if the parties reach a settlement with respect to such notification prior to such a determination, each party shall pay half of all fees charged by such entity, unless the parties otherwise agree.

(6) Timing of payment

The total plan or coverage payment required pursuant to subsection (a)(1) or (b)(1), with respect to a qualified IDR item or service for which a determination is made under paragraph (5)(A) or with respect to an item or service for which a payment amount is determined under open negotiations under paragraph (1), shall be

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made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made.

(7) Publication of information relating to the IDR process

(A) Publication of information

For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall make available on the public website of the Department of Health and Human Services--

(i) the number of notifications submitted under paragraph (1)(B) during such calendar quarter;

(ii) the size of the provider practices and the size of the facilities submitting notifications under paragraph (1)(B) during such calendar quarter;

(iii) the number of such notifications with respect to which a determination was made under paragraph (5)(A);

(iv) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made;

(v) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount, specified by items and services;

(vi) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

(vii) the total amount of fees paid under paragraph (8) during such calendar quarter; and

(viii) the total amount of compensation paid to certified IDR entities under paragraph (5)(F) during such calendar quarter.

(B) Information

For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under paragraph (1)(B) by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group or individual health insurance coverage--

(i) a description of each item and service included with respect to such notification;

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(ii) the geography in which the items and services with respect to such notification were provided;

(iii) the amount of the offer submitted under paragraph (5)(B) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider or nonparticipating emergency facility (as applicable) expressed as a percentage of the qualifying payment amount;

(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider or facility (as applicable) and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

(v) the category and practice specialty of each such provider or facility involved in furnishing such items and services;

(vi) the identity of the health plan or health insurance issuer, provider, or facility, with respect to the notification;

(vii) the length of time in making each determination;

(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

(ix) any other information specified by the Secretary.

(C) IDR entity requirements

For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines necessary to carry out the provisions of this subsection.

(D) Clarification

The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

(8) Administrative fee

(A) In general

Each party to a determination under paragraph (5) to which an entity is selected under paragraph (3)[5] in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for

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participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

(B) Amount of fee

The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

(9) Waiver authority

The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period described in paragraph (5)(E)(ii), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

(d) Certain access fees to certain databases

In the case of a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage that, pursuant to subsection (a)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.

(e) Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations

A group health plan or a health insurance issuer offering group or individual health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants, beneficiaries, or enrollees in the plan or coverage the following:

(1) Any deductible applicable to such plan or coverage.

(2) Any out-of-pocket maximum limitation applicable to such plan or coverage.

(3) A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage [6]

(f) Advanced explanation of benefits

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(1) In general

For plan years beginning on or after January 1, 2022, each group health plan, or a health insurance issuer offering group or individual health insurance coverage shall, with respect to a notification submitted under section 300gg-136 of this title by a health care provider or health care facility to the plan or issuer for a participant, beneficiary, or enrollee under plan or coverage scheduled to receive an item or service from the provider or facility (or authorized representative of such participant, beneficiary, or enrollee), not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made to such plan or coverage by such participant, beneficiary, or enrollee), 3 business days) after the date on which the plan or coverage receives such notification (or such request), provide to the participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) a notification (in clear and understandable language) including the following:

(A) Whether or not the provider or facility is a participating provider or a participating facility with respect to the plan or coverage with respect to the furnishing of such item or service and--

(i) in the case the provider or facility is a participating provider or facility with respect to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan or coverage for such item or service (based on the billing and diagnostic codes provided by such provider or facility); and

(ii) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan or coverage, a description of how such individual may obtain information on providers and facilities that, with respect to such plan or coverage, are participating providers and facilities, if any.

(B) The good faith estimate included in the notification received from the provider or facility (if applicable) based on such codes.

(C) A good faith estimate of the amount the plan or coverage is responsible for paying for items and services included in the estimate described in subparagraph (B).

(D) A good faith estimate of the amount of any cost-sharing for which the participant, beneficiary, or enrollee would be responsible for such item or service (as of the date of such notification).

(E) A good faith estimate of the amount that the participant, beneficiary, or enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan or coverage (as of the date of such notification).

(F) In the case such item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage under the plan or coverage, a disclaimer that coverage for such item or service is subject to such medical management technique.

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(G) A disclaimer that the information provided in the notification is only an estimate based on the items and services reasonably expected, at the time of scheduling (or requesting) the item or service, to be furnished and is subject to change.

(H) Any other information or disclaimer the plan or coverage determines appropriate that is consistent with information and disclaimers required under this section.

(2) Authority to modify timing requirements in the case of specified items and services

(A) In general

In the case of a participant, beneficiary, or enrollee scheduled to receive an item or service that is a specified item or service (as defined in subparagraph (B)), the Secretary may modify any timing requirements relating to the provision of the notification described in paragraph (1) to such participant, beneficiary, or enrollee with respect to such item or service. Any modification made by the Secretary pursuant to the previous sentence may not result in the provision of such notification after such participant, beneficiary, or enrollee has been furnished such item or service.

(B) Specified item or service defined

For purposes of subparagraph (A), the term "specified item or service" means an item or service that has low utilization or significant variation in costs (such as when furnished as part of a complex treatment), as specified by the Secretary.

CREDIT(S)

(July 1, 1944, c. 373, Title XXVII, § 2799A-1, as added and amended Pub.L. 116-260, Div. BB, Title I, §§ 102(a)(1), 103(a), 107(a), 111(a), Dec. 27, 2020, 134 Stat. 2759, 2797, 2858, 2861.)

Notes of Decisions (46)

Footnotes

1 See References in Text note set out under this section.

2 So in original. There should probably be only one closing parenthesis.

3 So in original. Probably should be "given".

4 So in original. Probably should be "30-day".

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5 So in original. Probably should be "paragraph (4)".

6 So in original. Probably should be followed by a period.

42 U.S.C.A. § 300gg-111, 42 USCA § 300gg-111
Current through P.L. 119-100. Some statute sections may be more current, see credits for details.

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Code of Federal Regulations
Title 45. Public Welfare
Subtitle A. Department of Health and Human Services (Refs & Annos)
Subchapter B. Requirements Relating to Health Care Access (Refs & Annos)
Part 149. Surprise Billing and Transparency Requirements (Refs & Annos)
Subpart F. Independent Dispute Resolution Process (Refs & Annos)

This section has been updated. Click here for the updated version.

45 C.F.R. § 149.510

§ 149.510 Independent dispute resolution process.

Effective: January 22, 2024 to August 2, 2026

<Text of section effective until Aug. 3, 2026.>

<For Constitutional and statutory provisions affecting validity of portions of par. (b)(3), see: U.S. Const. art. 3, § 2, cl. 1; 5 U.S.C.A. § 706(2)(A); 42 U.S.C.A. §§ 300gg-111(a)(3)(E)(i)(I)-(II), 300gg-111(c)(4), 300gg-111(c)(5)(C).>

(a) Scope and definitions—

(1) Scope. This section sets forth requirements with respect to the independent dispute resolution (IDR) process (referred to in this section as the Federal IDR process) under which a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services (as applicable), and a group health plan or health insurance issuer offering group or individual health insurance coverage completes a requisite open negotiation period and at least one party submits a notification under paragraph (b) of this section to initiate the Federal IDR process under paragraph (c) of this section, and under which an IDR entity (as certified under paragraph (e) of this section) determines the amount of payment under the plan or coverage for an item or service furnished by the provider or facility.

(2) Definitions. Unless otherwise stated, the definitions in § 149.30 of this part apply to this section. Additionally, for purposes of this section, the following definitions apply:

(i) Batched items and services means multiple qualified IDR items or services that are considered jointly as part of one payment determination by a certified IDR entity for purposes of the Federal IDR process. In order for a qualified IDR item or service to be included in a batched item or service, the qualified IDR item or service must meet the criteria set forth in paragraph (c)(3) of this section.

(ii) Breach means the acquisition, access, use, or disclosure of individually identifiable health information (IIHI) in a manner not permitted under paragraph (e)(2)(v) of this section that compromises the security or privacy of the IIHI.

(A) Breach excludes:

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(1) Any unintentional acquisition, access, or use of IIHI by personnel, a contractor, or a subcontractor of a certified IDR entity that is acting under the authority of that certified IDR entity, if the acquisition, access, or use was made in good faith and within the scope of that authority and that does not result in further use or disclosure in a manner not permitted under paragraph (e)(2)(v) of this section.

(2) Any inadvertent disclosure by a person who is authorized to access IIHI at a certified IDR entity to another person authorized to access IIHI at the same certified IDR entity, and the information received as a result of the disclosure is not further used or disclosed in a manner not permitted under paragraph (e)(2)(v) of this section.

(3) A disclosure of IIHI in which a certified IDR entity has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(B) Except as provided in paragraph (a)(2)(ii)(A) of this definition, access, use, or disclosure of IIHI in a manner not permitted under paragraph (e)(2)(v) of this section is presumed to be a breach unless the certified IDR entity demonstrates that there is a low probability that the security or privacy of the IIHI has been compromised based on a risk assessment encompassing at least the following factors:

(1) The nature and extent of the IIHI involved, including the types of identifiers and the likelihood of re-identification;

(2) The unauthorized person who used the IIHI or to whom the disclosure was made;

(3) Whether the IIHI was actually acquired or viewed; and

(4) The extent to which the risk to the IIHI has been mitigated.

(iii) Certified IDR entity means an entity responsible for conducting determinations under paragraph (c) of this section that meets the certification criteria specified in paragraph (e) of this section and that has been certified by the Secretary, jointly with the Secretaries of Labor and the Treasury.

(iv) Conflict of interest means, with respect to a party to a payment determination, or certified IDR entity, a material relationship, status, or condition of the party, or certified IDR entity that impacts the ability of the certified IDR entity to make an unbiased and impartial payment determination. For purposes of this section, a conflict of interest exists when a certified IDR entity is:

(A) A group health plan; a health insurance issuer offering group health insurance coverage, individual health insurance coverage, or short-term, limited-duration insurance; a carrier offering a health benefits plan under 5 U.S.C. 8902; or a provider, a facility, or a provider of air ambulance services;

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(B) An affiliate or a subsidiary of a group health plan; a health insurance issuer offering group health insurance coverage, individual health insurance coverage, or short-term limited-duration insurance; a carrier offering a health benefits plan under 5 U.S.C. 8902; or a provider, a facility, or a provider of air ambulance services;

(C) An affiliate or subsidiary of a professional or trade association representing group health plans; health insurance issuers offering group health insurance coverage, individual health insurance coverage, or short-term limited duration insurance; carriers offering a health benefits plan under 5 U.S.C. 8902; or providers, facilities, or providers of air ambulance services.

(D) A certified IDR entity, that has, or that has any personnel, contractors, or subcontractors assigned to a determination who have, a material familial, financial, or professional relationship with a party to the payment determination being disputed, or with any officer, director, or management employee of the plan, issuer, or carrier offering a health benefits plan under 5 U.S.C. 8902; the plan or coverage administrator, plan or coverage fiduciaries, or plan, issuer or carrier employees; the health care provider, the health care provider's group or practice association; the provider of air ambulance services, the provider of air ambulance services' group or practice association, or the facility that is a party to the dispute.

(v) Credible information means information that upon critical analysis is worthy of belief and is trustworthy.

(vi) IDR entity means an entity that may apply or has applied for certification to conduct determinations under paragraph (c) of this section, and that currently is not certified by the Secretary, jointly with the Secretaries of Labor and the Treasury, pursuant to paragraph (e) of this section.

(vii) Individually identifiable health information (IIHI) means any information, including demographic data, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(A) That identifies the individual; or

(B) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(viii) Material familial relationship means any relationship as a spouse, domestic partner, child, parent, sibling, spouse's or domestic partner's parent, spouse's or domestic partner's sibling, spouse's or domestic partner's child, child's parent, child's spouse or domestic partner, or sibling's spouse or domestic partner.

(ix) Material financial relationship means any financial interest of more than five percent of total annual revenue or total annual income of a certified IDR entity or an officer, director, or manager thereof, or of a reviewer or reviewing physician employed or engaged by a certified IDR entity to conduct or participate in any review in the Federal IDR process. The terms annual revenue and annual income do not include mediation fees received by mediators who are also arbitrators, provided that the mediator acts in the capacity of a mediator and does not represent a party in the mediation.

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(x) Material professional relationship means any physician-patient relationship, any partnership or employment relationship, any shareholder or similar ownership interest in a professional corporation, partnership, or other similar entity; or any independent contractor arrangement that constitutes a material financial relationship with any expert used by the certified IDR entity or any officer or director of the certified IDR entity.

(xi) Qualified IDR item or service means an item or service:

(A) That is an emergency service furnished by a nonparticipating provider or nonparticipating facility subject to the protections of 26 CFR 54.9816–4T, 29 CFR 2590.716–4, or § 149.110, as applicable, for which the conditions of § 149.410(b) are not met, or an item or service furnished by a nonparticipating provider at a participating health care facility, subject to the requirements of 26 CFR 54.9816–5T, 29 CFR 2590.717–5, or § 149.120, as applicable, for which the conditions of § 149.420(c)-(i) are not met, or air ambulance services furnished by a nonparticipating provider of air ambulance services subject to the protections of 26 CFR 54.9817–1T, 29 CFR 2590.717–1, or § 149.130, as applicable, and for which the out-of-network rate is not determined by reference to an All–Payer Model Agreement under section 1115A of the Social Security Act or a specified State law as defined in § 149.30;

(B) With respect to which a provider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage submits a notification under paragraph (b)(2) of this section;

(C) That is not an item or service that is the subject of an open negotiation under paragraph (b)(1) of this section; and

(D) That is not an item or service for which a notification under paragraph (b)(2) of this section is submitted during the 90–calendar-day period under paragraph (c)(4)(vi)(B) of this section, but that may include such an item or service if the notification is submitted during the subsequent 30–business-day period under paragraph (c)(4)(vi)(C) of this section.

(xii) Unsecured IIHI means IIHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor.

(b) Determination of payment amount through open negotiation and initiation of the Federal IDR process—

(1) Determination of payment amount through open negotiation—

(i) In general. With respect to an item or service that meets the requirements of paragraph (a)(2)(xii)(A) of this section, the provider, facility, or provider of air ambulance services or the group health plan or health insurance issuer offering group or individual health insurance coverage may, during the 30–business-day period beginning on the day the provider, facility, or provider of air ambulance services receives an initial payment or notice of denial of payment regarding the item or service, initiate an open negotiation period for purposes of determining the out-of-network rate for such item or service. To initiate the open negotiation period, a party must send a notice to the other party (open negotiation notice) in accordance with paragraph (b)(1)(ii) of this section.

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(ii) Open negotiation notice—

(A) Content. The open negotiation notice must include information sufficient to identify the item(s) and service(s) (including the date(s) the item(s) or service(s) were furnished, the service code, and initial payment amount, if applicable), an offer of an out-of-network rate, and contact information for the party sending the open negotiation notice.

(B) Manner. The open negotiation notice must be provided, using the standard form developed by the Secretary, in writing within 30 business days beginning on the day the provider, facility, or provider of air ambulance services receives an initial payment or a notice of denial of payment from the plan or issuer regarding the item or service. The day on which the open negotiation notice is first sent by a party is the date the 30–business-day open negotiation period begins. This notice may be provided to the other party electronically (such as by email) if the following two conditions are satisfied—

(1) The party sending the open negotiation notice has a good faith belief that the electronic method is readily accessible by the other party; and

(2) The notice is provided in paper form free of charge upon request.

(2) Initiating the Federal IDR process—

(i) In general. With respect to an item or service for which the parties do not agree upon an out-of-network rate by the last day of the open negotiation period under paragraph (b)(1) of this section, either party may initiate the Federal IDR process. To initiate the Federal IDR process, a party must submit a written notice of IDR initiation to the other party and to the Secretary, using the standard form developed by the Secretary, during the 4–business-day period beginning on the 31st business day after the start of the open negotiation period.

(ii) Exception for items and services provided by certain nonparticipating providers and facilities. A party may not initiate the Federal IDR process with respect to an item or service if, with respect to that item or service, the party knows (or reasonably should have known) that the provider or facility provided notice and received consent under 45 CFR 149.410(b) or 149.420(c) through (i).

(iii) Notice of IDR initiation—

(A) Content. The notice of IDR initiation must include:

(1) Information sufficient to identify the qualified IDR items or services under dispute (and whether the qualified IDR items or services are designated as batched items and services as described in paragraph (c)(3) of this section), including the date(s) and location the item or service was furnished, the type of item or service (such as whether the qualified IDR item or service is an emergency service as defined in 26 CFR 54.9816–4T(c)(2)(i), 29 CFR 2590.716–4(c)(2)(i), or § 149.110(c)(2)(i), as applicable, an emergency service as defined in 26 CFR

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54.9816–4T(c)(2)(ii), 29 CFR 2590.716–4(c)(2)(ii), or § 149.110(c)(2)(ii), as applicable, or a nonemergency service; and whether any service is a professional service or facility-based service), corresponding service codes, place of service code, the amount of cost sharing allowed, and the amount of the initial payment made for the qualified IDR item or service, if applicable;

(2) Names of the parties involved and contact information, including name, email address, phone number, and mailing address;

(3) State where the qualified IDR item or service was furnished;

(4) Commencement date of the open negotiation period under paragraph (b)(1) of this section;

(5) Preferred certified IDR entity;

(6) An attestation that the items and services under dispute are qualified IDR items or services;

(7) Qualifying payment amount;

(8) Information about the qualifying payment amount as described in § 149.140(d); and

(9) General information describing the Federal IDR process as specified by the Secretary.

(B) Manner. The initiating party must provide written notice of IDR initiation to the other party. The initiating party may satisfy this requirement by furnishing the notice of IDR initiation to the other party electronically (such as by email) if the following two conditions are satisfied—

(1) The initiating party has a good faith belief that the electronic method is readily accessible by the other party; and

(2) The notice is provided in paper form free of charge upon request.

(C) Notice to the Secretary. The initiating party must also furnish the notice of IDR initiation to the Secretary by submitting the notice through the Federal IDR portal. The initiation date of the Federal IDR process will be the date of receipt by the Secretary.

(c) Federal IDR process following initiation—

(1) Selection of certified IDR entity—

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(i) In general. The plan or issuer or the provider, facility, or provider of air ambulance services receiving the notice of IDR initiation under paragraph (b)(2) of this section may agree or object to the preferred certified IDR entity identified in the notice of IDR initiation. If the party in receipt of the notice of IDR initiation fails to object within 3 business days, the preferred certified IDR entity identified in the notice of IDR initiation will be selected and will be treated as jointly agreed to by the parties, provided that the certified IDR entity does not have a conflict of interest. If the party in receipt of the notice of IDR initiation objects, that party must notify the initiating party of the objection and propose an alternative certified IDR entity. The initiating party must then agree or object to the alternative certified IDR entity; if the initiating party fails to agree or object to the alternative certified IDR entity, the alternative certified IDR entity will be selected and will be treated as jointly agreed to by the parties. In order to select a preferred certified IDR entity, the plan or issuer and the provider, facility, or provider of air ambulance services must jointly agree on a certified IDR entity not later than 3 business days after the initiation date of the Federal IDR process. If the plan or issuer and the provider, facility, or provider of air ambulance services fail to agree upon a certified IDR entity within that time, the Secretary shall select a certified IDR entity in accordance with paragraph (c)(1)(iv) of this section.

(ii) Requirements for selected certified IDR entity. The certified IDR entity selected must be an IDR entity certified under paragraph (e) of this section, that:

(A) Does not have a conflict of interest as defined in paragraph (a)(2) of this section;

(B) Ensures that assignment of personnel to a payment determination and decisions regarding hiring, compensation, termination, promotion, or other similar matters related to personnel assigned to the dispute are not made based upon the likelihood that the assigned personnel will support a particular party to the determination being disputed other than as outlined under paragraph (c)(4)(iii) of this section; and

(C) Ensures that any personnel assigned to a payment determination do not have any conflicts of interests as defined in paragraph (a)(2) of this section regarding any party to the dispute within the 1 year immediately preceding an assignment of dispute determination, similar to the requirements laid out in 18 U.S.C. 207(b).

(iii) Notice of certified IDR entity selection. Upon the selection of a certified IDR entity, in accordance with paragraph (c)(1)(i) of this section, the plan or issuer or the provider or emergency facility that submitted the notice of IDR initiation under paragraph (b)(2) of this section must notify the Secretary of the selection as soon as reasonably practicable, but no later than 1 business day after such selection, through the Federal IDR portal. In addition, if the non-initiating party believes that the Federal IDR process is not applicable, the non-initiating party must also provide information regarding the Federal IDR process's inapplicability through the Federal IDR portal by the same date that the notice of certified IDR entity selection must be submitted.

(A) Content. If the parties have agreed on the selection of a certified IDR entity or the party in receipt of the notice of IDR initiation has not objected to the other party's selection, the notice of the certified IDR entity selection must include the following information:

(1) Name of the certified IDR entity;

(2) The certified IDR entity number; and

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(3) Attestation by both parties, or by the initiating party if the non-initiating party fails to object to the selection of the certified IDR entity, that the selected certified IDR entity meets the requirements of paragraph (c)(1)(ii) of this section.

(B) [Reserved]

(iv) Failure to select a certified IDR entity. If the plan or issuer and the provider, facility, or provider of air ambulance services fail to select a certified IDR entity in accordance with paragraph (c)(1)(i) of this section, the initiating party must notify the Secretary of the failure no later than 1 business day after the date of such failure (or in other words, 4 business days after initiation of the Federal IDR process) by electronically submitting the notice as described in paragraph (c)(1)(iii) of this section but indicating that the parties have failed to select a certified IDR entity. In addition, if the non-initiating party believes that the Federal IDR process is not applicable, the non-initiating party must also provide information regarding Federal IDR process's inapplicability through the Federal IDR portal by the same date that the notice of failure to select must be submitted. Upon notification of the failure of the parties to select a certified IDR entity, the Secretary will select a certified IDR entity that charges a fee within the allowed range of certified IDR entity fees through a random selection method not later than 6 business days after the date of initiation of the Federal IDR process and will notify the plan or issuer and the provider or facility of the selection. If there are insufficient certified IDR entities that charge a fee within the allowed range of certified IDR entity fees available to arbitrate the dispute, the Secretary, jointly with the Secretary of the Treasury and Secretary of Labor, will select a certified IDR entity that has received approval, as described in paragraph (e)(2)(vi)(B) of this section, to charge a fee outside of the allowed range of certified IDR entity fees.

(v) Review by certified IDR entity. After selection by the parties (including when the initiating party selects a certified IDR entity and the other party does not object), or by the Secretary under paragraph (c)(1)(iv) of this section, the certified IDR entity must review the selection and attest that it meets the requirements of paragraph (c)(1)(ii) of this section. If the certified IDR entity is unable to attest that it meets the requirements of paragraph (c)(1)(ii) of this section within 3 business days of selection, the parties, upon notification, must select another certified IDR entity under paragraph (c)(1) of this section, treating the date of notification of the failure to attest to the requirements of (c)(1)(ii) as the date of initiation of the Federal IDR process for purposes of the time periods in paragraphs (c)(1)(i) and (iv) of this section. Additionally, the certified IDR entity selected must review the information submitted in the notice of IDR initiation to determine whether the Federal IDR process applies. If the Federal IDR process does not apply, the certified IDR entity must notify the Secretary and the parties within 3 business days of making that determination.

(2) Authority to continue negotiations—

(i) In general. If the parties to the Federal IDR process agree on an out-of-network rate for a qualified IDR item or service after providing the notice of IDR initiation to the Secretary consistent with paragraph (b)(2) of this section, but before the certified IDR entity has made its payment determination, the amount agreed to by the parties for the qualified IDR item or service will be treated as the out-of-network rate for the qualified IDR item or service. To the extent the amount exceeds the initial payment amount (or initial denial of payment) and any cost sharing paid or required to be paid by the participant or beneficiary, payment must be made directly by the plan or issuer to the nonparticipating provider, facility, or nonparticipating provider of air ambulance services not later than 30 business days after the agreement is reached. In no instance may either party seek additional payment from the participant or beneficiary, including in instances in which the out-of-network rate exceeds the qualifying payment amount. The initiating party must send a notification to the Secretary and to the certified IDR entity (if selected) electronically, through the Federal IDR portal, as soon as possible, but no later

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than 3 business days after the date of the agreement. The notification must include the out-of-network rate for the qualified IDR item or service and signatures from authorized signatories for both parties.

(ii) Method of allocation of the certified IDR entity fee. In the case of an agreement described in paragraph (c)(2)(i) of this section, the certified IDR entity is required to return half of each parties' certified IDR entity fee, unless directed otherwise by both parties. The administrative fee under paragraph (d)(2) of this section will not be returned to the parties.

(3) Treatment of batched items and services—

(i) In general. Batched items and services may be submitted and considered jointly as part of one payment determination by a certified IDR entity only if the batched items and services meet the requirements of this paragraph (c)(3)(i). Batched items and services submitted and considered jointly as part of one payment determination under this paragraph (c)(3)(i) are treated as a batched determination and subject to the fee for batched determinations under this section.

(A) The qualified IDR items and services are billed by the same provider or group of providers, the same facility, or the same provider of air ambulance services. Items and services are billed by the same provider or group of providers, the same facility, or the same provider of air ambulance services if the items or services are billed with the same National Provider Identifier or Tax Identification Number;

(B) Payment for the qualified IDR items and services would be made by the same plan or issuer;

(C) The qualified IDR items and services are the same or similar items and services. The qualified IDR items and services are considered to be the same or similar items or services if each is billed under the same service code, or a comparable code under a different procedural code system, such as Current Procedural Terminology (CPT) codes with modifiers, if applicable, Healthcare Common Procedure Coding System (HCPCS) with modifiers, if applicable, or Diagnosis–Related Group (DRG) codes with modifiers, if applicable; and

(D) All the qualified IDR items and services were furnished within the same 30–business-day period, or the same 90–calendar-day period under paragraph (c)(4)(vi)(B) of this section, as applicable.

(ii) Treatment of bundled payment arrangements. In the case of qualified IDR items and services billed by a provider, facility, or provider of air ambulance services as part of a bundled payment arrangement, or where a plan or issuer makes or denies an initial payment as a bundled payment, the qualified IDR items and services may be submitted as part of one payment determination. Bundled payment arrangements submitted under this paragraph (c)(3)(ii) are subject to the rules for batched determinations and the certified IDR entity fee for single determinations.

(4) Payment determination for a qualified IDR item or service—

(i) Submission of offers. Not later than 10 business days after the selection of the certified IDR entity, the plan or issuer and the provider, facility, or provider of air ambulance services:

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(A) Must each submit to the certified IDR entity:

(1) An offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the qualifying payment amount represented by that dollar amount;

(2) Information requested by the certified IDR entity relating to the offer.

(3) The following additional information, as applicable—

(i) For providers and facilities, information on the size of the provider's practice or of the facility (if applicable). Specifically, a group of providers must specify whether the providers' practice has fewer than 20 employees, 20 to 50 employees, 51 to 100 employees, 101 to 500 employees, or more than 500 employees. For facilities, the facility must specify whether the facility has 50 or fewer employees, 51 to 100 employees, 101 to 500 employees, or more than 500 employees;

(ii) For providers and facilities, information on the practice specialty or type, respectively (if applicable);

(iii) For plans and issuers, information on the coverage area of the plan or issuer, the relevant geographic region for purposes of the qualifying payment amount, whether the coverage is fully-insured or partially or fully self-insured (or a FEHB carrier if the item or service relates to FEHB plans); and

(iv) The qualifying payment amount for the applicable year for the same or similar item or service as the qualified IDR item or service.

(B) May each submit to the certified IDR entity any information relating to the offer that was submitted by either party, except that the information may not include information on factors described in paragraph (c)(4)(v) of this section.

(ii) Payment determination and notification. Not later than 30 business days after the selection of the certified IDR entity, the certified IDR entity must:

(A) Select as the out-of-network rate for the qualified IDR item or service one of the offers submitted under paragraph (c)(4)(i) of this section, weighing only the considerations specified in paragraph (c)(4)(iii) of this section (as applied to the information provided by the parties pursuant to paragraph (c)(4)(i) of this section). The certified IDR entity must select the offer that the certified IDR entity determines best represents the value of the qualified IDR item or service as the out-of-network rate.

(B) Notify the plan or issuer and the provider or facility, as applicable, of the selection of the offer under paragraph (c)(4)(ii)(A) of this section, and provide the written decision required under (c)(4)(vi) of this section.

(iii) Considerations in determination. In determining which offer to select:

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(A) The certified IDR entity must consider the qualifying payment amount(s) for the applicable year for the same or similar item or service.

(B) The certified IDR entity must then consider information submitted by a party that relates to the following circumstances:

(1) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the qualified IDR item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).

(2) The market share held by the provider or facility or that of the plan or issuer in the geographic region in which the qualified IDR item or service was provided.

(3) The acuity of the participant, beneficiary, or enrollee receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee.

(4) The teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable.

(5) Demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(C) The certified IDR entity must also consider information provided by a party in response to a request by the certified IDR entity under paragraph (c)(4)(i)(A)(2) of this section that relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and that does not include information on factors described in paragraph (c)(4)(v) of this section.

(D) The certified IDR entity must also consider additional information submitted by a party that relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and that does not include information on factors described in paragraph (c)(4)(v) of this section.

(E) In weighing the considerations described in paragraphs (c)(4)(iii)(B) through (D) of this section, the certified IDR entity should evaluate whether the information is credible and relates to the offer submitted by either party for the payment amount for the qualified IDR item or service that is the subject of the payment determination. The certified IDR entity should not give weight to information to the extent it is not credible, it does not relate to either party's offer for the payment amount for the qualified IDR item or service, or it is already accounted for by the qualifying payment amount under paragraph (c)(4)(iii)(A) of this section or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section.

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(iv) Examples. The rules of paragraph (c)(4)(iii) of this section are illustrated in the following paragraphs. Each example assumes that the Federal IDR process applies for purposes of determining the out-of-network rate, that both parties have submitted the information parties are required to submit as part of the Federal IDR process, and that the submitted information does not include information on factors described in paragraph (c)(4)(v) of this section:

(A) Example 1—(1) Facts. A level 1 trauma center that is a nonparticipating emergency facility and an issuer are parties to a payment determination in the Federal IDR process. The facility submits an offer that is higher than the qualifying payment amount. The facility also submits additional written information showing that the scope of services available at the facility was critical to the delivery of care for the qualified IDR item or service provided, given the particular patient's acuity. This information is determined to be credible by the certified IDR entity. Further, the facility submits additional information showing the contracted rates used to calculate the qualifying payment amount for the qualified IDR item or service were based on a level of service that is typical in cases in which the services are delivered by a facility that is not a level 1 trauma center and that does not have the capability to provide the scope of services provided by a level 1 trauma center. This information is also determined to be credible by the certified IDR entity. The issuer submits an offer equal to the qualifying payment amount. No additional information is submitted by either party. The certified IDR entity determines that all the information submitted by the nonparticipating emergency facility relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination.

(2) Conclusion. In this paragraph (c)(4)(iv)(A) (Example 1), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the nonparticipating emergency facility, provided the information relates to circumstances described in paragraphs (c)(4)(iii)(B) through (D) of this section and relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination. If the certified IDR entity determines that it is appropriate to give weight to the additional credible information submitted by the nonparticipating emergency facility and that the additional credible information submitted by the facility demonstrates that the facility's offer best represents the value of the qualified IDR item or service, the certified IDR entity should select the facility's offer.

(B) Example 2—(1) Facts. A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process. The provider submits an offer that is higher than the qualifying payment amount. The provider also submits additional written information regarding the level of training and experience the provider possesses. This information is determined to be credible by the certified IDR entity, but the certified IDR entity finds that the information does not demonstrate that the provider's level of training and experience relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination (for example, the information does not show that the provider's level of training and experience was necessary for providing the qualified IDR service that is the subject of the payment determination to the particular patient, or that the training or experience made an impact on the care that was provided). The nonparticipating provider does not submit any additional information. The issuer submits an offer equal to the qualifying payment amount, with no additional information.

(2) Conclusion. In this paragraph (c)(4)(iv)(B) (Example 2), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity must then consider the additional information submitted by the nonparticipating provider, provided the information relates to circumstances described in paragraphs (c)(4)(iii)(B) through (D) of this section and relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination. In addition, the certified IDR entity should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines that the additional information submitted by the provider is credible but does not relate to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination, and determines that the issuer's offer best represents the value of the qualified IDR service, in the absence of any other credible information that relates to either party's offer, the certified IDR entity should select the issuer's offer.

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(C) Example 3—(1) Facts. A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process involving an emergency department visit for the evaluation and management of a patient. The provider submits an offer that is higher than the qualifying payment amount. The provider also submits additional written information showing that the acuity of the patient's condition and complexity of the qualified IDR service furnished required the taking of a comprehensive history, a comprehensive examination, and medical decision making of high complexity. This information is determined to be credible by the certified IDR entity. The issuer submits an offer equal to the qualifying payment amount for CPT code 99285, which is the CPT code for an emergency department visit for the evaluation and management of a patient requiring a comprehensive history, a comprehensive examination, and medical decision making of high complexity. The issuer also submits additional written information showing that this CPT code accounts for the acuity of the patient's condition. This information is determined to be credible by the certified IDR entity. The certified IDR entity determines that the information provided by the provider and issuer relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(2) Conclusion. In this paragraph (c)(4)(iv)(C) (Example 3), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the parties, but the certified IDR entity should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines the additional information on the acuity of the patient and complexity of the service is already accounted for in the calculation of the qualifying payment amount, the certified IDR entity should not give weight to the additional information provided by the provider. If the certified IDR entity determines that the issuer's offer best represents the value of the qualified IDR service, the certified IDR entity should select the issuer's offer.

(D) Example 4—(1) Facts. A nonparticipating emergency facility and an issuer are parties to a payment determination in the Federal IDR process. Although the facility is not participating in the issuer's network during the relevant plan year, it was a participating facility in the issuer's network in the previous 4 plan years. The issuer submits an offer that is higher than the qualifying payment amount and that is equal to the facility's contracted rate (adjusted for inflation) for the previous year with the issuer for the qualified IDR service. The issuer also submits additional written information showing that the contracted rates between the facility and the issuer during the previous 4 plan years were higher than the qualifying payment amount submitted by the issuer, and that these prior contracted rates account for the case mix and scope of services typically furnished at the nonparticipating facility. The certified IDR entity determines this information is credible and that it relates to the offer submitted by the issuer for the payment amount for the qualified IDR service that is the subject of the payment determination. The facility submits an offer that is higher than both the qualifying payment amount and the contracted rate (adjusted for inflation) for the previous year with the issuer for the qualified IDR service. The facility also submits additional written information, with the intent to show that the case mix and scope of services available at the facility were integral to the service provided. The certified IDR entity determines this information is credible and that it relates to the offer submitted by the facility for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(2) Conclusion. In this paragraph (c)(4)(iv)(D) (Example 4), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the parties, but should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines that the information submitted by the facility regarding the case mix and scope of services available at the facility includes information that is also accounted for in the information the issuer submitted regarding prior contracted rates, then the certified IDR entity should give weight to that information only once. The certified IDR entity also should not give weight to the same information provided by the nonparticipating emergency facility in relation to any other factor. If the certified IDR entity determines that the issuer's offer best represents the value of the qualified IDR service, the certified IDR entity should select the issuer's offer.

(E) Example 5—(1) Facts. A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process regarding a qualified IDR service for which the issuer downcoded the service code that the provider billed. The issuer

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submits an offer equal to the qualifying payment amount (which was calculated using the downcoded service code). The issuer also submits additional written information that includes the documentation disclosed to the nonparticipating provider under § 149.140(d)(1)(ii) at the time of the initial payment (which describes why the service code was downcoded). The certified IDR entity determines this information is credible and that it relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. The provider submits an offer equal to the amount that would have been the qualifying payment amount had the service code not been downcoded. The provider also submits additional written information that includes the documentation disclosed to the nonparticipating provider under § 149.140(d)(1)(ii) at the time of the initial payment. Further, the provider submits additional written information that explains why the billed service code was more appropriate than the downcoded service code, as evidence that the provider's offer, which is equal to the amount the qualifying payment amount would have been for the service code that the provider billed, best represents the value of the service furnished, given its complexity. The certified IDR entity determines this information to be credible and that it relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(2) Conclusion. In this paragraph (c)(4)(iv)(E) (Example 5), the certified IDR entity must consider the qualifying payment amount, which is based on the downcoded service code. The certified IDR entity then must consider whether to give weight to additional information submitted by the parties. If the certified IDR entity determines that the additional credible information submitted by the provider demonstrates that the nonparticipating provider's offer, which is equal to the qualifying payment amount for the service code that the provider billed, best represents the value of the qualified IDR service, the certified IDR entity should select the nonparticipating provider's offer.

(v) Prohibition on consideration of certain factors. In determining which offer to select, the certified IDR entity must not consider:

(A) Usual and customary charges (including payment or reimbursement rates expressed as a proportion of usual and customary charges);

(B) The amount that would have been billed by the provider or facility with respect to the qualified IDR item or service had the provisions of 45 CFR 149.410 and 149.420 (as applicable) not applied; or

(C) The payment or reimbursement rate for items and services furnished by the provider or facility payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act; the Medicaid program under title XIX of the Social Security Act; the Children's Health Insurance Program under title XXI of the Social Security Act; the TRICARE program under chapter 55 of title 10, United States Code; chapter 17 of title 38, United States Code; or demonstration projects under section 1115 of the Social Security Act.

(vi) Written decision.

(A) The certified IDR entity must explain its determination in a written decision submitted to the parties and the Secretary, in a form and manner specified by the Secretary;

(B) The certified IDR entity's written decision must include an explanation of their determination, including what information the certified IDR entity determined demonstrated that the offer selected as the out-of-network rate is the offer that best represents the value of the qualified IDR item or service, including the weight given to the qualifying

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payment amount and any additional credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity relies on information described under paragraphs (c)(4)(iii)(B) through (D) of this section in selecting an offer, the written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the qualifying payment amount.

(vii) Effects of determination—

(A) Binding. A determination made by a certified IDR entity under paragraph (c)(4)(ii) of this section:

(1) Is binding upon the parties, in the absence of fraud or evidence of intentional misrepresentation of material facts presented to the certified IDR entity regarding the claim; and

(2) Is not subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9, United States Code.

(B) Suspension of certain subsequent IDR requests. In the case of a determination made by a certified IDR entity under paragraph (c)(4)(ii) of this section, the party that submitted the initial notification under paragraph (b)(2) of this section may not submit a subsequent notification involving the same other party with respect to a claim for the same or similar item or service that was the subject of the initial notification during the 90–calendar-day period following the determination.

(C) Subsequent submission of requests permitted. If the end of the open negotiation period specified in paragraph (b)(1) of this section occurs during the 90–calendar-day suspension period regarding claims for the same or similar item or service that were the subject of the initial notice of IDR determination as described in paragraph (c)(4)(vi) of this section, either party may initiate the Federal IDR process for those claims by submitting a notification as specified in paragraph (b)(2) of this section during the 30–business-day period beginning on the day after the last day of the 90–calendar-day suspension period.

(viii) Recordkeeping requirements. The certified IDR entity must maintain records of all claims and notices associated with the Federal IDR process with respect to any determination for 6 years. The certified IDR entity must make these records available for examination by the plan, issuer, FEHB carrier, provider, facility, or provider of air ambulance services, or a State or Federal oversight agency upon request, except to the extent the disclosure would violate either State or Federal privacy law.

(ix) Payment. If applicable, the amount of the offer selected by the certified IDR entity (less the sum of the initial payment and any cost sharing paid or owed by the participant or beneficiary) must be paid directly to the provider, facility, or provider of air ambulance services not later than 30 calendar days after the determination by the certified IDR entity. If the offer selected by the certified IDR entity is less than the sum of the initial payment and any cost sharing paid by the participant or beneficiary, the provider, facility, or provider of air ambulance services will be liable to the plan or issuer for the difference. The provider, facility, or provider of air ambulance services must pay the difference directly to the plan or issuer not later than 30 calendar days after the determination by the certified IDR entity.

(d) Costs of IDR process—

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(1) Certified IDR entity fee.

(i) With respect to the Federal IDR process described in paragraph (c) of this section, the party whose offer submitted to the certified IDR entity under paragraph (c)(4)(ii)(A) of this section is not selected is responsible for the payment to the certified IDR entity of the predetermined fee charged by the certified IDR entity.

(ii) Each party to a determination for which a certified IDR entity is selected under paragraph (c)(1) of this section must pay the predetermined certified IDR entity fee charged by the certified IDR entity to the certified IDR entity at the time the parties submit their offers under (c)(4)(i) of this section. The certified IDR entity fee paid by the prevailing party whose offer is selected by the certified IDR entity will be returned to that party within 30 business days following the date of the certified IDR entity's determination.

(2) Administrative fee.

(i) Each party to a determination for which a certified IDR entity is selected under paragraph (c)(1) of this section must, at the time the certified IDR entity is selected under paragraph (c)(1) of this section, pay to the certified IDR entity a non-refundable administrative fee due to the Secretary for participating in the Federal IDR process described in this section.

(ii) The administrative fee amount will be established through notice and comment rulemaking no more frequently than once per calendar year in a manner such that the total administrative fees paid for a year are estimated to be equal to the amount of expenditures estimated to be made by the Secretaries of the Treasury, Labor, and Health and Human Services for the year in carrying out the Federal IDR process. The administrative fee amount will remain in effect until changed by notice and comment rulemaking. For disputes initiated on or after January 22, 2024, the administrative fee amount is $115 per party per dispute.

(3) Severability.

(i) Any provision of this paragraph (d) or paragraphs (e)(2)(vii) and (viii) of this section held to be invalid or unenforceable as applied to any person or circumstance shall be construed so as to continue to give the maximum effect to the provision permitted by law, including as applied to persons not similarly situated or to dissimilar circumstances, unless such holding is that the provision of this paragraph (d) or paragraphs (e)(2)(vii) and (viii) is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of this paragraph (d) or paragraphs (e)(2)(vii) and (viii) and shall not affect the remainder thereof.

(ii) The provisions in this paragraph (d) and paragraphs (e)(2)(vii) and (viii) of this section are intended to be severable from each other.

(e) Certification of IDR entity—

(1) In general. In order to be selected under paragraph (c)(1) of this section—

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(i) An IDR entity must meet the standards described in this paragraph (e) and be certified by the Secretary, jointly with the Secretaries of Labor and the Treasury, as set forth in this paragraph (e) of this section and guidance promulgated by the Secretary. Once certified, the IDR entity will be provided with a certified IDR entity number.

(ii) An IDR entity must provide written documentation to the Secretary regarding general company information (such as contact information, Taxpayer Identification Number, and website), as well as the applicable service area in which the IDR entity intends to conduct payment determinations under the Federal IDR process. IDR entities may choose to submit their application for all States or self-limit to a particular subset of States.

(iii) An IDR entity that the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, certifies must enter into an agreement as a condition of certification. The agreement shall include specified provisions encompassed by this section, including, but not limited to, the requirements applicable to certified IDR entities when making payment determinations as well as the requirements regarding certification and revocation (such as specifications for wind down activities and reallocation of certified IDR entity fees, where warranted).

(2) Requirements. An IDR entity must provide written documentation to the Secretary through the Federal IDR portal that demonstrates that the IDR entity satisfies the following standards to be a certified IDR entity under this paragraph (e):

(i) Possess (directly or through contracts or other arrangements) sufficient arbitration and claims administration of health care services, managed care, billing and coding, medical and legal expertise to make the payment determinations described in paragraph (c) of this section within the time prescribed in paragraph (c)(4)(ii) of this section.

(ii) Employ (directly or through contracts or other arrangements) a sufficient number of personnel to make the determinations described in paragraph (c) of this section within the time prescribed by (c)(4)(ii) of this section. To satisfy this standard, the written documentation must include a description of the IDR entity's organizational structure and capabilities, including an organizational chart and the credentials, responsibilities, and number of personnel employed to make determinations described in paragraph (c) of this section.

(iii) Maintain a current accreditation from a nationally recognized and relevant accrediting organization, such as URAC, or ensure that it otherwise possesses the requisite training to conduct payment determinations (for example, providing documentation that personnel employed by the IDR entity have completed arbitration training by the American Arbitration Association, the American Health Law Association, or a similar organization).

(iv) Have a process to ensure that no conflict of interest, as defined in paragraph (a)(2) of this section, exists between the parties and the personnel the certified IDR entity assigns to a payment determination to avoid violating paragraph (c)(1)(ii) of this section, including policies and procedures for conducting ongoing audits for conflicts of interest, to ensure that should any arise, the certified IDR entity has procedures in place to inform the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, of the conflict of interest and to mitigate the risk by reassigning the dispute to other personnel in the event that any personnel previously assigned have a conflict of interest.

(v) Have a process to maintain the confidentiality of IIHI obtained in the course of conducting determinations. A certified IDR entity's responsibility to comply with these confidentiality requirements shall survive revocation of the IDR entity's

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certification for any reason, and IDR entities must comply with the record retention and disposal requirements described in this section. Under this process, once certified, the certified IDR entity must comply with the following requirements:

(A) Privacy. The certified IDR entity may create, collect, handle, disclose, transmit, access, maintain, store, and/or use IIHI, only to perform:

(1) The certified IDR entity's required duties described in this section; and

(2) Functions related to carrying out additional obligations as may be required under applicable Federal or State laws or regulations.

(B) Security.

(1) The certified IDR entity must ensure the confidentiality of all IIHI it creates, obtains, maintains, stores, and transmits;

(2) The certified IDR entity must protect against any reasonably anticipated threats or hazards to the security of this information;

(3) The certified IDR entity must ensure that IIHI is securely destroyed or disposed of in an appropriate and reasonable manner 6 years from either the date of its creation or the first date on which the certified IDR entity had access to it, whichever is earlier.

(4) The certified IDR entity must implement policies and procedures to prevent, detect, contain, and correct security violations in the event of a breach of IIHI;

(C) Breach notification. The certified IDR entity must, following the discovery of a breach of unsecured IIHI, notify of the breach the provider, facility, or provider of air ambulance services; the plan and issuer; the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor; and each individual whose unsecured IIHI has been, or is reasonably believed to have been, subject to the breach, to the extent possible.

(1) Breaches treated as discovered. For purposes of this paragraph (e)(2)(v)(C), a breach shall be treated as discovered by a certified IDR entity as of the first day on which the breach is known to the certified IDR entity or, by exercising reasonable diligence, would have been known to the certified IDR entity. A certified IDR entity shall be deemed to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer, or other agent of the certified IDR entity;

(2) Timing of notification. A certified IDR entity must provide the notification required by this paragraph (e)(2)(v)(C) without unreasonable delay and in no case later than 60 calendar days after discovery of a breach.

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(3) Content of notification. The notification required by this paragraph (e)(2)(v)(C) must include, to the extent possible:

(i) The identification of each individual whose unsecured IIHI has been, or is reasonably believed by the certified IDR entity to have been, subject to the breach;

(ii) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, to the extent known;

(iii) A description of the types of unsecured IIHI that were involved in the breach (for example whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

(iv) A brief description of what the certified IDR entity involved is doing to investigate the breach, to mitigate harm to the affected parties, and to protect against any further breaches; and

(v) Contact procedures for individuals to ask questions or learn additional information, which must include a toll-free telephone number, email address, website, or postal address.

(4) Method for providing notification. A certified IDR entity must submit the notification required by this paragraph (e)(2)(v)(C) in written form (in clear and understandable language) either on paper or electronically through the Federal IDR portal or electronic mail.

(D) Application to contractor and subcontractors. The certified IDR entity must ensure compliance with this paragraph (e)(2)(v) of this section by any contractor or subcontractor with access to IIHI performing any duties related to the Federal IDR process.

(vi) Meet appropriate indicators of fiscal integrity and stability by demonstrating that the certified IDR entity has a system of safeguards and controls in place to prevent and detect improper financial activities by its employees and agents to assure fiscal integrity and accountability for all certified IDR entity fees and administrative fees received, held, and disbursed and by submitting 3 years of financial statements or, if not available, other information to demonstrate fiscal stability of the IDR entity.

(vii) Provide, no more frequently than once per calendar year, a fixed fee for single determinations and a separate fixed fee for batched determinations, as well as an additional fixed tiered fee for batched determinations, if applicable, within the upper and lower limits for each, as established by the Secretary in notice and comment rulemaking. The certified IDR entity fee ranges established by the Secretary in rulemaking will remain in effect until changed by notice and comment rulemaking. The certified IDR entity may not charge a fee outside the limits set forth in rulemaking unless the certified IDR entity or IDR entity seeking certification receives advance written approval from the Secretary to charge a fixed fee beyond the upper or lower limits by following the process described in paragraph (e)(2)(vii)(A) of this section. A certified IDR entity may also seek advance written approval from the Secretary to update its fees one additional time per calendar year by meeting the requirements described in paragraph (e)(2)(vii)(A). The Secretary will approve a request to charge a fixed

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fee beyond the upper or lower limits for fees as set forth in rulemaking or to update the fixed fee during the calendar year if, in their discretion, they determine the information submitted by a certified IDR entity or IDR entity seeking certification demonstrates that the proposed change to the certified IDR entity fee would ensure the financial viability of the certified IDR entity or IDR entity seeking certification and would not impose on parties an undue barrier to accessing the Federal IDR process.

(A) In order for the certified IDR entity or IDR entity seeking certification to receive the Secretary's written approval to charge a fixed fee beyond the upper or lower limits for fees as set forth in rulemaking or to update the fixed fee during the calendar year, the certified IDR entity or IDR entity seeking certification must submit to the Secretary, in the form and manner specified by the Secretary:

(1) The fixed fee the certified IDR entity or IDR entity seeking certification believes is appropriate for the certified IDR entity or IDR entity seeking certification to charge;

(2) A description of the circumstances that require the alternative fixed fee, or that require a change to the fixed fee during the calendar year, as applicable; and

(3) A detailed description that reasonably explains how the alternative fixed fee or the change to the fixed fee during the calendar year, as applicable, will be used to mitigate the effects of those circumstances.

(B) [Reserved]

(viii) For disputes initiated on or after January 22, 2024, certified IDR entities are permitted to charge a fixed certified IDR entity fee for single determinations within the range of $200 to $840, and a fixed certified IDR entity fee for batched determinations within the range of $268 to $1,173, unless a fee outside such ranges is approved by the Secretary, pursuant to paragraph (e)(2)(vii)(A) of this section. As part of the batched determination fee, certified IDR entities are permitted to charge an additional fixed tiered fee within the range of $75 to $250 for every additional 25 line items within a batched dispute, beginning with the 26th line item. The ranges for the certified IDR entity fees for single and batched determinations will remain in effect until changed by notice and comment rulemaking.

(ix) Have a procedure in place to retain the certified IDR entity fees described in paragraph (d)(1) of this section paid by both parties in a trust or escrow account and to return the certified IDR entity fee paid by the prevailing party of an IDR payment determination, or half of each party's certified IDR entity fee in the case of an agreement described in paragraph (c)(2)(i) of this section, within 30 business days following the date of the determination.

(x) Have a procedure in place to retain the administrative fees described in paragraph (d)(2) of this section and to remit the administrative fees to the Secretary in accordance with the timeframe and procedures set forth in guidance published by the Secretary.

(xi) Discharge its responsibilities in accordance with paragraph (c) of this section, including not making any determination with respect to which the certified IDR entity would not be eligible for selection pursuant to paragraph (c)(1) of this section.

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(xii) Collect the information required to be reported to the Secretary under paragraph (f) of this section and report the information on a timely basis in the form and manner provided in guidance published by the Secretary.

(3) Conflict-of-interest standards. In addition to the general standards set forth in paragraph (e)(2)(iv) of this section, an IDR entity must provide written documentation that the IDR entity satisfies the standards to be a certified IDR entity under this paragraph (e)(3).

(i) The IDR entity must provide an attestation indicating that it does not have a conflict of interest as defined in paragraph (a)(2) of this section;

(ii) The IDR entity must have procedures in place to ensure that personnel assigned to a determination do not have any conflicts of interest regarding any party to the dispute within the 1 year immediately preceding an assignment of dispute determination, similar to the requirements laid out in 18 U.S.C. 207(b). In order to satisfy this requirement, if certified, the IDR entity must ensure that any personnel assigned to a determination do not have any conflicts of interest as defined in paragraph (a)(2) of this section.

(iii) Following certification under this paragraph (e), if a certified IDR entity acquires control of, becomes controlled by, or comes under common control with any entity described in paragraph (e)(3)(i) of this section, the certified IDR entity must notify the Secretary in writing no later than 3 business days after the acquisition or exercise of control and shall be subject to the revocation of certification under paragraph (e)(6)(ii) of this section.

(4) Period of certification. Subject to paragraphs (e)(5) and (6) of this section, each certification (including a recertification) of a certified IDR entity under the process described in paragraph (e)(1) of this section will be effective for a 5–year period.

(5) Petition for denial or revocation—

(i) In general. An individual, provider, facility, provider of air ambulance services, plan, or issuer may petition for a denial of a certification for an IDR entity or a revocation of a certification for a certified IDR entity for failure to meet a requirement of this section using the standard form and manner set forth in guidance to be issued by the Secretary. The petition for denial of a certification must be submitted within the timeframe set forth in guidance issued by the Secretary.

(ii) Content of petition. The individual, provider, facility, provider of air ambulance services, plan, or issuer seeking denial or revocation of certification must submit a written petition using the standard form issued by the Secretary including the following information:

(A) The identity of the IDR entity seeking certification or certified IDR entity that is the subject of the petition;

(B) The reason(s) for the petition;

(C) Whether the petition seeks denial or revocation of a certification;

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(D) Documentation to support the reasons outlined in the petition; and

(E) Other information as may be required by the Secretary.

(iii) Process.

(A) The Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor will acknowledge receipt of the petition within 10 business days of receipt of the petition.

(B) If the Secretary finds that the petition adequately shows a failure of the IDR entity seeking certification or the certified IDR entity to follow the requirements of this paragraph (e), the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, will notify the IDR entity seeking certification or the certified IDR entity by providing a de-identified copy of the petition. Following the notification, the IDR entity seeking certification or certified IDR entity will have 10 business days to provide a response. After the time period for providing the response has passed, the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, will review the response (if any), determine whether a denial or revocation of a certification is warranted, and issue a notice of the decision to the IDR entity or certified IDR entity and to the petitioner. This decision will be subject to the appeal requirements of paragraph (e)(6)(v) of this section.

(C) Effect on certification under petition. Regarding a petition for revocation of a certified IDR entity's certification, if the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, finds that the petition adequately shows a failure to comply with the requirements of this paragraph (e), following the Secretary's notification of the failure to the certified IDR entity under paragraph (e)(5)(iii)(B) of this section, the certified IDR entity may continue to work on previously assigned determinations but may not accept new determinations until the Secretary issues a notice of the decision to the certified IDR entity finding that a revocation of certification is not warranted.

(6) Denial of IDR entity certification or revocation of certified IDR entity certification—

(i) Denial of IDR entity certification. The Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, may deny the certification of an IDR entity under paragraph (e)(1) of this section if, during the process of certification, including as a result of a petition described in paragraph (e)(5) of this section, the Secretary determines the following:

(A) The IDR entity fails to meet the applicable standards set forth under this paragraph (e);

(B) The IDR entity has committed or participated in fraudulent or abusive activities, including, during the certification process, submitting fraudulent data, or submitting information or data the IDR entity knows to be false to the Secretary, the Secretary of the Treasury or the Secretary of Labor;

(C) The IDR entity has failed to comply with requests for information from the Secretary, the Secretary of the Treasury, or the Secretary of Labor as part of the certification process;

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(D) In conducting payment determinations, including those outside the Federal IDR process, the IDR entity has failed to meet the standards that applied to those determinations or reviews, including standards of independence and impartiality; or

(E) The IDR entity is otherwise not fit or qualified to make determinations under the Federal IDR process.

(ii) Revocation of certification of a certified IDR entity. The Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, may revoke the certification of a certified IDR entity under paragraph (e)(1) of this section if, as a result of an audit, a petition described in paragraph (e)(5) of this section, or otherwise, the Secretary determines the following:

(A) The certified IDR entity has a pattern or practice of noncompliance with any requirements of this paragraph (e);

(B) The certified IDR entity is operating in a manner that hinders the efficient and effective administration of the Federal IDR process;

(C) The certified IDR entity no longer meets the applicable standards for certification set forth under this paragraph (e);

(D) The certified IDR entity has committed or participated in fraudulent or abusive activities, including submission of false or fraudulent data to the Secretary, the Secretary of the Treasury, or the Secretary of Labor;

(E) The certified IDR entity lacks the financial viability to provide arbitration under the Federal IDR process;

(F) The certified IDR entity has failed to comply with requests from the Secretary, the Secretary of the Treasury, or the Secretary of Labor made as part of an audit, including failing to submit all records of the certified IDR entity that pertain to its activities within the Federal IDR process; or

(G) The certified IDR entity is otherwise no longer fit or qualified to make determinations.

(iii) Notice of denial or revocation. The Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, will issue a written notice of denial to the IDR entity or revocation to the certified IDR entity within 10 business days of the Secretary's decision, including the effective date of denial or revocation, the reason(s) for denial or revocation, and the opportunity to request appeal of the denial or revocation.

(iv) Request for appeal of denial or revocation. To request an appeal, the IDR entity or certified IDR entity must submit a request for appeal to the Secretary within 30 business days of the date of the notice under paragraph (e)(6)(iii) of this section of denial or revocation and in the manner prescribed by the instructions to the notice. During this time period, the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, will not issue a notice of final denial or revocation and a certified IDR entity may continue to work on previously assigned determinations but may not accept new determinations. If the IDR entity or certified IDR entity does not timely submit a request for appeal of the denial or revocation, the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, will issue a notice of final denial or revocation to the IDR entity or certified IDR entity (if applicable) and the petitioner.

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(v) Denial or final revocation. Upon notice of denial or final revocation, the IDR entity shall not be considered a certified IDR entity and therefore shall not be eligible to accept payment determinations under the Federal IDR process. Moreover, after a notice of final revocation, the IDR entity may not re-apply to be a certified IDR entity until on or after the 181st day after the date of the notice of denial or final revocation.

(f) Reporting of information relating to the Federal IDR process—

(1) Reporting of information. Within 30 business days of the close of each month, for qualified IDR items and services furnished on or after January 1, 2022, each certified IDR entity must, in a form and manner specified by the Secretary, report:

(i) The number of notices of IDR initiation submitted under paragraph (b)(2) of this section to the certified IDR entity during the immediately preceding month;

(ii) The size of the provider practices and the size of the facilities submitting notices of IDR initiation under paragraph (b)(2) of this section during the immediately preceding month, as required to be provided to the certified IDR entity under paragraph (c)(4)(i)(A)(2) of this section;

(iii) The number of such notices of IDR initiation with respect to which a determination was made under paragraph (c)(4)(ii) of this section;

(iv) The number of times during the month that the out-of-network rate determined (or agreed to) under this section has exceeded the qualifying payment amount, specified by qualified IDR items and services;

(v) With respect to each notice of IDR initiation under paragraph (b)(2) of this section for which such a determination was made, the following information:

(A) A description of the qualified IDR items and services included with respect to the notification, including the relevant billing and service codes;

(B) The relevant geographic region for purposes of the qualifying payment amount for the qualified IDR items and services with respect to which the notification was provided;

(C) The amount of the offer submitted under paragraph (c)(4)(i) of this section by the plan or issuer (as applicable) and by the provider or facility (as applicable) expressed as a dollar amount and as a percentage of the qualifying payment amount;

(D) Whether the offer selected by the certified IDR entity under paragraph (c)(4) of this section was the offer submitted by the plan or issuer (as applicable) or by the provider or facility (as applicable);

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(E) The amount of the selected offer expressed as a dollar amount and as a percentage of the qualifying payment amount;

(F) The rationale for the certified IDR entity's decision, including the extent to which the decision relied on the criteria in paragraphs (c)(4)(iii)(B) through (D) of this section;

(G) The practice specialty or type of each provider or facility, respectively, involved in furnishing each qualified IDR item or service;

(H) The identity for each plan or issuer, and provider or facility, with respect to the notification. Specifically, each certified IDR entity must provide each party's name and address, as applicable; and

(I) For each determination, the number of business days elapsed between selection of the certified IDR entity and the determination of the out-of-network rate by the certified IDR entity.

(vi) The total amount of certified IDR entity fees paid to the certified IDR entity under paragraph (d)(1) of this section during the month.

(2) [Reserved]

(g) Extension of time periods for extenuating circumstances—

(1) General. The time periods specified in this section (other than the time for payment, if applicable, under paragraph (c)(4)(ix) of this section) may be extended in extenuating circumstances at the Secretary's discretion if:

(i) An extension is necessary to address delays due to matters beyond the control of the parties or for good cause; and

(ii) The parties attest that prompt action will be taken to ensure that the determination under this section is made as soon as administratively practicable under the circumstances.

(2) Process to request an extension. The parties may request an extension by submitting a request for extension due to extenuating circumstances through the Federal IDR portal if the extension is necessary to address delays due to matters beyond the control of the parties or for good cause.

(h) Applicability date. The provisions of this section are applicable with respect to plan years or in the individual market policy years beginning on or after January 1, 2022, except that the provisions regarding IDR entity certification at paragraphs (a) and (e) of this section are applicable beginning on October 7, 2021; and paragraphs (c)(4)(ii) through (iv) of this section regarding payment determinations, paragraph (c)(4)(vi)(B) of this section regarding written decisions, and paragraph (f)(1)(v)(F) of this section regarding reporting of information relating to the Federal IDR process are applicable with respect to items or services

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provided or furnished on or after October 25, 2022, for plan years or in the individual market policy years beginning on or after January 1, 2022.

Credits

[87 FR 52652, Aug. 26, 2022; 88 FR 88525, Dec. 21, 2023; 89 FR 4548, Jan. 24, 2024]

SOURCE: 62 FR 16955, 17005, April 8, 1997; 62 FR 31669, June 10, 1997; 86 FR 36970, July 13, 2021; 86 FR 56124, Oct. 7, 2021, unless otherwise noted.

AUTHORITY: 42 U.S.C. 300gg–92 and 300gg–111 through 300gg–139, as amended.

Notes of Decisions (15)

End of Document

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Unconstitutional or Preempted Prior Version Held Invalid Texas Medical Association v. United States Department of Health and Human Services, 5th Cir.(Tex.), Aug. 02, 2024

Code of Federal Regulations
Title 45. Public Welfare
Subtitle A. Department of Health and Human Services (Refs & Annos)
Subchapter B. Requirements Relating to Health Care Access (Refs & Annos)
Part 149. Surprise Billing and Transparency Requirements (Refs & Annos)
Subpart F. Independent Dispute Resolution Process (Refs & Annos)

45 C.F.R. § 149.510

§ 149.510 Independent dispute resolution process.

Effective: August 3, 2026
Currentness

<Text of section effective Aug. 3, 2026.>

<For compliance date(s) of amendment(s) to section, see 91 FR 33900.>

(a) Scope and definitions—

(1) Scope. This section sets forth requirements with respect to the independent dispute resolution (IDR) process (referred to in this section as the Federal IDR process) under which a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services (as applicable), and a group health plan or health insurance issuer offering group or individual health insurance coverage completes a requisite open negotiation period and at least one party submits a notification under paragraph (b) of this section to initiate the Federal IDR process under paragraph (c) of this section, and under which an IDR entity (as certified under paragraph (e) of this section) determines the amount of payment under the plan or coverage for an item or service furnished by the provider or facility.

(2) Definitions. Unless otherwise stated, the definitions in § 149.30 of this part apply to this section. Additionally, for purposes of this section, the following definitions apply:

(i) Batched qualified IDR items and services means multiple qualified IDR items or services that are considered jointly as part of one payment determination by a certified IDR entity for purposes of the Federal IDR process in accordance with paragraph (c)(4)(i) of this section.

(ii) Breach means the acquisition, access, use, or disclosure of individually identifiable health information (IIHI) in a manner not permitted under paragraph (e)(2)(v) of this section that compromises the security or privacy of the IIHI.

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(A) Breach excludes:

(1) Any unintentional acquisition, access, or use of IIHI by personnel, a contractor, or a subcontractor of a certified IDR entity that is acting under the authority of that certified IDR entity, if the acquisition, access, or use was made in good faith and within the scope of that authority and that does not result in further use or disclosure in a manner not permitted under paragraph (e)(2)(v) of this section.

(2) Any inadvertent disclosure by a person who is authorized to access IIHI at a certified IDR entity to another person authorized to access IIHI at the same certified IDR entity, and the information received as a result of the disclosure is not further used or disclosed in a manner not permitted under paragraph (e)(2)(v) of this section.

(3) A disclosure of IIHI in which a certified IDR entity has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(B) Except as provided in paragraph (a)(2)(ii)(A) of this definition, access, use, or disclosure of IIHI in a manner not permitted under paragraph (e)(2)(v) of this section is presumed to be a breach unless the certified IDR entity demonstrates that there is a low probability that the security or privacy of the IIHI has been compromised based on a risk assessment encompassing at least the following factors:

(1) The nature and extent of the IIHI involved, including the types of identifiers and the likelihood of re-identification;

(2) The unauthorized person who used the IIHI or to whom the disclosure was made;

(3) Whether the IIHI was actually acquired or viewed; and

(4) The extent to which the risk to the IIHI has been mitigated.

(iii) Certified IDR entity means an entity responsible for conducting determinations under paragraph (c) of this section that meets the certification criteria specified in paragraph (e) of this section and that has been certified by the Secretary, jointly with the Secretaries of Labor and the Treasury.

(iv) Conflict of interest means, with respect to a party to a payment determination, or certified IDR entity, a material relationship, status, or condition of the party, or certified IDR entity that impacts the ability of the certified IDR entity to make an unbiased and impartial payment determination. For purposes of this section, a conflict of interest exists when a certified IDR entity is:

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(A) A group health plan; a health insurance issuer offering group health insurance coverage, individual health insurance coverage, or short-term, limited-duration insurance; a carrier offering a health benefits plan under 5 U.S.C. 8902; or a provider, a facility, or a provider of air ambulance services;

(B) An affiliate or a subsidiary of a group health plan; a health insurance issuer offering group health insurance coverage, individual health insurance coverage, or short-term limited-duration insurance; a carrier offering a health benefits plan under 5 U.S.C. 8902; or a provider, a facility, or a provider of air ambulance services;

(C) An affiliate or subsidiary of a professional or trade association representing group health plans; health insurance issuers offering group health insurance coverage, individual health insurance coverage, or short-term limited duration insurance; carriers offering a health benefits plan under 5 U.S.C. 8902; or providers, facilities, or providers of air ambulance services.

(D) A certified IDR entity, that has, or that has any personnel, contractors, or subcontractors assigned to a determination who have, a material familial, financial, or professional relationship with a party to the payment determination being disputed, or with any officer, director, or management employee of the plan, issuer, or carrier offering a health benefits plan under 5 U.S.C. 8902; the plan or coverage administrator, plan or coverage fiduciaries, or plan, issuer or carrier employees; the health care provider, the health care provider's group or practice association; the provider of air ambulance services, the provider of air ambulance services' group or practice association, or the facility that is a party to the dispute.

(v) Credible information means information that upon critical analysis is worthy of belief and is trustworthy.

(vi) IDR entity means an entity that may apply or has applied for certification to conduct determinations under paragraph (c) of this section, and that currently is not certified by the Secretary, jointly with the Secretaries of Labor and the Treasury, pursuant to paragraph (e) of this section.

(vii) Individually identifiable health information (IIHI) means any information, including demographic data, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(A) That identifies the individual; or

(B) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(viii) Material familial relationship means any relationship as a spouse, domestic partner, child, parent, sibling, spouse's or domestic partner's parent, spouse's or domestic partner's sibling, spouse's or domestic partner's child, child's parent, child's spouse or domestic partner, or sibling's spouse or domestic partner.

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(ix) Material financial relationship means any financial interest of more than five percent of total annual revenue or total annual income of a certified IDR entity or an officer, director, or manager thereof, or of a reviewer or reviewing physician employed or engaged by a certified IDR entity to conduct or participate in any review in the Federal IDR process. The terms annual revenue and annual income do not include mediation fees received by mediators who are also arbitrators, provided that the mediator acts in the capacity of a mediator and does not represent a party in the mediation.

(x) Material professional relationship means any physician-patient relationship, any partnership or employment relationship, any shareholder or similar ownership interest in a professional corporation, partnership, or other similar entity; or any independent contractor arrangement that constitutes a material financial relationship with any expert used by the certified IDR entity or any officer or director of the certified IDR entity.

(xi) Qualified IDR item or service means an item or service:

(A) That is an emergency service furnished by a nonparticipating provider or nonparticipating facility subject to the protections of 26 CFR 54.9816–4T, 29 CFR 2590.716–4, or § 149.110, as applicable, for which the conditions of § 149.410(b) are not met, or an item or service furnished by a nonparticipating provider at a participating health care facility, subject to the requirements of 26 CFR 54.9816–5T, 29 CFR 2590.717–5, or § 149.120, as applicable, for which the conditions of § 149.420(c)-(i) are not met, or air ambulance services furnished by a nonparticipating provider of air ambulance services subject to the protections of 26 CFR 54.9817–1T, 29 CFR 2590.717–1, or § 149.130, as applicable, and for which the out-of-network rate is not determined by reference to an All–Payer Model Agreement under section 1115A of the Social Security Act or a specified State law as defined in § 149.30;

(B) With respect to which a provider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage submits a notification under paragraph (b)(2) of this section;

(C) That is not an item or service that is the subject of an open negotiation under paragraph (b)(1) of this section; and

(D) That is not an item or service for which a notification under paragraph (b)(2) of this section is submitted during the 90–calendar-day period under paragraph (c)(4)(vi)(B) of this section, but that may include such an item or service if the notification is submitted during the subsequent 30–business-day period under paragraph (c)(4)(vi)(C) of this section.

(xii) Unsecured IIHI means IIHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor.

(b) Determination of payment amount through open negotiation and initiation of the Federal IDR process.

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(1) Determination of payment amount through open negotiation.

(i) In general. For an item or service that meets the requirements of paragraph (a)(2)(xi)(A) of this section, the provider, facility, or provider of air ambulance services or the group health plan or health insurance issuer offering group or individual health insurance coverage may, during the 30–business-day period beginning on the day the provider, facility, or provider of air ambulance services receives an initial payment or notice of denial of payment regarding the item or service, initiate a 30–business-day open negotiation period for purposes of determining the out-of-network rate for such item or service. To initiate the open negotiation period, a party must submit a written open negotiation notice with the content specified in paragraph (b)(1)(ii) of this section to the other party and to the Secretary in the manner specified in paragraph (b)(3) of this section. The 30–business-day open negotiation period begins on the day on which the party first submits the open negotiation notice, including the remittance advice documentation specified in paragraph (b)(1)(ii)(A)(12) of this section, to the other party and the Secretary. The party in receipt of the open negotiation notice must provide to the party that initiated open negotiation and to the Secretary in the manner specified in paragraph (b)(3) of this section, as soon as practicable, but no later than the 15th business day of the 30–business-day open negotiation period, a written notice and supporting documentation in response to the open negotiation notice, as specified in paragraph (b)(1)(iii)(A) of this section.

(ii) Open negotiation notice.

(A) Content. The open negotiation notice must include, for the item or service that is the subject of the open negotiation notice, information about the item or service and the parties, including:

(1) Information sufficient to identify the provider, facility, or provider of air ambulance services, including the name and current contact information (including the legal business name, email address, phone number, and mailing address) as provided with the claim form submitted by the provider, facility, or provider of air ambulance services to the plan or issuer, and the applicable National Provider Identifier (NPI);

(2) Information sufficient to identify the plan or issuer, including the plan's or issuer's registration number, as required under § 149.530, or an attestation from the party submitting the open negotiation notice that the plan's or issuer's registration number was not provided on any remittance advice associated with the initial payment or notice of denial of payment for the item or service; the legal business name of the plan or issuer (or, in the case of a self-insured group health plan that does not have a legal business name, the legal business name of the plan sponsor), as well as the current contact information (name, email address, phone number, and mailing address) of the plan or issuer as provided with any remittance advice associated with the initial payment or notice of denial of payment for the item or service; and if the party submitting the open negotiation notice is a plan or issuer, the plan type (for example, self-insured or fully-insured);

(3) The name and contact information (including the legal business name, email address, phone number, and mailing address) for any third party representing the party submitting the open

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negotiation notice, and an attestation that the third party has the authority to act on behalf of the party it represents in the open negotiation;

(4) Information sufficient to identify the item or service, including: the date(s) the item or service was furnished and, if the party submitting the open negotiation notice is a provider, facility, or provider of air ambulance services, the date(s) that the provider, facility, or provider of air ambulance services received the initial payment or notice of denial of payment for the item or service from the plan or issuer; the type of item or service (specifically, whether the item or service is an emergency service as defined in § 149.110(c)(2)(i) or (ii), a non-emergency service as described in § 149.120(b), or an air ambulance service as defined in § 149.30); whether the service is a professional service or facility-based service; the State where the item or service was furnished; the claim number; the service code; and information to identify the location where the item or service was furnished (such as, place of service code or bill type code);

(5) The initial payment amount (including $0 if payment is denied);

(6) The qualifying payment amount, if provided in a remittance advice associated with the initial payment or notice of denial of payment, or if the party submitting the open negotiation notice is a plan or issuer;

(7) An offer of an out-of-network rate for each item or service;

(8) If the party submitting the open negotiation notice is a plan or issuer, the amount of cost sharing imposed for the item or service, if any;

(9) If the party submitting the open negotiation notice is a provider or facility, a statement that the items and services do not qualify for the notice and consent exception described at 45 § 149.410(b) or § 149.420(c) through (i);

(10) A statement that the provider, facility, or provider of air ambulance services was a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services on the date the item or service was furnished;

(11) General information listed in the standard open negotiation notice developed by the Secretary pursuant to paragraph (b)(3) of this section describing the open negotiation period and the Federal IDR process (including a description of the purpose of the open negotiation period and Federal IDR process and key deadlines in the open negotiation period and Federal IDR process); and

(12) A copy of any remittance advice associated with the initial payment or notice of denial of payment for the item or service.

(B) [Reserved]

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(iii) Open negotiation response notice.

(A) Content. The response to the open negotiation notice must include, for the item or service that is the subject of the open negotiation response notice, information about the item or service and the parties, including:

(1) Information sufficient to identify the provider, facility, or provider of air ambulance services, including the name and current contact information (including the legal business name, email address, phone number, and mailing address) as provided with the claim form submitted by the provider, facility, or provider of air ambulance services to the plan or issuer, and the applicable NPI;

(2) Information sufficient to identify the plan or issuer, including the plan's or issuer's registration number, as required under § 149.530, or an attestation from the party submitting the open negotiation response notice that the plan's or issuer's registration number was not provided on any remittance advice associated with the initial payment or notice of denial of payment for the item or service, as well as the legal business name of the plan or issuer (or, in the case of a self-insured group health plan that does not have a legal business name, the legal business name of the plan sponsor), the current contact information (name, email address, phone number, and mailing address) of the plan or issuer as provided with any remittance advice associated with the initial payment or notice of denial of payment for the item or service; and if the party submitting the open negotiation response notice is a plan or issuer, the plan type (for example, self-insured or fully-insured);

(3) The name and contact information (including the legal business name, email address, phone number, and mailing address) for any third party representing the party submitting the open negotiation response notice, and an attestation that the third party has the authority to act on behalf of the party it represents in the open negotiation;

(4) Information sufficient to identify the item or service included in the open negotiation notice, including the date(s) the item or service was furnished, and if the party submitting the open negotiation response notice is a provider, facility, or provider of air ambulance services, the date(s) that the provider, facility, or provider of air ambulance services received the initial payment or notice of denial of payment for the item or service from the plan or issuer, and the claim number;

(5) If the party submitting the open negotiation response notice is a plan or issuer, a statement as to whether it agrees that the initial payment amount (including $0 if payment is denied) and the qualifying payment amount reflected in the open negotiation notice accurately reflect the initial payment amount and qualifying payment amount disclosed with the initial payment for the item or service, and if not, or if the open negotiation notice indicates that the initial payment amount or qualifying payment amount was not communicated by the plan or issuer in a remittance advice associated with the initial payment or notice of denial of payment, the initial payment amount (including $0 if payment is denied) and/or qualifying payment amount it believes to be correct, and documentation to support the statement (for example, the remittance advice confirming the qualifying payment amount);

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(6) If the party submitting the open negotiation response notice is a plan or issuer, the amount of cost sharing imposed for the item or service, if any;

(7) If the party submitting the open negotiation response notice is a provider or facility, a statement that the items and services do not qualify for the notice and consent exception described at § 149.410(b) or § 149.420(c) through (i);

(8) For each item or service, either a statement and supporting documentation that explains why the item or service is not subject to the Federal IDR process or a statement agreeing that the item or service is subject to the Federal IDR process;

(9) A statement as to whether any of the information provided in the open negotiation notice is inaccurate and the basis for the statement, as well as supporting documentation; and

(10) A statement confirming that the initial payment or notice of denial of payment or other remittance advice reflected in the open negotiation notice under paragraph (b)(1)(ii)(A)(12) of this section is accurate, or, if inaccurate, a copy of the accurate remittance advice associated with the initial payment or notice of denial of payment for the item or service.

(B) [Reserved]

(2) Initiating the Federal IDR process.

(i) In general. Either party may initiate the Federal IDR process for a qualified IDR item or service as defined in paragraph (a)(2)(xi) of this section for which the parties have not agreed on an out-of-network rate by the last day of the open negotiation period provided for under paragraph (b)(1) of this section. To initiate the Federal IDR process, a party (the initiating party) must submit a written notice of IDR initiation, consistent with paragraph (b)(2)(ii) of this section, to the other party to the dispute (the non-initiating party) and to the Secretary in the manner specified in paragraph (b)(3) of this section, during the 4–business-day period beginning on the first business day after the last day of the open negotiation period (unless it is otherwise required to be submitted in the timeframe specified in paragraph (c)(5)(vii)(C) of this section). The date of IDR initiation is the date the Secretary receives the notice of IDR initiation described in paragraph (b)(2)(ii) of this section.

(A) Exception for items and services provided by certain nonparticipating providers and facilities. A party may not initiate the Federal IDR process for an item or service if, for that item or service, the party knows (or reasonably should have known) that the provider or facility provided notice and received consent under § 149.410(b) or § 149.420(c) through (i).

(B) [Reserved]

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(ii) Notice of IDR initiation.

(A) Content. The notice of IDR initiation must include, for the item or service that is the subject of the notice, information about the item or service and the parties including:

(1) Information sufficient to identify the provider, facility, or provider of air ambulance services, including the name and current contact information (including the legal business name, email address, phone number, and mailing address), and the NPI; and if the initiating party is a provider, facility, or provider of air ambulance services, the Taxpayer Identification Number (TIN);

(2) Information sufficient to identify the plan or issuer, including the plan's or issuer's registration number, as required under § 149.530, or an attestation from the initiating party that the plan's or issuer's registration number was not provided on any remittance advice associated with the initial payment or notice of denial of payment for the item or service; the legal business name of the plan or issuer (or, in the case of a self-insured group health plan that does not have a legal business name, the legal business name of the plan sponsor), as well as the current contact information (name, email address, phone number, and mailing address) of the plan or issuer as provided with any remittance advice associated with the initial payment or notice of denial of payment for the item or service; and if the initiating party is a plan or issuer, the plan type (for example, self-insured or fully-insured) and TIN (or, in the case of a plan that does not have a TIN, the TIN of the plan sponsor);

(3) The name and contact information (including the legal business name, email address, phone number, TIN, and mailing address) for any third party representing the initiating party, and an attestation that the third party has the authority to act on behalf of the party it represents in the Federal IDR process;

(4) Information sufficient to identify whether the dispute being initiated includes batched or bundled qualified IDR items or services as described in paragraph (c)(4) of this section;

(5) Information sufficient to identify the qualified IDR item or service that is the subject of the notice of IDR initiation, including the date(s) the qualified IDR item or service was furnished; if the initiating party is a provider, facility, or provider of air ambulance services, the date(s) that the provider, facility, or provider of air ambulance services received the initial payment or notice of denial of payment for such item or service from the plan or issuer; the date the open negotiation period under paragraph (b)(1) of this section began; the type of item or service (specifically, whether the item or service that meets the requirements of paragraph (a)(2)(xi)(A) of this section is an emergency service as defined in § 149.110(c)(2)(i) or (ii), a non-emergency service as described in § 149.120(b), or an air ambulance service as defined in § 149.30); whether the service is a professional service or facility-based service; the State where the item or service was furnished; the claim number; the service code; and information to identify the location the item or service was furnished (including place of service code or bill type code);

(6) The initial payment amount (including $0 if payment is denied);

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(7) If the initiating party is a plan or issuer, the amount of cost sharing imposed for the item or service, if any;

(8) The qualifying payment amount, if provided with the initial payment or notice of denial of payment, or if the initiating party is a plan or issuer;

(9) If the initiating party is a provider or facility, a statement that the items and services do not qualify for the notice and consent exception described at § 149.410(b) or § 149.420(c) through (i);

(10) A statement that the provider, facility, or provider of air ambulance services was a nonparticipating provider, a nonparticipating emergency facility, or nonparticipating provider of air ambulance services on the date the item or service was furnished;

(11) Attestation that the item or service under dispute is a qualified IDR item or service as defined in paragraph (a)(2)(xi) of this section and is eligible for the Federal IDR process, and the basis for the attestation;

(12) General information listed in the standard notice of IDR initiation developed by the Secretary under paragraph (b)(3) of this section describing the Federal IDR process (including a description of the purpose of the Federal IDR process and key deadlines in the Federal IDR process);

(13) A copy of any remittance advice associated with the initial payment or notice of denial of payment for the item or service; and

(14) Preferred certified IDR entity.

(B) [Reserved]

(iii) Notice of IDR initiation response. The non-initiating party must provide to the initiating party and the Secretary in the manner specified in paragraph (b)(3) of this section within 3 business days after the date of IDR initiation, a written notice and supporting documentation in response to the notice of IDR initiation, as specified in paragraph (b)(2)(iii)(A) of this section.

(A) Content. The notice of IDR initiation response must include, for the item or service that is the subject of the notice, information about the item or service and the parties, including:

(1) Information sufficient to identify the provider, facility, or provider of air ambulance services, including the name and current contact information (including the legal business name, email address, phone number, and mailing address), and the NPI; and if the non-initiating party is a provider, facility, or provider of air ambulance services, the TIN;

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(2) Information sufficient to identify the plan or issuer, including the plan's or issuer's registration number, as required under § 149.530, or an attestation from the non-initiating party that the plan's or issuer's registration number was not provided on any remittance advice associated with the initial payment or notice of denial of payment for the item or service; the legal business name of the plan or issuer (or, in the case of a self-insured group health plan that does not have a legal business name, the legal business name of the plan sponsor), as well as the current contact information (name, email address, phone number, and mailing address) of the plan or issuer as provided with any remittance advice associated with the initial payment or notice of denial of payment; and if the non-initiating party is a plan or issuer, the plan type (for example, self-insured or fully-insured) and TIN (or, in the case of a plan that does not have a TIN, the TIN of the plan sponsor);

(3) The name and contact information (including the legal business name, email address, phone number, TIN, and mailing address) for any third party representing the non-initiating party, and an attestation that the third party has the authority to act on behalf of the party it represents in the Federal IDR process;

(4) Information sufficient to identify each item or service included in the notice of IDR initiation, including the date(s) the item or service was furnished and if the non-initiating party is a provider, facility, or provider of air ambulance services, the date(s) that the provider, facility, or provider of air ambulance services received the initial payment or notice of denial of payment for such item or service from the plan or issuer, and the claim number;

(5) If the non-initiating party is a plan or issuer, a statement as to whether the non-initiating party agrees that the initial payment (including $0 if payment is denied) and the qualifying payment amount reflected in the notice of IDR initiation is accurate for the item or service that is the subject of the dispute, and if not, the initial payment amount (including $0 if payment is denied) and/or qualifying payment amount it believes to be correct, and documentation to support the statement (for example, the remittance advice confirming the qualifying payment amount);

(6) If the non-initiating party is a plan or issuer, the amount of cost sharing imposed for the item or service, if any;

(7) If the non-initiating party is a provider or facility, a statement that the items and services do not qualify for the notice and consent exception described at § 149.410(b) or § 149.420(c) through (i);

(8) For each item or service that is the subject of the dispute, either an attestation that the item or service is a qualified IDR item or service as defined in paragraph (a)(2)(xi) of this section and is eligible for the Federal IDR process, or for each item or service that the non-initiating party asserts is not a qualified IDR item or service that is eligible for the Federal IDR process, an explanation and documentation to support the assertion;

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(9) A statement confirming that the remittance advice associated with the initial payment or notice of denial of payment provided by the initiating party under paragraph (b)(2)(ii)(A)(13) of this section is accurate, or, if inaccurate, a copy of the accurate remittance advice associated with the initial payment or notice of denial of payment for the item or service;

(10) A statement as to whether any of the information provided in the notice of IDR initiation is inaccurate and the basis for the statement, as well as any supporting documentation; and

(11) A statement as to whether the non-initiating party agrees or objects to the initiating party's preferred certified IDR entity. If the non-initiating party objects to the initiating party's preferred certified IDR entity, the notice of IDR initiation response must include the name of an alternative preferred certified IDR entity and, if applicable, an explanation of any conflict of interest with the initiating party's preferred certified IDR entity.

(B) [Reserved]

(3) Manner. A party furnishing notices as required under paragraphs (b)(1)(ii) and (iii) and (b)(2)(ii) and (iii) of this section must furnish the notices using the standard forms developed by the Secretary and must furnish the notices and supporting documentation to the other party and the Secretary through the Federal IDR portal.

(c) Federal IDR process following initiation—

(1) Selection of certified IDR entity.

(i) Preliminary selection of the certified IDR entity. Within 3 business days after the date of IDR initiation, the non-initiating party must agree or object to the preferred certified IDR entity identified in the notice of IDR initiation by submitting the notice of IDR initiation response described in paragraph (b)(2)(iii) of this section, which contains the information described in subordinate paragraph (b)(2)(iii)(A)(11) thereof.

(A) If the non-initiating party agrees or fails to respond to the selection of the initiating party's preferred certified IDR entity in the manner and timeframe described in paragraph (c)(1)(i) of this section, the initiating party's preferred certified IDR entity will be considered jointly selected on the third business day after the date of IDR initiation.

(B) If the non-initiating party objects to the selection of the initiating party's preferred certified IDR entity by designating an alternative preferred certified IDR entity in the manner and timeframe described in paragraph (c)(1)(i) of this section, the initiating party may then agree or object to the non-initiating party's alternative preferred certified IDR entity by submitting the notice of certified IDR entity selection in the manner specified in paragraph (c)(1)(i)(D) of this section.

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(1) If the initiating party agrees to the non-initiating party's alternative preferred certified IDR entity within 3 business days after the date of IDR initiation, the alternative preferred certified IDR entity will be considered jointly selected by the parties.

(2) If the non-initiating party submits the notice of IDR initiation response on the first or second business day after the date of IDR initiation, and the initiating party fails to respond within 3 business days after the date of IDR initiation, the alternative preferred certified IDR entity will be considered jointly selected by the parties.

(3) If the non-initiating party submits the notice of IDR initiation response on the third business day after the date of IDR initiation and the initiating party fails to respond on the same day, selection will proceed pursuant to paragraph (c)(1)(i)(C) of this section.

(C) If a certified IDR entity is not jointly selected under paragraph (c)(1)(i)(A) or (B) of this section, either party may select an alternative preferred certified IDR entity by submitting the notice of certified IDR entity selection in the manner specified in paragraph (c)(1)(i)(D) of this section, until the earlier of the date that the parties agree on the alternative preferred certified IDR entity or the deadline for joint selection, which is 3 business days after the date of IDR initiation. Once a party submits a notice of certified IDR entity selection, it may not submit another notice of certified IDR entity selection until it receives a responding notice of certified IDR entity selection from the other party.

(1) If a party submits a notice of certified IDR entity selection to the other party on the first or second business day after the date of IDR initiation and the party in receipt of the notice agrees or fails to respond to the alternative preferred certified IDR entity by the third business day after the date of IDR initiation, the alternative preferred certified IDR entity will be considered jointly selected by the parties.

(2) If a party submits a notice of certified IDR entity selection to the other party on the third business day after the date of IDR initiation and the party last in receipt of the notice agrees to the alternative preferred certified IDR entity on the same day, the alternative preferred certified IDR entity will be considered jointly selected by the parties.

(3) If a party submits a notice of certified IDR entity selection to the other party on the third business day after the date of IDR initiation, and the party last in receipt of the notice fails to respond to the alternative preferred certified IDR entity on the same day, the parties will have failed to jointly select a certified IDR entity.

(D) To notify the other party and the Secretary of an agreement or objection to an alternative preferred certified IDR entity as described in paragraph (c)(1)(i)(C) of this section, a party must furnish a notice of certified IDR entity selection, using the standard form developed by the Secretary, to the other party and the Secretary through the Federal IDR portal within 3 business days after the date of IDR initiation. The notice of certified IDR entity selection must include a statement indicating the party's agreement with or objection to the other party's alternative preferred certified IDR entity and, if applicable, an

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explanation of any conflict of interest with the alternative preferred certified IDR entity, and the name of another alternative preferred certified IDR entity. However, in the event the conditions for failure to jointly select a certified IDR entity apply, selection will proceed in accordance with paragraph (c)(1)(ii) of this section.

(ii) Failure to jointly select a certified IDR entity. If the parties fail to jointly select a certified IDR entity within 3 business days after the date of IDR initiation, the Secretary will select a certified IDR entity. The parties will have failed to jointly select a certified IDR entity if, by the end of the third business day after the date of IDR initiation, the party last in receipt of the notice of IDR initiation response or the notice of certified IDR entity selection has received an objection to their preferred or alternative preferred certified IDR entity in the applicable notice. Alternatively, the parties will have failed to jointly select a certified IDR entity if the notice of IDR initiation response or the notice of certified IDR entity selection is submitted to the other party on the third business day after the date of IDR initiation and the party in receipt of the notice fails to respond to the alternative preferred certified IDR entity on the same day.

(A) In selecting the certified IDR entity, the Secretary will first confirm whether a party submitted the notice of IDR initiation response or the notice of certified IDR entity selection with an alternative preferred certified IDR entity on the third business day after the date of IDR initiation without the other party's agreement to the selection. If either notice was provided on the third business day after the date of IDR initiation without the other party's agreement to the alternative preferred certified IDR entity by the end of the third business day after the date of IDR initiation, the Secretary will provide the party last in receipt of the applicable notice, as of the end of the third business day after the date of IDR initiation, 2 additional business days to agree or object to the other party's alternative preferred certified IDR entity selection.

(1) If the party last in receipt of the applicable notice, as of the end of the third business day after the date of IDR initiation, agrees with the other party's alternative preferred certified IDR entity and notifies the Secretary of the agreement, or fails to respond, in the Federal IDR portal by the fifth business day after the date of IDR initiation, the Secretary will select the final alternative preferred certified IDR entity selected in the applicable notice.

(2) If the party last in receipt of the applicable notice, as of the end of the third business day after the date of IDR initiation, notifies the Secretary of its objection to the alternative preferred certified IDR entity by the fifth business day after the date of IDR initiation, the Secretary will randomly select a certified IDR entity from among the certified IDR entities (other than the preferred certified IDR entity and any alternative preferred certified IDR entity previously selected in such dispute by a party, unless there is no other certified IDR entity available to select) that charge a fee within the allowed range of certified IDR entity fees, not later than the sixth business day after the date of IDR initiation. If there are insufficient certified IDR entities that charge a fee within the allowed range of certified IDR entity fees available to arbitrate the dispute, the Secretary will select a certified IDR entity that has received approval, as described in paragraph (e)(2)(vii)(A) of this section, to charge a fee outside of the allowed range of certified IDR entity fees. In either case, the Secretary will notify the parties of the preliminary selection of the certified IDR entity not later than 6 business days after the date of IDR initiation.

(B) [Reserved]

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(iii) Date of preliminary selection of the certified IDR entity. The date of preliminary selection of the certified IDR entity will be:

(A) Three business days after the date of IDR initiation if the parties jointly select a certified IDR entity, as specified in paragraph (c)(1)(i) of this section; or

(B) Six business days after the date of IDR initiation, if the parties fail to jointly select a certified IDR entity as specified in paragraph (c)(1)(ii) of this section.

(iv) Final selection of the certified IDR entity—

(A) Conflict-of-interest review. The certified IDR entity preliminarily selected for a dispute must review the selection. The selection of the certified IDR entity will be finalized only if the certified IDR entity attests to the Secretary that it meets the following requirements:

(1) The certified IDR entity does not have a conflict of interest as defined in paragraph (a)(2)(iv) of this section;

(2) The certified IDR entity will only assign personnel to a dispute and make decisions regarding hiring, compensation, termination, promotion, or other similar matters related to personnel assigned to the dispute in a manner that is not based upon the likelihood that the assigned personnel will support a particular party to the dispute; and

(3) The certified IDR entity will not assign any personnel to a dispute who would have any conflicts of interest, as defined in paragraph (a)(2)(iv) of this section, regarding any party to the dispute or whose relationship with a party within the 1 year immediately preceding the assignment to the dispute would violate the restrictions on aiding or advising a former employer or principal in a manner similar to the restrictions set forth in 18 U.S.C. 207(b).

(B) Failure to meet conflict-of-interest requirements. If the certified IDR entity fails to attest to the Secretary within 3 business days of the date of preliminary selection of the certified IDR entity that it meets the requirements of paragraphs (c)(1)(iv)(A)(1) through (3) of this section, the Secretary will randomly select another certified IDR entity consistent with paragraph (c)(1)(ii) of this section. The Secretary will notify the parties of the new randomly preliminarily selected certified IDR entity no later than 1 business day after the date of preliminary selection of the certified IDR entity, no later than 1 business day after the end of the 3–business-day period.

(C) Date of final selection of the certified IDR entity. If the certified IDR entity that has been preliminarily selected attests within 3 business days that it meets the requirements of paragraph (c)(1)(iv)(A) of this section, the Secretary will notify the parties of the final selection of the certified IDR entity no later than 1 business day after the certified IDR entity attests that it meets the conflict-of-

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interest requirements. The date of final selection of the certified IDR entity is the date that the Secretary provides this notice to the parties.

(2) Federal IDR process eligibility review—

(i) Federal IDR process eligibility determination by certified IDR entity. The selected certified IDR entity must review the information in the notice of IDR initiation, notice of IDR initiation response, and any additional information described in paragraph (c)(2)(ii) of this section, and make a final determination as to whether the item or service is a qualified IDR item or service (and in the case of a batched dispute, whether the items or services are qualified IDR items or services), as defined in paragraph (a)(2)(xi) of this section, that is eligible for the Federal IDR process. The certified IDR entity must make such a determination and notify the Secretary and both parties no later than 5 business days after the date of final selection of the certified IDR entity. If the certified IDR entity determines that the item or service is not a qualified IDR item or service that is eligible for the Federal IDR process, the dispute will be closed, and the selected certified IDR entity will not take any further action with respect to the dispute. In the case of a batched dispute, only those items and services determined to be qualified IDR items or services that are eligible for the Federal IDR process and that meet the requirements of paragraph (c)(4)(i) of this section will continue through the Federal IDR process, and the selected certified IDR entity will not take any further action with respect to the other items and services included in the batched dispute.

(ii) Request for additional information. The selected certified IDR entity may request additional information from either party to a dispute at any time, including for the purpose of assessing whether a conflict of interest exists, conducting an eligibility determination, or making a payment determination.

(A) Upon request, a party must submit the additional information within 5 business days to the selected certified IDR entity through the Federal IDR portal. Following a request for additional information, the time period for the applicable stage of the Federal IDR process will be tolled until the earlier of the date either all of the requested information is provided or the 5–business-day period expires, and each subsequent timeframe in the Federal IDR process will be determined based on the date of completion of the stage of the Federal IDR process that was tolled for provision of the requested information.

(B) If a party fails to submit the additional information as required, the related determination, including the conflict-of-interest review, eligibility determination, or payment determination, will be made without the requested information unless a good-cause extension of the 5–business-day period, as specified in paragraph (g)(1)(i) of this section, has been provided, and the party subsequently submits the additional information requested within the extended period. If the related determination cannot be made because both parties failed to provide the additional information as required, the dispute will be considered withdrawn, as specified in paragraph (c)(3)(ii) of this section.

(3) Authority to continue negotiations or withdraw.

(i) Authority to continue to negotiate. If the parties to the Federal IDR process agree on an out-of-network rate for a qualified IDR item or service after providing the notice of IDR initiation to the Secretary required under paragraph (b)(2)(ii) of this section, but before the certified IDR entity has made its payment determination,

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the amount agreed to by the parties for the qualified IDR item or service will be treated as the out-of-network rate for the qualified IDR item or service. To the extent the amount exceeds the initial payment amount and any cost sharing paid or owed by the participant, beneficiary, or enrollee, payment must be made directly by the plan or issuer to the nonparticipating provider, nonparticipating facility, or nonparticipating provider of air ambulance services not later than 30 calendar days after the date the agreement is reached. In no instance may either party seek additional payment from the participant, beneficiary, or enrollee, calculated based on the agreed-upon amount, in instances in which the out-of-network rate exceeds the qualifying payment amount. The initiating party must send a notification for the parties' agreement to the Secretary and the certified IDR entity (if selected) through the Federal IDR portal as soon as possible, but no later than 3 business days after the date of the agreement. The notification must include the dispute number, a statement of the agreed-on out-of-network rate for the qualified IDR item or service, and signatures from authorized signatories for both parties.

(ii) Withdrawal of disputes. A dispute may be withdrawn from the Federal IDR process by the initiating party, the Secretary, or a certified IDR entity before a payment determination is made, if one of the following conditions is met:

(A) The initiating party provides notification through the Federal IDR portal to the Secretary and the certified IDR entity (if selected) that both parties to the dispute agree to withdraw the dispute from the Federal IDR process without agreement on an out-of-network rate. The notification must include the dispute number, a statement about both parties' agreement to withdraw, and signatures from authorized signatories for both parties;

(B) The initiating party provides a standard withdrawal request notice through the Federal IDR portal to the Secretary, the certified IDR entity (if selected), and the non-initiating party of its request to withdraw the dispute from the Federal IDR process, and the non-initiating party notifies the Secretary, certified IDR entity (if selected), and the initiating party through the Federal IDR portal of its agreement to withdraw from the Federal IDR process within 5 business days of the initiating party's request. Provision of the withdrawal request through the Federal IDR portal pauses the Federal IDR process for 5 business days or until the non-initiating party responds, whichever happens first. If the non-initiating party fails to respond within 5 business days of the initiating party's request, the non-initiating party will be considered to have agreed to the withdrawal, and the dispute will be withdrawn;

(C) The certified IDR entity cannot determine eligibility, for example, because both parties to the dispute are nonresponsive to any requests for additional information to determine eligibility as described in paragraph (c)(2)(ii) of this section; or

(D) The certified IDR entity cannot make a payment determination, for example, because both parties to the dispute have failed to submit an offer as described in paragraph (c)(5)(i) of this section.

(4) Treatment of batched qualified IDR items and services—

(i) In general. For purposes of encouraging efficiencies (including minimizing costs) in the Federal IDR process, a certified IDR entity may consider up to 50 qualified IDR items and services jointly as part of a

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single payment determination that is subject to the certified IDR entity fee for batched disputes, only if the qualified IDR items and services meet the requirements of this paragraph (c)(4)(i) of this section:

(A) [Reserved]

(B) Payment for the qualified IDR items and services is required to be made by the same group health plan or health insurance issuer. For group or individual health insurance coverage, this requirement is satisfied if the same issuer is required to make payment for the qualified IDR items and services, even if the qualified IDR items and services relate to claims from different group health plans or individual market policies. For self-insured group health plans, this requirement is satisfied if the same self-insured group health plan is required to make payment for the qualified IDR items and services, including when the plan makes payments through a third party administrator; the requirement is not satisfied if multiple self-insured group health plans are required to make payments for the qualified IDR items and services, even if those group health plans make payments through the same third party administrator;

(C) The qualified IDR items and services meet any of the following criteria under which multiple qualified IDR items and services relate to the treatment of a similar condition:

(1) The qualified IDR items or services were furnished to a single patient during a single patient encounter. For purposes of this section, a single patient encounter is defined as a patient encounter on one or more consecutive days during which the qualified IDR items or services were furnished to the same patient and billed on the same claim form; or

(2) The qualified IDR items and services were furnished to one or more patients and were billed under the same service code or a comparable code under a different procedural coding system, such as Current Procedural Terminology (CPT) codes with modifiers, if applicable, Healthcare Common Procedure Coding System (HCPCS) codes with modifiers, if applicable, or Diagnosis–Related Group (DRG) codes with modifiers, if applicable; or

(3) For anesthesiology, radiology, pathology, and laboratory qualified IDR items and services, the qualified IDR items and services were furnished to one or more patients and were billed under service codes belonging to the same Category I CPT code range, as specified in guidance published by the Secretary; and

(D) All the qualified IDR items and services were furnished within the same 30–business-day period following the date on which the first item or service included in the batched dispute was furnished, and the qualified IDR items and services were the subjects of a 30–business-day open negotiation period that ended within 4 business days of IDR initiation, except as provided in paragraph (c)(5)(vii)(B) of this section.

(ii) Treatment of bundled payment arrangements. Qualified IDR items and services that meet the definition of a bundled payment arrangement under § 149.30 may be submitted and considered as a single payment determination, and the certified IDR entity must make a single payment determination for the multiple

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qualified IDR items and services included in the bundled payment arrangement. Bundled payment arrangements as defined in § 149.30 and submitted under this paragraph (c)(4)(ii) are subject to the certified IDR entity fee for single determinations.

(5) Payment determination for a qualified IDR item or service.

(i) Submission of offers. Not later than 10 business days after the date of final selection of the certified IDR entity as described in paragraph (c)(1)(iv)(C) of this section (or not later than 10 business days after the qualified IDR items and services are determined eligible as described in paragraph (c)(2) of this section, when the Secretary determines that any of the extenuating circumstances described in paragraph (g)(1)(ii) of this section apply), the plan or issuer and the provider, facility, or provider of air ambulance services:

(A) [Reserved]

(B) [Reserved]

(ii) Payment determination and notification. Not later than 30 business days after the date of final selection of the certified IDR entity as described in paragraph (c)(1)(iv)(C) of this section (or not later than 30 business days after the qualified IDR items and services are determined eligible as described in paragraph (c)(2) of this section, when the Secretary determines that any of the extenuating circumstances described in paragraph (g) of this section apply), the certified IDR entity must:

(A) Select as the out-of-network rate for the qualified IDR item or service one of the offers submitted under paragraph (c)(5)(i) of this section, weighing only the considerations specified in paragraph (c)(5)(iii) of this section (as applied to the information provided by the parties pursuant to 29 CFR 2590.716–8(c)(5)(i). The certified IDR entity must select the offer that the certified IDR entity determines best represents the value of the qualified IDR item or service as the out-of-network rate.

(1) Prevailing party. In the case of single determinations, the party whose offer is selected by the certified IDR entity is considered the prevailing party. In the case of batched determinations, the party with the most determinations in its favor is considered the prevailing party.

(2) Non-prevailing party. In the case of single determinations, the party whose offer is not selected by the certified IDR entity is considered the non-prevailing party. In the case of batched determinations, the party with the fewest determinations in its favor is considered the non-prevailing party.

(3) Parties prevailing in equal numbers of determinations. If each party prevails in an equal number of determinations, neither party will be considered the prevailing party or the non-prevailing party, and the certified IDR entity fee will be split evenly between the parties.

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(B) Notify the plan or issuer and the provider or facility, as applicable, of the selection of the offer under paragraph (c)(5)(ii)(A) of this section, and provide the written decision required under (c)(5)(vi) of this section.

(iii) Considerations in determination. In determining which offer to select:

(A) The certified IDR entity must consider the qualifying payment amount(s) for the applicable year for the same or similar item or service.

(B) The certified IDR entity must consider information submitted by a party that relates to the following circumstances:

(1) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the qualified IDR item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).

(2) The market share held by the provider or facility or that of the plan or issuer in the geographic region in which the qualified IDR item or service was provided.

(3) The acuity of the participant, beneficiary, or enrollee receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee.

(4) The teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable.

(5) Demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(C) The certified IDR entity must also consider information provided by a party in response to a request by the certified IDR entity under paragraph (c)(5)(i)(A)(2) of this section that relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and that does not include information on factors described in paragraph (c)(5)(v) of this section.

(D) The certified IDR entity must also consider additional information submitted by a party that relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and that does not include information on factors described in paragraph (c)(4)(v) of this section.

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(iv) [Reserved]

(v) Prohibition on consideration of certain factors. In determining which offer to select, the certified IDR entity must not consider:

(A) Usual and customary charges (including payment or reimbursement rates expressed as a proportion of usual and customary charges);

(B) The amount that would have been billed by the provider or facility for the qualified IDR item or service had the provisions of 45 CFR 149.410 and 149.420 (as applicable) not applied; or

(C) The payment or reimbursement rate for items and services furnished by the provider or facility payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act; the Medicaid program under title XIX of the Social Security Act; the Children's Health Insurance Program under title XXI of the Social Security Act; the TRICARE program under chapter 55 of title 10, United States Code; chapter 17 of title 38, United States Code; or demonstration projects under section 1115 of the Social Security Act.

(vi) Written decision.

(A) The certified IDR entity must explain its determination in a written decision submitted to the parties and the Secretary, in a form and manner specified by the Secretary;

(B) The certified IDR entity's written decision must include an explanation of their determination, including what information the certified IDR entity determined demonstrated that the offer selected as the out-of-network rate is the offer that best represents the value of the qualified IDR item or service, including the weight given to the qualifying payment amount and any additional credible information under paragraphs (c)(5)(iii)(B) through (D) of this section.

(vii) Effects of determination.

(A) Binding. A determination made by a certified IDR entity under paragraph (c)(5)(ii) of this section:

(1) [Reserved]

(2) [Reserved]

(B) Suspension of certain subsequent IDR requests. In the case of a single determination made by a certified IDR entity under paragraph (c)(5)(ii) of this section, the party that submitted the initial notification under paragraph (b)(2) of this section may not submit a subsequent notification involving

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the same other party for a claim for the same item or service that was the subject of the initial notification during the 90–calendar-day period following the determination. In the case of a batched determination made by a certified IDR entity under paragraph (c)(5)(ii) of this section, the party that submitted the initial notification under paragraph (b)(2) of this section may not submit a subsequent notification involving the same other party for a claim for the same items or services that were the subject of the initial notification during the 30–business-day period following the determination.

(C) Subsequent submission of requests permitted. In the case of a single determination made by a certified IDR entity under paragraph (c)(5)(ii) of this section, if the end of the open negotiation period specified in paragraph (b)(1) of this section occurs during the 90–calendar-day suspension period regarding claims for the same item or service that were the subject of the single determination, either party may initiate the Federal IDR process for those claims by submitting a notification as specified in paragraph (b)(2) of this section during the 30–business-day period beginning on the day after the last day of the 90–calendar-day suspension period. In the case of a batched determination made by a certified IDR entity under paragraph (c)(5)(ii) of this section, if the end of the open negotiation period specified in paragraph (b)(1) of this section is completed in the 30 business days prior to or during the 30–business-day suspension period regarding claims for the same items or services that were the subject of the batched determination, either party may initiate the Federal IDR process for those claims by submitting a notification as specified in paragraph (b)(2) of this section during the 4–business-day period beginning on the business day after the 30–business-day suspension period as described in paragraph (c)(5)(vii)(B) of this section.

(viii) [Reserved]

(ix) [Reserved]

(d) Costs of IDR process—

(1) Certified IDR entity fee.

(i) Timing of payment of certified IDR entity fee. Each party to a dispute for which there is a final selection of the certified IDR entity and a determination that the dispute is eligible for the Federal IDR process in accordance with paragraph (c)(2) of this section must pay to the certified IDR entity the predetermined certified IDR entity fee charged by the certified IDR entity. The certified IDR entity fee must be paid no later than the date a party submits its offer to the certified IDR entity, in accordance with paragraph (c)(5)(i) of this section.

(ii) Failure to timely pay certified IDR entity fee. If a party fails to pay the certified IDR entity fee as specified in paragraph (d)(1)(i) of this section, that party's offer will not be considered received. Such party will continue to be responsible for payment of the certified IDR entity fee.

(iii) Method of allocation of the certified IDR entity fee after a payment determination. After making a payment determination, the certified IDR entity will retain the certified IDR entity fee described under

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paragraph (d)(1)(i) of this section paid by the non-prevailing party as defined in paragraph (c)(5)(ii)(A)(2) of this section. The certified IDR entity must return the fee paid by the prevailing party, as defined in paragraph (c)(5)(ii)(A)(1) of this section, within 30 business days following the date of the certified IDR entity's payment determination. In the event of a batched dispute in which each party prevails in an equal number of determinations, the certified IDR entity fee will be split evenly between the parties. In that case, the certified IDR entity must return half of the fee paid by each party within 30 business days following the date of the certified IDR entity's payment determination.

(iv) Method of allocation of the certified IDR entity fee upon agreement or withdrawal after an eligibility determination. For a dispute for which there is a final selection of the certified IDR entity and a determination that the dispute is eligible for the Federal IDR process in accordance with paragraph (c)(2) of this section, unless directed otherwise by both parties, the certified IDR entity is required to return half of each party's certified IDR entity fee within 30 business days of the date both parties notify the certified IDR entity that they have:

(A) Reached an agreement on an out-of-network rate for qualified IDR items or services before the certified IDR entity has made its payment determination, as described in paragraph (c)(3)(i) of this section; or

(B) Withdrawn the dispute before the certified IDR entity has made its payment determination, as described in paragraph (c)(3)(ii) of this section.

(v) Method of allocation of the certified IDR entity fee upon agreement or withdrawal before an eligibility determination. For a dispute for which there is a final selection of the certified IDR entity, but the dispute has been determined ineligible or no eligibility determination has been made for the dispute, in accordance with paragraph (c)(2) of this section (excluding situations as provided in paragraph (c)(3)(ii)(C) of this section where a certified IDR entity cannot determine eligibility), the certified IDR entity is required to return the entirety of each party's certified IDR entity fee within 30 business days of the date both parties notify the certified IDR entity that they have:

(A) Reached an agreement on an out-of-network rate for qualified IDR items or services before the certified IDR entity has made its payment determination, as described in paragraph (c)(3)(i) of this section; or

(B) Withdrawn the dispute before the certified IDR entity has made its payment determination, as described in paragraph (c)(3)(ii) of this section.

(2) Administrative fee.

(i) Each party to a determination for which a certified IDR entity is selected under paragraph (c)(1) of this section must, at the time the certified IDR entity is selected under paragraph (c)(1) of this section, pay to the certified IDR entity a non-refundable administrative fee due to the Secretary for participating in the Federal IDR process described in this section.

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(ii) Administrative fee amount. The administrative fee amount will be established through notice and comment rulemaking no more frequently than once per calendar year in a manner such that the total administrative fees paid for a year are estimated to be equal to the amount of expenditures estimated to be made by the Secretaries of the Treasury, Labor, and Health and Human Services for the year in carrying out the Federal IDR process. The administrative fee amount will remain in effect until changed by notice and comment rulemaking.

(A) For disputes initiated on January 22, 2024, through June 10, 2026, the administrative fee amount is $115 per party per dispute.

(B) For disputes initiated on or after June 11, 2026, the administrative fee amount is $15 per party per dispute.

(iii) Failure to pay the administrative fee. If a party fails to pay the administrative fee as specified in paragraph (d)(2) of this section, that party's offer will not be considered received. Such party will continue to be responsible for payment of the administrative fee.

(e) Certification of IDR entity—

(1) In general. In order to be selected under paragraph (c)(1) of this section—

(i) An IDR entity must meet the standards described in this paragraph (e) and be certified by the Secretary, jointly with the Secretaries of Labor and the Treasury, as set forth in this paragraph (e) of this section and guidance promulgated by the Secretary. Once certified, the IDR entity will be provided with a certified IDR entity number.

(ii) An IDR entity must provide written documentation to the Secretary regarding general company information (such as contact information, Taxpayer Identification Number, and website), as well as the applicable service area in which the IDR entity intends to conduct payment determinations under the Federal IDR process. IDR entities may choose to submit their application for all States or self-limit to a particular subset of States.

(iii) An IDR entity that the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, certifies must enter into an agreement as a condition of certification. The agreement shall include specified provisions encompassed by this section, including, but not limited to, the requirements applicable to certified IDR entities when making payment determinations as well as the requirements regarding certification and revocation (such as specifications for wind down activities and reallocation of certified IDR entity fees, where warranted).

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(2) Requirements. An IDR entity must provide written documentation to the Secretary through the Federal IDR portal that demonstrates that the IDR entity satisfies the following standards to be a certified IDR entity under this paragraph (e):

(i) Possess (directly or through contracts or other arrangements) sufficient arbitration and claims administration of health care services, managed care, billing and coding, medical and legal expertise to make the payment determinations described in paragraph (c) of this section within the time prescribed in paragraph (c)(4)(ii) of this section.

(ii) Employ (directly or through contracts or other arrangements) a sufficient number of personnel to make the determinations described in paragraph (c) of this section within the time prescribed by (c)(4)(ii) of this section. To satisfy this standard, the written documentation must include a description of the IDR entity's organizational structure and capabilities, including an organizational chart and the credentials, responsibilities, and number of personnel employed to make determinations described in paragraph (c) of this section.

(iii) Maintain a current accreditation from a nationally recognized and relevant accrediting organization, such as URAC, or ensure that it otherwise possesses the requisite training to conduct payment determinations (for example, providing documentation that personnel employed by the IDR entity have completed arbitration training by the American Arbitration Association, the American Health Law Association, or a similar organization).

(iv) Have a process to ensure that no conflict of interest, as defined in paragraph (a)(2) of this section, exists between the parties and the personnel the certified IDR entity assigns to a payment determination to avoid violating paragraph (c)(1)(ii) of this section, including policies and procedures for conducting ongoing audits for conflicts of interest, to ensure that should any arise, the certified IDR entity has procedures in place to inform the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, of the conflict of interest and to mitigate the risk by reassigning the dispute to other personnel in the event that any personnel previously assigned have a conflict of interest.

(v) Have a process to maintain the confidentiality of IIHI obtained in the course of conducting determinations. A certified IDR entity's responsibility to comply with these confidentiality requirements shall survive revocation of the IDR entity's certification for any reason, and IDR entities must comply with the record retention and disposal requirements described in this section. Under this process, once certified, the certified IDR entity must comply with the following requirements:

(A) Privacy. The certified IDR entity may create, collect, handle, disclose, transmit, access, maintain, store, and/or use IIHI, only to perform:

(1) The certified IDR entity's required duties described in this section; and

(2) Functions related to carrying out additional obligations as may be required under applicable Federal or State laws or regulations.

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(B) Security.

(1) The certified IDR entity must ensure the confidentiality of all IIHI it creates, obtains, maintains, stores, and transmits;

(2) The certified IDR entity must protect against any reasonably anticipated threats or hazards to the security of this information;

(3) The certified IDR entity must ensure that IIHI is securely destroyed or disposed of in an appropriate and reasonable manner 6 years from either the date of its creation or the first date on which the certified IDR entity had access to it, whichever is earlier.

(4) The certified IDR entity must implement policies and procedures to prevent, detect, contain, and correct security violations in the event of a breach of IIHI;

(C) Breach notification. The certified IDR entity must, following the discovery of a breach of unsecured IIHI, notify of the breach the provider, facility, or provider of air ambulance services; the plan and issuer; the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor; and each individual whose unsecured IIHI has been, or is reasonably believed to have been, subject to the breach, to the extent possible.

(1) Breaches treated as discovered. For purposes of this paragraph (e)(2)(v)(C), a breach shall be treated as discovered by a certified IDR entity as of the first day on which the breach is known to the certified IDR entity or, by exercising reasonable diligence, would have been known to the certified IDR entity. A certified IDR entity shall be deemed to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer, or other agent of the certified IDR entity;

(2) Timing of notification. A certified IDR entity must provide the notification required by this paragraph (e)(2)(v)(C) without unreasonable delay and in no case later than 60 calendar days after discovery of a breach.

(3) Content of notification. The notification required by this paragraph (e)(2)(v)(C) must include, to the extent possible:

(i) The identification of each individual whose unsecured IIHI has been, or is reasonably believed by the certified IDR entity to have been, subject to the breach;

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(ii) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, to the extent known;

(iii) A description of the types of unsecured IIHI that were involved in the breach (for example whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

(iv) A brief description of what the certified IDR entity involved is doing to investigate the breach, to mitigate harm to the affected parties, and to protect against any further breaches; and

(v) Contact procedures for individuals to ask questions or learn additional information, which must include a toll-free telephone number, email address, website, or postal address.

(4) Method for providing notification. A certified IDR entity must submit the notification required by this paragraph (e)(2)(v)(C) in written form (in clear and understandable language) either on paper or electronically through the Federal IDR portal or electronic mail.

(D) Application to contractor and subcontractors. The certified IDR entity must ensure compliance with this paragraph (e)(2)(v) of this section by any contractor or subcontractor with access to IIHI performing any duties related to the Federal IDR process.

(vi) Meet appropriate indicators of fiscal integrity and stability by demonstrating that the certified IDR entity has a system of safeguards and controls in place to prevent and detect improper financial activities by its employees and agents to assure fiscal integrity and accountability for all certified IDR entity fees and administrative fees received, held, and disbursed and by submitting 3 years of financial statements or, if not available, other information to demonstrate fiscal stability of the IDR entity.

(vii) Provide, no more frequently than once per calendar year, a fixed fee for single determinations and a separate fixed fee for batched determinations, as well as an additional fixed tiered fee for batched determinations, if applicable, within the upper and lower limits for each, as established by the Secretary in notice and comment rulemaking. The certified IDR entity fee ranges established by the Secretary in rulemaking will remain in effect until changed by notice and comment rulemaking. The certified IDR entity may not charge a fee outside the limits set forth in rulemaking unless the certified IDR entity or IDR entity seeking certification receives advance written approval from the Secretary to charge a fixed fee beyond the upper or lower limits by following the process described in paragraph (e)(2)(vii)(A) of this section. A certified IDR entity may also seek advance written approval from the Secretary to update its fees one additional time per calendar year by meeting the requirements described in paragraph (e)(2)(vii)(A). The Secretary will approve a request to charge a fixed fee beyond the upper or lower limits for fees as set forth in rulemaking or to update the fixed fee during the calendar year if, in their discretion, they determine the information submitted by a certified IDR entity or IDR entity seeking certification demonstrates that the proposed change to the certified IDR entity fee would ensure the financial viability of the certified IDR entity or IDR entity seeking certification and would not impose on parties an undue barrier to accessing the Federal IDR process.

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(A) In order for the certified IDR entity or IDR entity seeking certification to receive the Secretary's written approval to charge a fixed fee beyond the upper or lower limits for fees as set forth in rulemaking or to update the fixed fee during the calendar year, the certified IDR entity or IDR entity seeking certification must submit to the Secretary, in the form and manner specified by the Secretary:

(1) The fixed fee the certified IDR entity or IDR entity seeking certification believes is appropriate for the certified IDR entity or IDR entity seeking certification to charge;

(2) A description of the circumstances that require the alternative fixed fee, or that require a change to the fixed fee during the calendar year, as applicable; and

(3) A detailed description that reasonably explains how the alternative fixed fee or the change to the fixed fee during the calendar year, as applicable, will be used to mitigate the effects of those circumstances.

(B) [Reserved]

(viii) For disputes initiated on or after January 22, 2024, certified IDR entities are permitted to charge a fixed certified IDR entity fee for single determinations within the range of $200 to $840, and a fixed certified IDR entity fee for batched determinations within the range of $268 to $1,173, unless a fee outside such ranges is approved by the Secretary, pursuant to paragraph (e)(2)(vii)(A) of this section. As part of the batched determination fee, certified IDR entities are permitted to charge an additional fixed tiered fee within the range of $75 to $250 for every additional 25 line items within a batched dispute, beginning with the 26th line item. The ranges for the certified IDR entity fees for single and batched determinations will remain in effect until changed by notice and comment rulemaking.

(ix) Have a procedure in place to retain the certified IDR entity fees described in paragraph (d)(1) of this section paid by both parties in a trust or escrow account and to return the certified IDR entity fee paid by the prevailing party or a portion of each party's certified IDR entity fee in the case of an agreement described in paragraph (c)(3)(i) of this section, a withdrawal described in paragraph (c)(3)(ii) of this section, or a circumstance in which each party prevails in an equal number of determinations, as described in paragraph (d)(1)(iii) of this section, within 30 business days following the date of the determination or the date the certified IDR entity is notified by both parties of an agreement or withdrawal, as applicable;

(x) Have a procedure in place to retain the administrative fees described in paragraph (d)(2) of this section and to remit the administrative fees to the Secretary in accordance with the timeframe and procedures set forth in guidance published by the Secretary.

(xi) Discharge its responsibilities in accordance with paragraph (c) of this section, including not making any determination with respect to which the certified IDR entity would not be eligible for selection pursuant to paragraph (c)(1) of this section.

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(xii) Collect the information required to be reported to the Secretary under paragraph (f) of this section and report the information on a timely basis in the form and manner provided in guidance published by the Secretary.

(3) Conflict-of-interest standards. In addition to the general standards set forth in paragraph (e)(2)(iv) of this section, an IDR entity must provide written documentation that the IDR entity satisfies the standards to be a certified IDR entity under this paragraph (e)(3).

(i) The IDR entity must provide an attestation indicating that it does not have a conflict of interest as defined in paragraph (a)(2) of this section;

(ii) The IDR entity must have procedures in place to ensure that personnel assigned to a determination do not have any conflicts of interest regarding any party to the dispute within the 1 year immediately preceding an assignment of dispute determination, similar to the requirements laid out in 18 U.S.C. 207(b). In order to satisfy this requirement, if certified, the IDR entity must ensure that any personnel assigned to a determination do not have any conflicts of interest as defined in paragraph (a)(2) of this section.

(iii) Following certification under this paragraph (e), if a certified IDR entity acquires control of, becomes controlled by, or comes under common control with any entity described in paragraph (e)(3)(i) of this section, the certified IDR entity must notify the Secretary in writing no later than 3 business days after the acquisition or exercise of control and shall be subject to the revocation of certification under paragraph (e)(6)(ii) of this section.

(4) Period of certification. Subject to paragraphs (e)(5) and (6) of this section, each certification (including a recertification) of a certified IDR entity under the process described in paragraph (e)(1) of this section will be effective for a 5–year period.

(5) Petition for denial or revocation—

(i) In general. An individual, provider, facility, provider of air ambulance services, plan, or issuer may petition for a denial of a certification for an IDR entity or a revocation of a certification for a certified IDR entity for failure to meet a requirement of this section using the standard form and manner set forth in guidance to be issued by the Secretary. The petition for denial of a certification must be submitted within the timeframe set forth in guidance issued by the Secretary.

(ii) Content of petition. The individual, provider, facility, provider of air ambulance services, plan, or issuer seeking denial or revocation of certification must submit a written petition using the standard form issued by the Secretary including the following information:

(A) The identity of the IDR entity seeking certification or certified IDR entity that is the subject of the petition;

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(B) The reason(s) for the petition;

(C) Whether the petition seeks denial or revocation of a certification;

(D) Documentation to support the reasons outlined in the petition; and

(E) Other information as may be required by the Secretary.

(iii) Process.

(A) The Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor will acknowledge receipt of the petition within 10 business days of receipt of the petition.

(B) If the Secretary finds that the petition adequately shows a failure of the IDR entity seeking certification or the certified IDR entity to follow the requirements of this paragraph (e), the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, will notify the IDR entity seeking certification or the certified IDR entity by providing a de-identified copy of the petition. Following the notification, the IDR entity seeking certification or certified IDR entity will have 10 business days to provide a response. After the time period for providing the response has passed, the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, will review the response (if any), determine whether a denial or revocation of a certification is warranted, and issue a notice of the decision to the IDR entity or certified IDR entity and to the petitioner. This decision will be subject to the appeal requirements of paragraph (e)(6)(v) of this section.

(C) Effect on certification under petition. Regarding a petition for revocation of a certified IDR entity's certification, if the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, finds that the petition adequately shows a failure to comply with the requirements of this paragraph (e), following the Secretary's notification of the failure to the certified IDR entity under paragraph (e)(5)(iii)(B) of this section, the certified IDR entity may continue to work on previously assigned determinations but may not accept new determinations until the Secretary issues a notice of the decision to the certified IDR entity finding that a revocation of certification is not warranted.

(6) Denial of IDR entity certification or revocation of certified IDR entity certification—

(i) Denial of IDR entity certification. The Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, may deny the certification of an IDR entity under paragraph (e)(1) of this section if, during the process of certification, including as a result of a petition described in paragraph (e)(5) of this section, the Secretary determines the following:

(A) The IDR entity fails to meet the applicable standards set forth under this paragraph (e);

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(B) The IDR entity has committed or participated in fraudulent or abusive activities, including, during the certification process, submitting fraudulent data, or submitting information or data the IDR entity knows to be false to the Secretary, the Secretary of the Treasury or the Secretary of Labor;

(C) The IDR entity has failed to comply with requests for information from the Secretary, the Secretary of the Treasury, or the Secretary of Labor as part of the certification process;

(D) In conducting payment determinations, including those outside the Federal IDR process, the IDR entity has failed to meet the standards that applied to those determinations or reviews, including standards of independence and impartiality; or

(E) The IDR entity is otherwise not fit or qualified to make determinations under the Federal IDR process.

(ii) Revocation of certification of a certified IDR entity. The Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, may revoke the certification of a certified IDR entity under paragraph (e)(1) of this section if, as a result of an audit, a petition described in paragraph (e)(5) of this section, or otherwise, the Secretary determines the following:

(A) The certified IDR entity has a pattern or practice of noncompliance with any requirements of this paragraph (e);

(B) The certified IDR entity is operating in a manner that hinders the efficient and effective administration of the Federal IDR process;

(C) The certified IDR entity no longer meets the applicable standards for certification set forth under this paragraph (e);

(D) The certified IDR entity has committed or participated in fraudulent or abusive activities, including submission of false or fraudulent data to the Secretary, the Secretary of the Treasury, or the Secretary of Labor;

(E) The certified IDR entity lacks the financial viability to provide arbitration under the Federal IDR process;

(F) The certified IDR entity has failed to comply with requests from the Secretary, the Secretary of the Treasury, or the Secretary of Labor made as part of an audit, including failing to submit all records of the certified IDR entity that pertain to its activities within the Federal IDR process; or

(G) The certified IDR entity is otherwise no longer fit or qualified to make determinations.

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(iii) Notice of denial or revocation. The Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, will issue a written notice of denial to the IDR entity or revocation to the certified IDR entity within 10 business days of the Secretary's decision, including the effective date of denial or revocation, the reason(s) for denial or revocation, and the opportunity to request appeal of the denial or revocation.

(iv) Request for appeal of denial or revocation. To request an appeal, the IDR entity or certified IDR entity must submit a request for appeal to the Secretary within 30 business days of the date of the notice under paragraph (e)(6)(iii) of this section of denial or revocation and in the manner prescribed by the instructions to the notice. During this time period, the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, will not issue a notice of final denial or revocation and a certified IDR entity may continue to work on previously assigned determinations but may not accept new determinations. If the IDR entity or certified IDR entity does not timely submit a request for appeal of the denial or revocation, the Secretary, jointly with the Secretary of the Treasury and the Secretary of Labor, will issue a notice of final denial or revocation to the IDR entity or certified IDR entity (if applicable) and the petitioner.

(v) Denial or final revocation. Upon notice of denial or final revocation, the IDR entity shall not be considered a certified IDR entity and therefore shall not be eligible to accept payment determinations under the Federal IDR process. Moreover, after a notice of final revocation, the IDR entity may not re-apply to be a certified IDR entity until on or after the 181st day after the date of the notice of denial or final revocation.

(f) Reporting of information relating to the Federal IDR process—

(1) Reporting of information. Within 30 business days of the close of each month, for qualified IDR items and services furnished on or after January 1, 2022, each certified IDR entity must, in a form and manner specified by the Secretary, report:

(i) The number of notices of IDR initiation submitted under paragraph (b)(2) of this section to the certified IDR entity during the immediately preceding month;

(ii) The size of the provider practices and the size of the facilities submitting notices of IDR initiation under paragraph (b)(2) of this section during the immediately preceding month, as required to be provided to the certified IDR entity under paragraph (c)(4)(i)(A)(2) of this section;

(iii) The number of such notices of IDR initiation with respect to which a determination was made under paragraph (c)(4)(ii) of this section;

(iv) The number of times during the month that the out-of-network rate determined (or agreed to) under this section has exceeded the qualifying payment amount, specified by qualified IDR items and services;

(v) With respect to each notice of IDR initiation under paragraph (b)(2) of this section for which such a determination was made, the following information:

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(A) A description of the qualified IDR items and services included with respect to the notification, including the relevant billing and service codes;

(B) The relevant geographic region for purposes of the qualifying payment amount for the qualified IDR items and services with respect to which the notification was provided;

(C) The amount of the offer submitted under paragraph (c)(4)(i) of this section by the plan or issuer (as applicable) and by the provider or facility (as applicable) expressed as a dollar amount and as a percentage of the qualifying payment amount;

(D) Whether the offer selected by the certified IDR entity under paragraph (c)(4) of this section was the offer submitted by the plan or issuer (as applicable) or by the provider or facility (as applicable);

(E) The amount of the selected offer expressed as a dollar amount and as a percentage of the qualifying payment amount;

(F) The rationale for the certified IDR entity's decision, including the extent to which the decision relied on the criteria in paragraphs (c)(4)(iii)(B) through (D) of this section;

(G) The practice specialty or type of each provider or facility, respectively, involved in furnishing each qualified IDR item or service;

(H) The identity for each plan or issuer, and provider or facility, with respect to the notification. Specifically, each certified IDR entity must provide each party's name and address, as applicable; and

(I) For each determination, the number of business days elapsed between selection of the certified IDR entity and the determination of the out-of-network rate by the certified IDR entity.

(vi) The total amount of certified IDR entity fees paid to the certified IDR entity under paragraph (d)(1) of this section during the month.

(2) [Reserved]

(g) Extension of time periods for extenuating circumstances.

(1) In general. The time periods specified in this section (other than the time for payment, if applicable, under paragraph (c)(5)(ix) of this section) may be extended in extenuating circumstances at the Secretary's discretion. Extenuating circumstances include, but are not limited to, when:

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(i) For a specific dispute, the Secretary determines that the parties or certified IDR entity cannot meet applicable timeframes due to matters beyond the control of one or both parties or the certified IDR entity, or for other good cause. The certified IDR entity or either party may also submit a request for an extension due to extenuating circumstances to the Secretary through the Federal IDR portal. The requesting certified IDR entity or party must attest that it will take prompt action to ensure that the certified IDR entity's payment determination under this section may be made as soon as administratively practicable under the circumstances; or

(ii) The Secretary determines that the parties or certified IDR entity cannot meet applicable timeframes due to systematic delays in processing disputes under the Federal IDR process, such as an unforeseen volume of disputes or Federal IDR portal system failures. Extensions provided due to extenuating circumstances caused by an unforeseen volume of disputes will be applied to the timeframe for eligibility determinations under paragraph (c)(2) of this section. Extensions provided due to extenuating circumstances caused by systems failures within the Federal IDR portal will be applied to the Federal IDR process timeframe(s) determined relevant by the Secretary. The Secretary will post a public notice regarding any extensions of time periods under this paragraph (g)(1)(ii).

(A) Timeframe following an extension to eligibility determination. When an extension to the eligibility determination timeframe under paragraph (g)(1)(ii) of this section is in effect, the start date of the subsequent timeframes in the Federal IDR process will be determined based on the date of completion of the eligibility determination by the certified IDR entity.

(1) Submission of offers. The parties must submit their offers and certified IDR entity fees to the certified IDR entity not later than 10 business days after the qualified IDR items and services are determined eligible as described in paragraph (c)(2) of this section.

(2) Payment determination. The certified IDR entity must make the payment determination and provide notification of the payment determination to the parties not later than 30 business days after the qualified IDR items and services are determined eligible as described in paragraph (c)(2) of this section.

(B) Timeframe following an extension to other timeframes in the Federal IDR process. When an extension to any timeframe within the Federal IDR process, other than the eligibility timeframe, is in effect under paragraph (g)(1)(ii) of this section, the start date of each subsequent timeframe in the Federal IDR process will be determined based on the date of completion of the process for which the extension was granted.

(2) [Reserved]

(h) Applicability date.

(1) Paragraph (a) of this section is applicable for plan years (or in the individual market, policy years) beginning on or after January 1, 2022, except that the provisions regarding IDR entity certification at

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paragraph (a) of this section are applicable beginning on October 7, 2021, and the revised definition for batched IDR items and services at paragraph (a)(2)(i) of this section is applicable to disputes with open negotiation periods beginning on November 1, 2026.

(2) Paragraph (b) of this section is applicable to disputes with open negotiation periods beginning 90 calendar days after the Departments issue guidance announcing that the functionality supporting these provisions has become available.

(3) Paragraph (c)(1) of this section, regarding the selection of a certified IDR entity, is applicable for plan years (or in the individual market, policy years) beginning on or after January 1, 2022, and the modifications at paragraph (c)(1) of this section are applicable to disputes with open negotiation periods beginning 90 calendar days after the Departments issue guidance announcing that the functionality supporting these provisions has become available.

(4) Paragraph (c)(2) of this section, regarding the Federal IDR process eligibility review, paragraph (c)(3) of this section, regarding the authority to continue negotiations or withdraw, and paragraph (c)(4) of this section, regarding the treatment of batched and bundled qualified IDR items and services, are applicable for plan years (or in the individual market, policy years) beginning on or after January 1, 2022. The modifications at paragraphs (c)(3)(i) and (c)(3)(ii)(C) and (D) of this section are applicable beginning on November 1, 2026. The amendments at paragraphs (c)(2), (c)(3)(ii)(A) and (B), and (c)(4) of this section are applicable to disputes with open negotiation periods beginning 90 calendar days after the Departments issue guidance announcing that the functionality supporting these provisions has become available.

(5) Paragraphs (c)(5)(ii) and (iii) of this section regarding payment determination and notification and considerations in payment determinations, and paragraph (c)(5)(vi)(B) of this section regarding written decisions are applicable for items or services furnished on or after October 25, 2022, are applicable for plan years (or in the individual market policy years) beginning on or after January 1, 2022. Paragraphs (c)(5)(i), (c)(5)(v) through (c)(5)(vi)(A), and (c)(5)(vii) through (ix) of this section regarding submission of offers, prohibition on consideration of certain factors, written decision, effects of determination, recordkeeping requirements, and payment are applicable for plan years (or in the individual market, policy years) beginning on or after January 1, 2022. The modifications at paragraphs (c)(5)(i) and (ii), and (c)(5)(vii)(B) and (C) of this section regarding the deadlines for the submission of offers, payment determination and notification, suspension of certain subsequent IDR requests, and subsequent submission of requests permitted are applicable to disputes with open negotiation periods beginning 90 calendar days after the Departments issue guidance announcing that the functionality supporting these provisions has become available

(6) Paragraph (d)(1) of this section regarding the certified IDR entity fee is applicable to disputes initiated on or after August 3, 2026. Paragraph (d)(2)(ii) of this section regarding the administrative fee is applicable to disputes initiated on or after June 11, 2026. Paragraph (d)(2)(iii) of this section regarding failure to pay the administrative fee is applicable beginning on August 3, 2026.

(7) Paragraph (e) of this section is applicable for plan years (or in the individual market, policy years) beginning on or after January 1, 2022, except that the provisions regarding IDR entity certification at paragraphs (e)(1), (e)(2)(i) through (vi), (e)(2)(x) and (xi), and (e)(3) through (6) of this section are applicable

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beginning on October 7, 2021. Paragraph (e)(2)(ix) of this section regarding procedures to retain the certified IDR entity fee is applicable beginning on August 3, 2026.

(8) Paragraph (f) of this section is applicable for plan years (or in the individual market, policy years) beginning on or after January 1, 2022, except that paragraph (f)(1)(v)(F) of this section regarding reporting of information relating to the Federal IDR process is applicable for items or services furnished on or after October 25, 2022, for plan years (or in the individual market policy years) beginning on or after January 1, 2022.

(9) Paragraph (g) of this section regarding the extension of time periods for extenuating circumstances is applicable for plan years (or in the individual market, policy years) beginning on or after January 1, 2022. The modifications at paragraph (g) of this section are applicable beginning on November 1, 2026.

(10) Until the relevant applicability date for the requirements of this section, plans, issuers, providers, facilities, providers of air ambulance services and certified IDR entities are required to continue to comply with the corresponding section of § 149.510 in effect prior to June 4, 2026

(i) Severability.

(1) Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, will be construed so as to continue to give maximum effect to the provision permitted by law, unless such holding is one of utter invalidity or unenforceability, in which event the provision will be severable from this section and will not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

(2) The provisions of paragraphs (b)(1), (c)(2)(ii), (c)(4), (d)(2), and (g)(1) of this section are intended to be severable from one another, from any grant of forbearance from removal resulting from this subpart, and from any provision referenced in those paragraphs. The provisions in this section are intended to be severable from the provisions in §§ 149.100, 149.140, and 149.530, from any grant of forbearance from removal resulting from this subpart, and from any provision referenced in §§ 149.100, 149.140, and 149.530.

Credits

[87 FR 52652, Aug. 26, 2022; 88 FR 88525, Dec. 21, 2023; 89 FR 4548, Jan. 24, 2024; 91 FR 34070, June 4, 2026]

SOURCE: 62 FR 16955, 17005, April 8, 1997; 62 FR 31669, June 10, 1997; 86 FR 36970, July 13, 2021; 86 FR 56124, Oct. 7, 2021, unless otherwise noted.

AUTHORITY: 42 U.S.C. 300gg–92 and 300gg–111 through 300gg–139, as amended.

Notes of Decisions (15)

Current through July 30, 2026, 91 FR 47978. Some sections may be more current. See credits for details.

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No. 26-2355

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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

Plaintiffs-Appellants,

v.

HALOMD, LLC, *et al.*,

Defendants-Appellees.

On Appeal from the United States District Court for the
Central District of California,
No. 8:25-cv-01467-KES
The Honorable Karen E. Scott, Magistrate Judge

APPELLANTS' EXCERPTS OF RECORD INDEX VOLUME

Martin J. Bishop
Jason T. Mayer
Alexandra M. Lucas
CROWELL & MORING LLP
300 N. LaSalle Drive. Suite 2500
Chicago, IL 60654
Telephone: 312-321-4200

Jared Levine
CROWELL & MORING LLP
Two Manhattan West
375 Ninth Ave.
New York, NY, 10001
Telephone: 212-223-4000

Emily T. Kuwahara (SB# 252411)
CROWELL & MORING LLP
EKuwahara@crowell.com
515 S. Flower St., 41st Floor
Los Angeles, CA 90071
Telephone: 213-622-4750
Facsimile: 213-622-2690

Attorneys for Plaintiffs and Appellants Anthem Blue Cross Life and Health Insurance Company, and Blue Cross of California d/b/a Anthem Blue Cross

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No. 26-2355

IN THE UNITED STATES COURT OF APPEALS
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ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, et al.,

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v.

HALOMD, LLC, *et al.*,

Defendants-Appellees.

On Appeal from the United States District Court for the
Central District of California,
No. 8:25-cv-01467-KES
The Honorable Karen E. Scott, Magistrate Judge

APPELLANTS' EXCERPTS OF RECORD
VOLUME 1 OF 3

Martin J. Bishop
Jason T. Mayer
Alexandra M. Lucas
CROWELL & MORING LLP
300 N. LaSalle Drive. Suite
2500 Chicago, IL 60654
Telephone: 312-321-4200

Jared Levine
CROWELL & MORING LLP
Two Manhattan West
375 Ninth Ave.
New York, NY, 10001
Telephone: 212-223-4000

Emily T. Kuwahara (SB# 252411)
CROWELL & MORING LLP
EKuwahara@crowell.com
515 S. Flower St., 41st Floor
Los Angeles, CA 90071
Telephone: 213-622-4750
Facsimile: 213-622-2690

Attorneys for Plaintiffs and Appellants Anthem Blue Cross Life and Health Insurance Company, and Blue Cross of California d/b/a Anthem Blue Cross

JS-6

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

JUDGMENT

IT IS ADJUDGED that Plaintiffs' vacatur claims are DISMISSED WITH PREJUDICE. Plaintiffs' remaining claims are dismissed for lack of jurisdiction.

DATED: April 9, 2026

Karen E. Scott

Hon. Karen E. Scott
UNITED STATES DISTRICT JUDGE

O

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

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

No. 26-2355

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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

Plaintiffs-Appellants,

v.

HALOMD, LLC, *et al.*,

Defendants-Appellees.

On Appeal from the United States District Court for the
Central District of California,
No. 8:25-cv-01467-KES
The Honorable Karen E. Scott, Magistrate Judge

APPELLANTS' EXCERPTS OF RECORD VOLUME 2 OF 3

Martin J. Bishop
Jason T. Mayer
Alexandra M. Lucas
CROWELL & MORING LLP
300 N. LaSalle Drive. Suite
2500 Chicago, IL 60654
Telephone: 312-321-4200

Jared Levine
CROWELL & MORING LLP
Two Manhattan West
375 Ninth Ave.
New York, NY, 10001
Telephone: 212-223-4000

Emily T. Kuwahara (SB# 252411)
CROWELL & MORING LLP
EKuwahara@crowell.com
515 S. Flower St., 41st Floor
Los Angeles, CA 90071
Telephone: 213-622-4750
Facsimile: 213-622-2690

Attorneys for Plaintiffs and Appellants Anthem Blue Cross Life and Health Insurance Company, and Blue Cross of California d/b/a Anthem Blue Cross

Anthem Blue Cross Life and Health Ins. Co. v. HaloMD, LLC, et al.

No. 8:25-cv-01467-KES (C.D. Cal.)

March 10, 2026

Crowell

Background



Defendants' NSA Scheme

- First, Defendants ***commit fraud*** by making false attestations and representations of eligibility for disputes that they know are ineligible for the IDR process. (AC at ¶¶ 3-4, 54-71, 86-104, 168-205, 224-248).

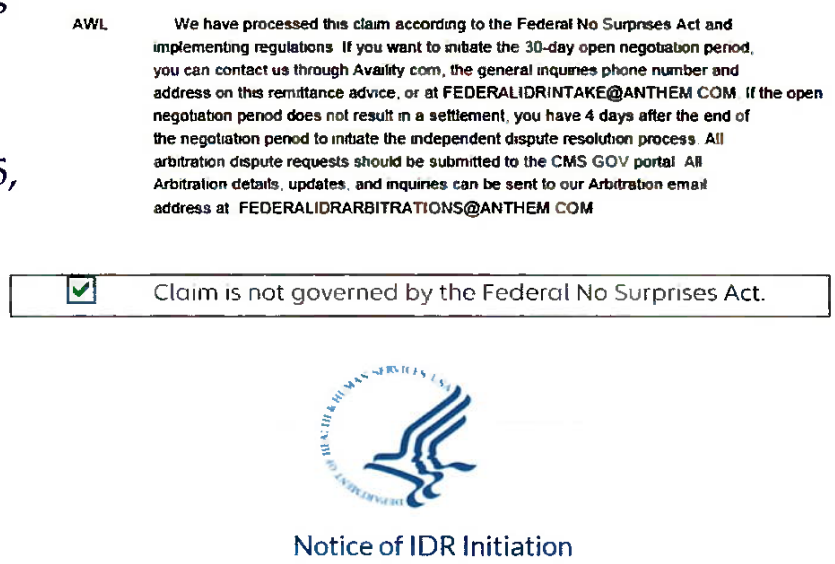
- Second, Defendants ***conceal their fraud*** by using artificial intelligence (AI) to strategically initiate massive volumes of IDR disputes simultaneously. (AC at ¶¶ 3, 105-118, 226, 232).

- Third, Defendants ***capitalize on their fraud*** by submitting – and often prevailing with – wildly inflated payment offers that often exceed their inflated, non-market based billed charges. (AC at ¶¶ 119-125, 182, 188, 200, 205, 235).



Defendants *Commit* Fraud

- The IDR process is only available for a "qualified IDR item or service," subject to strict criteria. (AC at ¶¶ 42-53).
- Providers and their agents know which services are eligible for the IDR process and which are not.
  - Explanations of payment (EOPs) (AC at ¶¶ 35, 71, 168, 231).
  - Open negotiations (AC at ¶¶ 68-69, 185, 191, 197, 203, 238, 244).
  - The IDR Portal (AC ¶¶ 54-67).



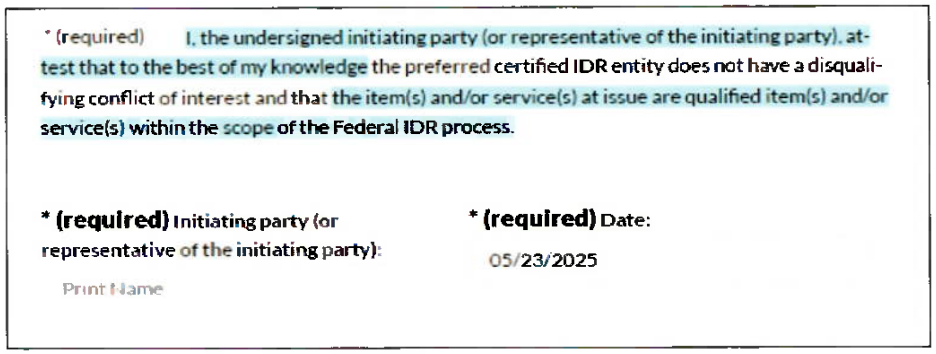
AWL We have processed this claim according to the Federal No Surprises Act and implementing regulations. If you want to initiate the 30-day open negotiation period, you can contact us through Availity.com, the general inquiries phone number and address on this remittance advice, or at FEDERALIDRINTAKE@ANTHEM.COM. If the open negotiation period does not result in a settlement, you have 4 days after the end of the negotiation period to initiate the independent dispute resolution process. All arbitration dispute requests should be submitted to the CMS GOV portal. All Arbitration details, updates, and inquiries can be sent to our Arbitration email address at FEDERALIDRARBITRATIONS@ANTHEM.COM

☑ Claim is not governed by the Federal No Surprises Act.

Notice of IDR Initiation

Defendants *Commit* Fraud – the IDR Portal

- The IDR Portal is designed to notify initiating parties of ineligible disputes. (AC at ¶¶ 54-67).
- Providers must answer "Qualifications Questions" by entering information and uploading documentation about open negotiations, the type of plan at issue, the type of services, and the QPA.
- At the end of the Qualifications Questions, providers and/or their agents affirmative attest that the dispute is over "qualified item(s) and/or service(s) within the scope of the Federal IDR process."



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

*** (required)** Initiating party (or representative of the initiating party):

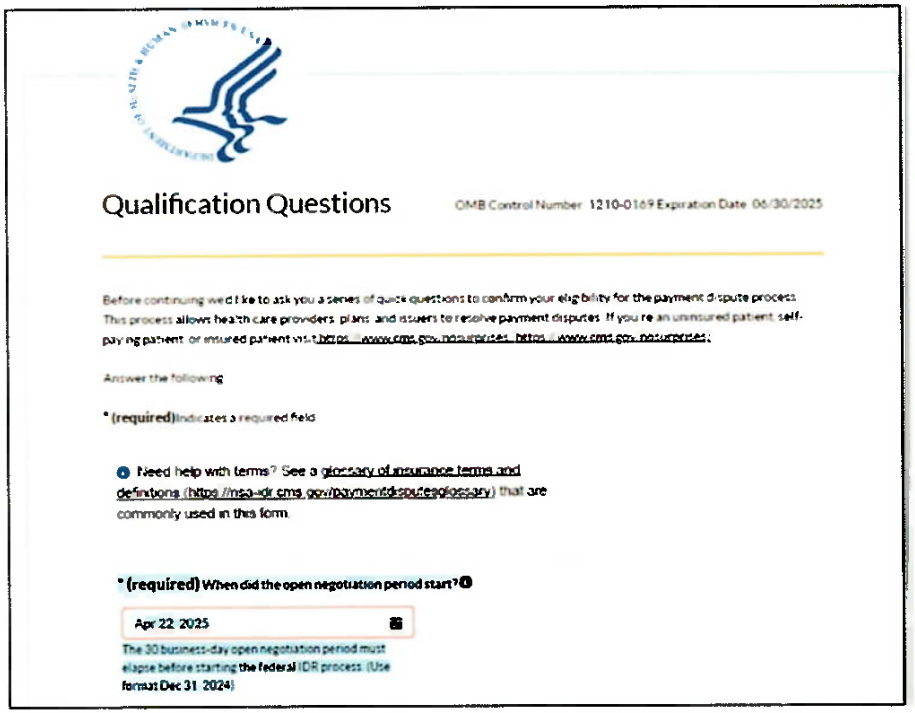
Print Name

*** (required)** Date:

05/23/2025

Defendants *Commit* Fraud – No Open Negotiations

- DISP-1455557 and DISP-1455555 (AC at ¶¶ 173-182)
- The initiating party knows whether it initiated open negotiations before initiating the IDR process.
- IDR Portal Qualifications Questions require the initiating party to identify the specific date that the open negotiation period started ***and*** upload supporting documentation.



Qualification Questions

OMB Control Number: 1210-0169 Expiration Date: 06/30/2025

Before continuing we'd like to ask you a series of quick questions to confirm your eligibility for the payment dispute process. This process allows health care providers, plans, and issuers to resolve payment disputes. If you're an uninsured patient, self-paying patient, or insured patient visit https://www.cms.gov/nosurprises. https://www.cms.gov/nosurprises.

Answer the following:

* (required) Indicates a required field

Need help with terms? See a glossary of insurance terms and definitions (https://nsa-idr.cms.gov/payment/disputes/glossary) that are commonly used in this form.

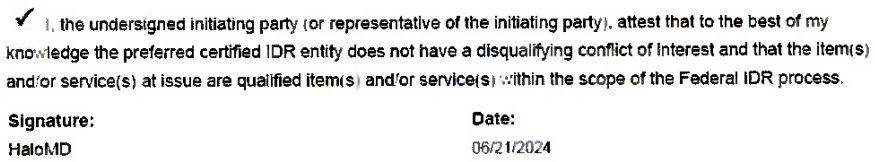
* (required) When did the open negotiation period start?

Apr 22 2025

The 30 business-day open negotiation period must elapse before starting the federal IDR process. (Use format Dec 31 2024)

Defendants *Commit* Fraud – No Open Negotiations

- HaloMD must have provided a fake open negotiations date and uploaded fictitious documentation.
- HaloMD also falsely attested that the dispute was within the scope of the Federal IDR process:



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

Signature: HaloMD

Date: 06/21/2024

- Anthem objected to both disputes as ineligible due to lack of open negotiations, but they both proceeded to a payment determination.

Defendants *Commit* Fraud – Ineligible State Law Claims

- DISP-2193991, DISP-2193967, DISP-945678, DISP-1568233, and DISP-2639953 (AC at ¶¶ 183-200, 236-248).

- Anthem's EOP informs providers when disputes are eligible for IDR:

AKD	THIS AMOUNT IS THE DIFFERENCE BETWEEN WHAT YOUR HEALTH PLAN ALLOWS FOR THIS CARE AND WHAT THE DOCTOR FACILITY CHARGED YOU AREN'T RESPONSIBLE FOR THIS AMOUNT CALIFORNIA LAW AB72 PROHIBITS DOCTORS/FACILITIES NOT IN YOUR PLAN'S NETWORK FROM CHARGING MORE THAN YOUR PLAN ALLOWS WHEN THEY ARE WORKING IN A HOSPITAL FACILITY THAT IS IN YOUR PLAN'S NETWORK.	AWL	We have processed this claim according to the Federal No Surprises Act and implementing regulations If you want to initiate the 30-day open negotiation period, you can contact us through Availity com, the general inquiries phone number and address on this remittance advice, or at FEDERALIDRINTAKE@ANTHEM.COM If the open negotiation period does not result in a settlement, you have 4 days after the end of the negotiation period to initiate the independent dispute resolution process All arbitration dispute requests should be submitted to the CMS GOV portal All Arbitration details, updates, and inquiries can be sent to our Arbitration email address at FEDERALIDRARBITRATIONS@ANTHEM COM

- If the plan has questions about plan type, it may contact Anthem:

If you have questions regarding this Remittance Advice, please contact our Custom Service Department.



Defendants *Commit* Fraud – Ineligible State Law Claims

– When the relevant defendant improperly initiated open negotiations, Anthem informed the defendant that the dispute did not qualify for IDR:

SOUND PHYSICIANS ANESTHES
PO BOX 741658
LOS ANGELES, CA 90074-1658

Request Number: REQ-COMM-3139043

Subject: Receipt Denial Letter

Dear SOUND PHYSICIANS ANESTHES,

Thank you for taking the time to contact Anthem Blue Cross . We appreciate the care you provided to our member(s).

The Independent Dispute Resolution (IDR) team with Anthem received a request for negotiation on 1/8/2025 , regarding the below referenced claim(s). Unfortunately, we are unable to process your request for negotiation due to the following marked reasons:

☑ Claim is not governed by the Federal No Surprises Act.

Defendants *Commit* Fraud – Ineligible State Law Claims

- IDR Portal contains a link identifying states with specified state laws, which govern and preclude the IDR process:

> Review the IDR State list to determine which states will have processes that apply to payment determinations for the items, services, and parties involved. FEHB plans are subject to the Federal IDR process unless OPM contracts with FEHB carriers to include terms that adopt state law as governing for this purpose.

- HaloMD falsely attested that the dispute was within the scope of the Federal IDR process:

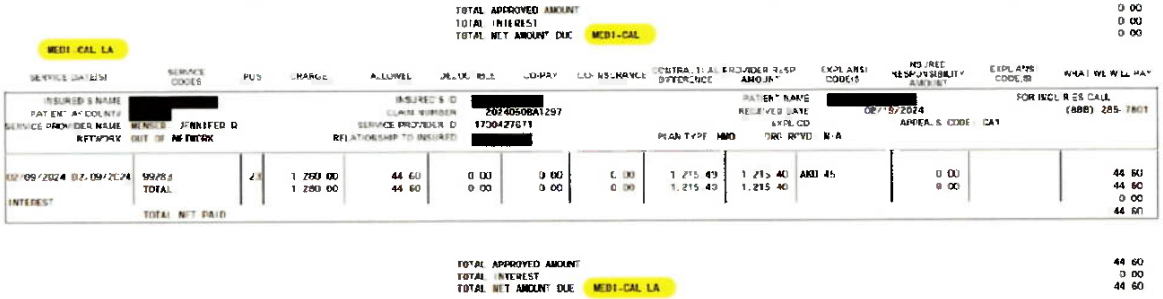
> ✓ I, the undersigned initiating party (or representative of the initiating party), attest that to the best of my knowledge the preferred certified IDR entity does not have a disqualifying conflict of interest and that the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) within the scope of the Federal IDR process.
>
> **Signature:** HaloMD
>
> **Date:** 02/25/2025

- Anthem objected to each of these disputes as ineligible, but they all proceeded to a payment determination.

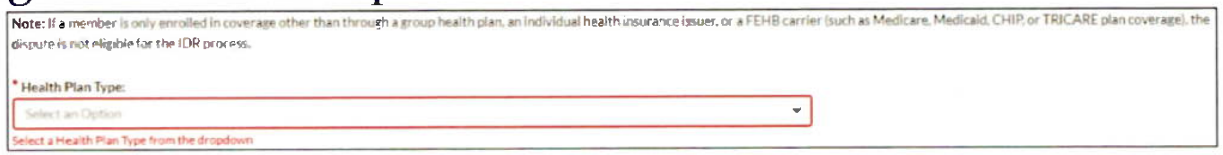


Defendants *Commit* Fraud – Ineligible Medicaid Claims

- DISP-1289721 (AC at ¶¶ 230-35)
- SPEMSC submitting a ***Medicaid*** claim through the IDR process:

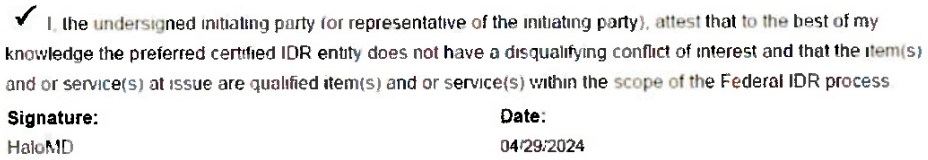


- The IDR Portal requires initiating parties to identify the health plan type and expressly states that if the member is enrolled in a Medicaid plan, the dispute is not eligible for the IDR process.



Defendants *Commit* Fraud – Ineligible Medicaid Claims

- SPEMC initiated open negotiations for this ineligible dispute, and HaloMD affirmatively attested that this dispute was eligible for the IDR process.


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

Signature: HaloMD

Date: 04/29/2024

- Anthem objected to eligibility: "Medicare/Medicaid claim ineligible for the NSA." Nevertheless, this dispute proceeded to a payment determination.


☑ Medicare/ Medicaid claim ineligible for NSA.

Defendants *Conceal* Their Fraud

- Defendants use artificial intelligence (AI) to strategically initiate a massive number of fraudulent IDR disputes all at once. (AC at ¶¶ 105-118, 226, 232).
  - On May 3, 2024, Defendants initiated ***126*** IDR proceedings against Anthem. (AC at ¶ 112).
  - DISP-1289721 (Ineligible Medicaid Claim) → Defendants emailed Anthem with a spreadsheet purporting to "negotiate" *88* individual claims and services all at once. (AC at ¶¶ 230-235).
- Defendants' goals are to overwhelm Anthem and the IDR system and push their ineligible disputes to a payment determination.



Defendants *Capitalize* on Their Fraud

- Defendants submit – and frequently prevail with – grossly inflated and commercially unreasonable payment offers on their ineligible disputes.
- Offers often far exceed the provider's "inflated," "non-market-based" billed charges.
  - DISP-2193991 (AC at ¶¶ 183-188) → Anthem paid more than double the billed charges for this ineligible dispute.
  - DISP-945678 (AC at ¶¶ 195-200) → Anthem paid nearly double the billed charges for this ineligible dispute.
  - DISP-937342 (AC at ¶¶ 201-205) → Anthem paid more than six times the billed charges for this ineligible dispute.
  - DISP-1289721 (AC at ¶¶ 230-25) → This was a Medicaid claim. Anthem paid more than SPEMSC's billed charges and more than 42 times the Medicaid rate.



Damages

- Non-refundable administrative fee → due upon provider's initiation of IDR with false representations of eligibility.
- IDRE fee → due before IDRE makes the payment determination.
- IDR award payments
- Substantial time and resources
- Downstream market distorting effects (*e.g.*, causes providers to go out-of-network, increasing the cost of care)



Why the NSA Schemes Are Successful

- Volume of disputes
- IDR is limited, informal, streamlined, and lacks procedural safeguards
- IDR is private.
- IDREs have a direct financial stake in eligibility decisions.
  - IDREs are only compensated if they issue a payment determination. 42 U.S.C. § 300gg-111(c)(5)(F).
  - IDREs are not compensated for evaluating eligibility.
  - IDREs receive ***no compensation*** if they report that a dispute is ineligible.



NSA Judicial Review Provision



NSA's Judicial Review Provision

- The standard of review counsels against Defendants' position.
- The NSA does not support Defendants' position.
- NSA regulations refutes Defendants' position.
- Congress's legislation in other contexts refutes Defendants' position.



NSA Judicial Review Provision – Standard of Review

- Strong presumption in favor of judicial review, which can only be overcome by clear and convincing indications that Congress meant to foreclose review.
  - *SAS Inst., Inc. v. Iancu*, 584 U.S. 357, 370 (2018).
  - *Guerro-Lasprilla v. Barr*, 589 U.S. 221, 229 (2020).
- If there is ambiguity, the Court must resolve the ambiguity in favor of providing for judicial review.
  - *McLaughlin Chiropractic Assocs., Inc. v. McKesson Corp.*, 606 U.S. 146, 162 (2025).
  - *Salinas v. United States R.R. Ret. Bd.*, 592 U.S. 188, 196 (2021).
- If a statute does expressly preclude judicial review, the preclusion must be read narrowly.
  - *Cuozzo Speed Techs. v. Com. for Intell. Prop.*, 579 U.S. 261, 273 (2016).
  - *El Paso Natural Gas Co. v. United States*, 632 F.3d 1272, 1276 (D.C. Cir. 2011).



The NSA Does Not Support Defendants' Position

- NSA (42 U.S.C. § 300gg-111(c)(5)(E)) states:

(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.

- The ***only*** determination an IDRE makes in Subparagraph (A) is a payment determination, in which the IDRE selects one of the parties' offers:

(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).

NSA Regulations Refute Defendants' Position

- The NSA regulations (45 C.F.R. § 149.510(c)(4)(vii)) state:

- The only decision in 45 C.F.R. § 149.510(c)(4)(ii) is the payment determination:

- Eligibility is discussed in an entirely separate portion of the regulation (45 C.F.R. § 149.510(c)(1)(v)).

(vii) ***Effects of determination*** –

(A) ***Binding.*** A determination made by a certified IDR entity under paragraph (c)(4)(ii) of this section –

(1) Is binding upon the parties, in the absence of fraud or evidence of intentional misrepresentation of material facts presented to the certified IDR entity regarding the claim; and

(2) Is not subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9, United States Code.

(ii) ***Payment determination and notification.*** Not later than 30 business days after the selection of the certified IDR entity, the certified IDR entity must –

(A) Select as the out-of-network rate for the qualified IDR item or service one of the offers submitted under paragraph (c)(4)(i) of this section, weighing only the considerations specified in paragraph (c)(4)(iii) of this section (as applied to the information provided by the parties pursuant to paragraph (c)(4)(i) of this section). The certified IDR entity must select the offer that the certified IDR entity determines best represents the value of the qualified IDR item or service as the out-of-network rate.

(B) Notify the plan or issuer and the provider or facility, as applicable, of the selection of the offer under paragraph (c)(4)(ii)(A) of this section, and provide the written decision required under (c)(4)(vi) of this section.

Congress's Legislation in Other Contexts Refutes Defendants' Position

NSA

42 U.S.C. § 300gg-111(c)(5)(E)(i)(II)

(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.

Congressional Review Act

5 U.S.C. § 805

"No determination, finding, action, or omission under this chapter shall be subject to judicial review"



Congress's Legislation in Other Contexts Refutes Defendants' Position

NSA

42 U.S.C. § 300gg-111(c)(5)(E)(i)(II)

(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.

Veterans Judicial Review Act

38 U.S.C. § 511

(a) The Secretary shall decide all questions of law and fact necessary to a decision by the Secretary under a law that affects the provision of benefits by the Secretary to veterans or the dependents or survivors of veterans. Subject to subsection (b), the decision of the Secretary as to any such question shall be final and conclusive and may not be reviewed by any other official or by any court, whether by an action in the nature of mandamus or otherwise.



The NSA's Air Ambulance Provision Does Not Support Defendants' Position

- The air ambulance provision does not apply here and is no different than the provision that applies to Defendants.
- The air ambulance statute (42 U.S.C. § 300gg-112(b)(5)(D)) states:
- The "notification" referred to in this provision (from 42 U.S.C. § 300gg-111(c)(5)(E)) is the notification to the parties of the IDRE's payment determination:

(D) Effects of determination

The provisions of section 300gg–111(c)(5)(E) of this title shall apply with respect to a determination of a certified IDR entity under subparagraph (A), the notification submitted with respect to such determination, the services with respect to such notification, and the parties to such notification in the same manner as such provisions apply with respect to a determination of a certified IDR entity under section 300gg–111(c)(5)(E) of this title, the notification submitted with respect to such determination, the items and services with respect to such notification, and the parties to such notification.

(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).

Collateral Attack/Exclusive Remedy



Collateral Attack/Exclusive Remedy

- The NSA's Judicial Review Provision does not limit the Court's review of Defendants' NSA Schemes.
- The NSA does not provide an exclusive remedy for a party when challenging an IDR payment determination.

> **(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.

- Anthem is not seeking damages that it sought and failed to procure in the underlying IDRs.



Collateral Estoppel



Collateral Estoppel

- Defendants present no evidence of eligibility "decisions"
- Defendants fail to meet the elements of collateral estoppel
  - The issues at stake in this action are not identical to the prior proceedings.
  - In IDR, Defendants' fraudulent NSA Scheme was neither litigated nor necessary.
  - Anthem did not have a full and fair opportunity to litigate Defendants' fraudulent NSA Scheme.



No Full and Fair Opportunity: Partial IDREs

- IDRE "decisions" on eligibility are not impartial and thus not preclusive.
- Judge's income cannot directly depend on how she decides matters before her.
  - IDREs are only compensated if they issue a payment determination. 42 U.S.C. § 300gg-111(c)(5)(F).
  - IDREs are not compensated for evaluating eligibility.
  - IDREs receive ***no compensation*** if they report that a dispute is ineligible.



No Full and Fair Opportunity: Insufficient Procedures

- IDR is tailored to the prompt, inexpensive determination of small claims.
- IDR does not require legal counsel.
- IDR has no evidentiary standards.
- IDR has no cross-examination or even view and rebut other party's evidence.
- IDRE payment determinations include minimal justification, and there is limited transparency into how IDREs evaluate submissions.
- IDR is riddled with errors.



Noerr-Pennington



Noerr-Pennington – Overview

- Inappropriate to apply *Noerr-Pennington* immunity at the motion to dismiss stage.
- *Noerr-Pennington* immunity does not apply to IDR, which resolves purely private commercial disputes.
- *Noerr-Pennington* does not immunize Defendants' fraudulent NSA Schemes.



Noerr-Pennington Immunity Does Not Apply to IDR

- IDRs are payment disputes that proceed before private entities (IDREs).
- The IDR process is private and closed to the public.
- Government's role in each IDR is ministerial.
- Private IDREs have the authority to issue "binding" payment determinations with no agency review.
- Seeking additional money from a health plan in a private dispute resolution process before a private entity is not petitioning activity.



Noerr Does Not immunize Defendants' Fraudulent NSA Schemes

- There is no First Amendment protection for false statements used in the adjudicatory process.
- This action centers on Defendants' false attestations and representations of eligibility.
- These misrepresentations are necessary to initiate the IDR process → no misrepresentation = no IDR.



RICO



RICO – Overview

- Litigation activities doctrine does not apply to IDR.
  - ➢ No court has exempted IDR from RICO liability, and policy reasons for doctrine do not support it.
  - ➢ Doctrine does not apply because Defendants intentionally deceived HHS and other health plans.
- Anthem pled a claim for wire fraud per Rule 9(b) with representative examples.
- Defendants' NSA Schemes proximately caused Anthem's injuries.



Litigation Activities: RICO Does Not Exempt Fraud in IDR

- Policy-based doctrine applied on case-by-case basis
- Reasoning → Courts have extensive procedures for policing fraud and producing reliable results
- IDR has none of these procedures:
  - No requirement of attorney involvement.
  - No penalty of perjury.
  - No discovery.
  - No cross-examination.
  - IDREs cannot issue sanctions.
  - IDR cannot support malicious prosecution claim.
  - Res judiciata and collateral estoppel do not apply.
  - IDR is a privateprocess; there is no public accountability of IDRE decisions
  - IDR is unreliable and has been riddled with errors.



Litigation Activities: Defendants Intentionally Deceived HHS

- Litigation Activities does not apply to schemes that:
  - Seek to deceive a third party, and not simply the tribunal; and
  - Target victims who were not parties to the underlying proceedings.
- Defendants' scheme deceives the Departments, not simply the IDREs.
- Defendants' scheme targets numerous other health plans in addition to Anthem.
- Defendants' scheme involves hundreds of fraudulent disputes, not one.



ERISA



ERISA

- Anthem is a fiduciary
- Anthem pled violations of ERISA
  - Failure to initiate open negotiations violates ERISA. 29 U.S.C. § 1185e(c)(1).
  - False attestations of eligibility violate ERISA. 29 U.S.C. § 1185e(c)(1)(B).



California Anti-SLAPP Motion



Miller v. Gammie, 335 F.3d 889, 893, 900 (9th Cir. 2003) (en banc)

"[W]here the reasoning or theory of our prior circuit authority is clearly irreconcilable with the reasoning or theory of intervening higher authority . . . district courts should consider themselves bound by the intervening higher authority and reject the prior opinion of this court as having been effectively overruled."



Berk v. Choy, 607 U.S. ___ (Jan. 20, 2026)

"If a Federal Rule answers the disputed question, it governs, unless it 'exceeds statutory authorization or Congress's rulemaking power.'"

"Here, by contrast, the state law and the Federal Rule address the same issue: the information that a plaintiff must provide about the merits of his claim at the outset of litigation."

Cannot simply "rewrite" the state law as a "workaround."



Anti-SLAPP v. Rule 12(b)(6)

CCP 425.16(b)(1)

"[S]hall be subject to a special motion to strike, unless the court determines that the plaintiff has established that there is a **probability** that the plaintiff will prevail on the claim."

Bell Atlantic Corp. v. Twombly, 550 U.S. 544 (2007)

To survive under 12(b)(6), need "only enough facts to state a claim to relief that is **plausible** on its face. . . .

Asking for plausible grounds to infer an agreement **does not impose a probability requirement** at the pleading stage."



Kibler v. Northern Inyo County Local Hospital District, 39 Cal. 4th 192 (2006)

Hospital peer review is an "official proceeding" because it:

- "[S]erves an important public interest . . . protecting the public against incompetent, impaired, or negligent physicians."
- "[S]ubject to judicial review by administrative mandate. . . a status comparable to that of quasi-judicial public agencies whose decisions likewise are reviewable by administrative mandate."



Silberg v. Anderson, 50 Cal. 3d 205 (1990)

"Quasi-judicial proceeding" -- Anti-SLAPP **purpose**:

- encouraging "open channels of communication and the presentation of evidence" in judicial proceedings
- assure utmost freedom of communication between citizens and public authorities whose responsibility is to investigate and remedy wrongdoing.
- eliminate the threat of liability for communications made during all kinds of **truth-seeking proceedings**
- the law places upon litigants the burden of exposing during trial the bias of witnesses and the falsity of evidence



Picton v. Anderson Union High Sch. Dist., 50 Cal. App. 4th 726 (1996)

The primary **factors** which determine whether an administrative body possesses a quasi-judicial power for section 47(b) "official proceeding" purposes are:

(1) whether the administrative body is vested with discretion based upon investigation and consideration of evidentiary facts,

(2) whether it is entitled to hold hearings and decide the issue by the application of rules of law to the ascertained facts, and

(3) whether its power affects the personal or property rights of private persons.



Thank you



UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
SOUTHERN DIVISION - SANTA ANA

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, ET AL, Plaintiff, vs. HALO MD, LLC, ET AL, Defendants.	CASE NO: 8:25-cv-01467-KES CIVIL Santa Ana, California Tuesday, March 10, 2026 (10:11 a.m. to 12:01 p.m.)

HEARING RE: MOTIONS TO DISMISS / MOTIONS TO STRIKE
[DKT.NOS.68,69,72,73,76-78]

BEFORE THE HONORABLE KAREN E. SCOTT,
UNITED STATES MAGISTRATE JUDGE

APPEARANCES: SEE PAGE 2

Court Reporter: Recorded; CourtSmart

Courtroom Deputy: Jazmin Dorado

Transcribed by: Exceptional Reporting Services, Inc.
20079 Stone Oak Pkwy., Ste 1105-237
San Antonio, TX 78258
361 949-2988

Proceedings recorded by electronic sound recording;
transcript produced by transcription service.

APPEARANCES:

For Plaintiff:

JASON T. MAYER, ESQ.
Crowell & Moring
300 N. LaSalle
Suite 2500
Chicago, IL 60655

JOSHUA M. ROBBINS, ESQ.
Crowell & Moring
3 Park Plaza
20th Floor
Irvine, CA 99614

For Defendants:

JONAH D. RETZINGER, ESQ.
CHRISTOPHER D. GRIGG, ESQ.
APRIL CHEN YANG, ESQ.
Nixon Peabody
One California Plaza
300 S. Grand Ave.
Suite 4100
Los Angeles, CA 90071

MATTHEW L. KNOWLES, ESQ.
McDermott Will & Schulte
200 Clarendon St.
Boston, MA 02116

ERICA BENTLEY LANG, ESQ.
McDermott Will & Schulte
2049 Century Park East
Suite 3200
Los Angeles, CA 90067

B. KURT COPPER, ESQ.
Jones Day
2727 N. Harwood St.
Suite 500
Dallas, TX 75201

DAVID M. DEVITO, ESQ.
Jones Day
555 California St.
26th Floor
San Francisco, CA 94104

Santa Ana, California; Tuesday, March 10, 2026; 10:11 a.m.

(Call to Order)

THE CLERK: Calling case #8:25-CV-1467-(KES), Anthem Blue Cross Life and Health Insurance Company, et al. versus HaloMD, LLC, et al.

Counsel, please state your appearances for the record.

MR. MAYER: Good morning, Your Honor. Jason Mayer and Josh Robbins on behalf of the Plaintiffs.

THE COURT: Good morning.

MR. RETZINGER: Good morning, Your Honor. Jonah Retzinger for Defendant, HaloMD, and Alla LaRoque and Scott LaRoque.

MR. KNOWLES: Good morning, Your Honor. Matthew Knowles with Erica Lang, who is with me as well. I represent Sound Physicians Emergency Medicine and Sound Physicians Anesthesia, the two Sound Defendants.

MR. COPPER: Good morning, Your Honor. I'm Kurt Copper, here along with my colleague, David DeVito. We're here on behalf of the MPOWER Defendants, MPOWER Practice Management, LLC, Bruin Neurophysiology, PC, iNeurology, PC, N Express, PC, and North American Neurological Associates, PC.

THE COURT: Good morning.

MR. RETZINGER: May I also just add, Your Honor, I'm here with my colleagues, Chris Grigg and April Yang, also of

Nixon Peabody.

THE COURT: All right. Very good. I'll just note that you've probably already seen that we don't have a traditional Court reporter in this Courtroom. We rely on an audio recording system to make an accurate record. So if everyone addresses the Court could make sure that they're speaking into a microphone, that will help us get a clear record. You can either speak at counsel table or speak at the podium. Either way is fine. But what's really important is that we speak into a microphone.

Let me start by noting that there are a number of different motions we're here to address, Motions to Dismiss the Complaint, Motions to Strike the Complaint as an {sic} Strategic Lawsuit Against Public Participation. As a threshold matter, I wanted to note that among the filings, I saw a Request for Judicial Notice at Docket 76.2. That is asking the Court to take judicial notice of some publications that are on a government website that talks about how the IDR process is supposed to work. It has guidance for people who might be using that process and some FAQs and that kind of thing.

Does any party object to the Court taking judicial notice of those materials as requested?

MR. MAYER: Your Honor, I think we objected to relevance. But to the extent that the Court wants to consider them for a Request for Judicial Notice, we don't have an

objection there.

THE COURT: Okay. Then let me start by just asking a few questions about how the IDE {sic} process works to make sure that I'm clear on that. There was a lot of other law in the briefs, which was really easy to research. But the actual process itself is something a little bit novel. So I'll let Plaintiff's counsel response, since we're taking his version of the facts in the complaint as true. And if counsel on the other side think that there's something inaccurate that's been said or want to weigh in, they can certainly do so.

So my understanding is that when an IDR request is initiated, that your client, Blue Cross, would get an electronic notice of that, and then they would have a certain amount of time -- I think it was 30 days -- to upload their response to that request. Is that right?

MR. MAYER: That is -- there's an open negotiations period, and then there's an IDR-initiation period. The IDR-initiation period, Your Honor, I believe that my client has four days to object and to file -- I believe it's called an IDR-Entity Form. So, yeah. I'm not sure if that answers Your Honor's question.

THE COURT: Okay.

MR. MAYER: Yeah.

THE COURT: I was meaning to distinguish those two periods, but I think I had the time duration. So it's a 30-day

discussion period. And then after, that fails, and the IDR is initiated, and you get notice of it. You've got four days to upload your response.

MR. MAYER: There's four days to object and to file, I believe, in an IDR-Entity Form, as I understand it. So there's a process for, essentially, selecting the IDRE. There's -- you know, there's -- responding parties are permitted to object to the eligibility within four days. And then, subsequent to that, the parties will submit blind payment offers to the IDRE for the selection of the payment determination, presuming that the IDRE does not report and dismiss the case due to ineligibility.

THE COURT: Okay. So that actually answers my next question, which is that the eligibility and the merits are somewhat separated in this process, in that you first object to the merits -- I'm sorry. You first object to eligibility. And then if that doesn't result in dismissal, then you go forward and submit your number for the baseball-style arbitration?

MR. MAYER: Yes, that's my understanding, Your Honor.

THE COURT: Okay. And with regard to the fees, when the process is initiated, you get assessed a $200 administrative fee?

MR. MAYER: Maybe $115, but it's a non-refundable administrative fee that is, essentially, due as soon as the case is initiated. That's correct, Your Honor.

THE COURT: And if the IDRE determines that a claim is not eligible, what happens with that administrative fee?

MR. MAYER: My understanding is that it's non-refundable.

THE COURT: So the other side doesn't pay you back? You just (indiscern.) the administrative fee?

MR. MAYER: Correct, Your Honor.

THE COURT: Is there something in the No Surprises Act that requires IDR submissions to be truthful? I'm thinking of either the language of the attestation or something kind of comparable to Rule 11 in federal court?

MR. MAYER: Your Honor, if the -- if I'm understanding your question correctly, if you're asking whether there are, for instance, penalties of perjury, I am not aware of any within the IDR process.

THE COURT: And the lawyers don't have to -- they have to attest that what they're saying is truthful. But as far as you're aware, there's not a penalty or a consequence if it's later determined that that attestation was false?

MR. MAYER: That's my understanding, Your Honor. And I do want to clarify. Attorneys are not required to be involved and typically are not involved. In fact, as we allege in the complaint, a lot of times, it's artificial intelligence that is being used to make these submissions. And it's companies often that are making the attestations. So, for

instance, you know, in a lot of the dispute examples we have in the complaint, it was actually "HaloMD" was the name of the party that was making the attestation.

THE COURT: I think I saw something in the No Surprises Act that talked about the ability of the overseeing governmental department to assess civil penalties for certain kinds of violations. Is that something that would apply if they determine that someone had submitted a false attestation?

MR. MAYER: I don't believe so, Your Honor. You know, the section that discusses the IDR process, the Government's enforcement authority is as to health plans within that section. There's a separate section that apples to providers. I believe it's Subchapter E that states that providers cannot balance bill patients, for instance. The Government does have enforcement authority over that. I do not believe that the Government has enforcement authority as against providers for Subchapter D, which is what we're talking about, which is where the IDR process is codified in the statute.

THE COURT: There were some screenshots in the complaint and some of the other documents that showed what you would encounter if you were going through the process of submitting an IDR request. And one of them asked for information about when the informal discussion period began, when it ended, and whether or not the Request for IDR was being

submitted late. And, if so, there were some buttons you could click to explain why. Does the IDRE have discretion to excuse a late filing? For example, if a provider said, "Well, I'm filing this late, and I admit it. But, you know, I sprained my ankle last week. I was in the hospital," you know, some -- the kind of excuses we get at Court, right, something that they say, you know, "There's a good cause for me to be late." Is that something that the IDRE can consider, or are they supposed to say, "No. You filed outside the window. The claim is now statutorily ineligible?"

MR. MAYER: Your Honor, we're stretching the bounds of my knowledge --

THE COURT: Okay.

MR. MAYER: -- but I'll answer it to the best that I can. So the portal requires parties to, essentially, implement a date to -- for when the open negotiation period started. If the open-negotiation period -- if the provider is -- or the agent is attempting to file too early, they cannot do that. The system does not allow for it. I believe that there is a process within the IDR portal where there is room for exceptions that the portal will accept. I apologize. I don't know exactly how they work. So -- but there are very specific exceptions that the portal, essentially, will or will not accept.

As far as what the IDREs consider, you know, as we point

out, the regulations only state that they need to look at the initiation form to determine eligibility. In terms of what discretion they have, you know, Your Honor, I don't know if that's clear from the regulations or even necessarily the technical guidance.

THE COURT: Okay. So before we move on to the substance of the motions, was there anything in that summary that the folks on the right side of the room would like to comment on?

MR. RETZINGER: Yes. Many things, Your Honor.

THE COURT: Okay.

MR. RETZINGER: So Jonah Retzinger, counsel for HaloMD. The first thing I'll say is, you know, your initial question about the Request for Judicial Notice, right? They objected based on relevancy. I think that was their position. I don't quite understand that. This whole -- this entire case is about the IDR process, nor do I understand how someone could proceed with a fraud claim, by counsel's own admission, doesn't quite understand how the process works.

So the reason that we offered the guidance documents into the record for the Court's consideration on the Motions to Dismiss is so the Court can understand how the process actually works. And so we offered -- really, it's five documents, Your Honor. There's the Notice of IDR Initiation Form that is explicitly referenced in the pleading. There are two

authoritative sets of guidance documents that are issued by CMS and the federal agencies, right, to parties that participate in the process. One of them is directed to disputing parties. The other one is directed to the arbitrators, the IDREs themselves.

The fourth guidance document that we offered was technical guidance that was issued in 2022, but it's effectively 10 pages of if/and statements that give direction to the IDREs when they're evaluating eligibility objections, how the IDREs should proceed.

And then the fifth document that we offered relates to a new process that CMS created this past summer, which related to -- it's a {sic} error resolution process or reconsideration process, pursuant to which any party, right, to a proceeding can ultimately ask to reopen the proceeding, given that the IDREs do sometimes make errors.

THE COURT: So, for example, if you received a Notice of Determination where the IDRE had picked a number that was not submitted by either party and seemed to have made some kind of error of confusion, you could activate that process and ask the IDRE to review it?

MR. RETZINGER: Yeah. Absolutely, Your Honor. So that fifth guidance document talks about the different types of errors that the IDRE can make. But that provides that if one of those errors or other errors -- it's not sort of an

exhaustive list -- become apparent to the parties, that they can go back to the IDREs and, ultimately, reopen and vacate the (inaudible), right?

THE COURT: Okay.

MR. RETZINGER: That is the process as it exists. Your Honor had a couple of questions about, I think, sort of the timing obligations. And I did want to point out I'm looking at it right now, Your Honor. But it's one of the guidance documents, but it's sort of a helpful flowchart. It's --

THE COURT: Can you just give me the Docket and page number from the blue text at the top?

MR. RETZINGER: Yeah. It's Document 76.6 -- or {dash} 6, Page 10 of 45. It is Page 62 of Exhibit-C to the Retzinger declaration --

THE COURT: Okay.

MR. RETZINGER: -- Your Honor. But the process is incredibly complex. And, actually, you know, much of -- I'm happy that Your Honor decided to start here because the deck that we have prepared that is on the screen right now really addresses, I think, some of the critical questions here about how the process works because the Court is not obligated right now just to take their word with respect to how the -- the legal authorities with respect to how the process works. Certainly, at the Motion to Dismiss stage, the Court is

obligated to take all material facts, right, that they are alleging as true. Not going to dispute that.

But to the extent that they are characterizing the process as something other than what the process actually is, the Court is not obligated at this stage to just take them at their word. And they have framed in their pleading, right, and in their opposition briefing that the IDR process is an honor system. It is not in any respect. And I'll start actually -- and you can see -- so this is, I think, Page -- and I'll submit these to the Court, Your Honor. We did not have a paper copy, unfortunately.

THE COURT: Okay.

MR. RETZINGER: But we can submit this after the hearing. But these go through the guidance documents that we have offered to the Court. What you're seeing right now is, on the left side, that is a graphic of the pleading itself, the first amended complaint, where they reference the Notice of IDR Initiation Form. On the right is that link, right, which is the first guidance document that we have offered to the Court. That is actually the document that contains the attestation that is central to this case. And you'll see -- I know it's a very, very small font, Your Honor, and I really apologize for that.

But it's an attestation. It is not a certification of eligibility. What it is is an attestation that an initiating

party, to the best of its belief, right, believes that a dispute is eligible for the IDR process. And that's a really, really important distinction because what Anthem is contending in this case is that this attestation is functionally equivalent to something like a certification that is contained in -- I don't know if Your Honor is familiar with, like, a CMS 1500 Form. So this jurisdiction, this venue, deals with the highest volumes of False Claims Act cases, right, in the entire country, right, year to year. That's often the case.

And in the False Claims Act context, right, there is a specific certification that healthcare providers make where they certify things like medical necessity of a service. This is not that. And, I think, one of the obvious examples for why this is not that is because, in this context, in the IDR-process context, the arbitrator reviews eligibility every single time. They are mandated by federal agencies to determine eligibility every single time.

So just to give the Court some context, the second slide right here, this is actually the definition of "qualified IDR item of service," right? And I think both amici that are both supporting Plaintiff in this case, as well as, frankly, Plaintiffs themselves, have framed the IDR process as something that lawyers shouldn't need to navigate, right, that this is something that was designed so that, you know, healthcare providers without representation could go through this process.

Just looking at this regulatory definition, Your Honor, I can tell you it doesn't get any easier the deeper you go into the cross references with respect to whether something is a qualified item or service or not. It actually is sort of a tremendously confusing thing. And federal agencies have acknowledged that there's an information asymmetry between people like -- between healthcare providers and commercial healthcare insurers, which is why they designed the process to do two things.

Yes, the initiating party does make that initial attestation, Your Honor. But the burden is then on the non-initiating party, in this case, the healthcare insurer, to provide information demonstrating ineligibility. That is -- by regulation, they are obligated to do that. So, in some respects, this is an attempt, right? It's sort of masquerading as a fraud action, right? But this is an attempt to otherwise shift what is otherwise their regulatory burden to provide information demonstrating ineligibility.

THE COURT: And how much time do they have to do that? I remember one of the arguments they made was, "Well, we get hit with 200 of these a day, and, you know, to research and contest eligibility is difficult."

MR. RETZINGER: Yeah. So I just I flashed it up for you right now, Your Honor.

THE COURT: Okay.

MR. RETZINGER: But this is from the guidance that's directed to the disputing parties as to when they must actually do that by, right? There is a temporal scope to it, right? There is a period. You know, and if they don't do it, you know, that can have repercussions. But federal agencies have created a process. And pursuant to that process, they have said, "If you think that a case is ineligible, you have an obligation, right, to provide that information demonstrating ineligibility to the IDRE."

Now, the next -- both this guidance document, Your Honor, and the next guidance document that we offer, right, both go through in explicit detail that the IDRE must decide eligibility in every single circumstance. And that demonstrates that this is not a certification of eligibility in any respect. If you -- the first form, Your Honor, and I'll go back to it, that actually contains the attestation, right, at the bottom, if you actually go through that form, which is Exhibit-1 in the Request for Judicial Notice, that form contemplates that a provider can check things off like "unknown" because they simply do not have the information.

So I think the first point that we would want to make, Your Honor, is that this is not the honor system that has been described. It's a very self-interested way of describing it. But it reflects what is the real agenda of this lawsuit, which is to chill the use of the process. And there are things

Anthem alleges in their pleading that commercial healthcare insurers, like Anthem, are losing 85% of the time in this process. I don't need any discovery on that. They plead as much.

But that's what this case is ultimately about. There's a paradigm shift, right, in the healthcare marketplace. Providers have more market power. And so what this lawsuit is designed to do is to chill the use of the IDR process in general to restrict people from accessing that process that Congress created to resolve this disputes. That is functionally what this lawsuit is. It's masquerading as a fraud action. But, ultimately, it's a challenge to rulemaking, and it's a prohibited administrative appeal. I know I deviated a little at the end there, and I apologize for that, Your Honor. But I do think the guidance documents are very helpful in explaining how the process works.

MR. COPPER: Your Honor, if I may briefly?

THE COURT: Okay.

MR. COPPER: I want to clarify what our objection is to the Request for Judicial Notice. We do not have an issue with the Court reviewing the guidance documents. I think what our issue is the Court taking those for the truth of the matter asserted, that that's actually how the process works in practice. These are guidance documents. I agree that if the process worked appropriately, independent of Defendant's

fraudulent scheme, as we've alleged in the amended complaint, that is how the process is supposed to work.

But that is not how it works in practice, and we look for -- you know, we have a presentation to talk about the background facts, which we'll share with Your Honor. But we do have an objection to Your Honor taking the Request for Judicial Notice as evidence of how the process works in practice. We understand that that's how the departments intended it to work and that that is the guidance that the Government has provided for parties to make it work. But as was clear from the technical assistance even, the Government was admonishing IDREs because they made grave errors.

There's been -- there's the amici briefs in support of Plaintiff's position that explain how this process is going completely off the rails from fraudulent and exploitative conduct from Defendants like those in this case. And so, Your Honor, we do object to taking those guidance documents as gospel for what actually happens in the IDR process over what Anthem's allegations are. We believe that that is inappropriate.

THE COURT: I understand. I think we had told the parties before the hearing that we were going to give everybody about two hours from 10:00 to 12:00. And I know I see a PowerPoint from one side. I hear there's a presentation on the other side. And so, you know, I'm happy with we want to start

with the moving parties. That's what we usually do and let them present what they want to present to the Court and then have some response from the party who was opposing the motions. And rather than having me, you know, go through a series of questions, I'll just ask questions as they arise in the course of the parties' presentations.

I will say it would -- you know, there are subject-matter jurisdiction challenges here, challenges that argue that the Court simply lacks the ability to adjudicate this dispute based on the limitations on judicial review that are found in the No Surprises Act. And since that's a very big threshold issue that, if the parties want to, you know, focus on that or talk about that, that's probably going to be time better spent then, you know, what is the proper test for unfair competition under the (indiscern.), etc.

So I'll let the folks on the right side of the room decide how they want to divide up their time, and they can lead us off.

MR. KNOWLES: So, Your Honor, good morning again. I represent the two Sound Defendants. And I do have some arguments to make at the appropriate point about my clients in particular, but I'm not going to make those here because I want to start with your first question about subject-matter jurisdiction, and that's an argument, I think, applies to all the parties uniformly. So let me bracket, I think, some

important things I do want to share about the allegations (indiscern.) my clients and set those aside because if there's no subject matter jurisdiction, there's no subject-matter jurisdiction, period.

And so the reason we've argued there is no subject-matter jurisdiction is the plain language of the statute, right? So it says, "An -- IDREs, the arbitrator's decision, is not subject to judicial review, unless the -- these" -- I'll call them the "four factors" under the FAA, these four ways you can get judicial review -- "unless one of those is met." That's the core reason that we would say there's no subject-matter jurisdiction because that's the law. And then those -- none of those four things is present here.

THE COURT: And if I understand your argument correctly, I know that language talks about the determination of the arbitrator under Section A, something of that nature. Your position is that that's whatever determination the arbitrator makes. Whether they find it eligible or ineligible, whether they award money or they don't award money, it's the concluding determination of the arbitrator that's being referenced there?

MR. KNOWLES: That is our position. And the Plaintiff's position is different. The Plaintiff is arguing that the eligibility decision isn't part of that. I think they would concede, as I understand it, that the decision about

which payment is selected is. So they would have to meet the FAA test. Our position is that the plain language of the law controls, that there is no -- so it's Subparagraph A of Section 111 in the hospital section. That's what it talks about what the IDREs do.

There's no Subparagraph B that talks separately about eligibility determinations, and that's removed from the jurisdiction strip. There's the IDRE's function, and it's all baked into that. And I think it's important to be clear up front. No Court has ever held that this distinction exists. So if you did -- if you ruled that there was subject-matter jurisdiction to reanalyze eligibility decisions, that would be the first ruling to say that. And one of the problems with that, in addition to what the law says, is there's really no -- there's no bound or limiting principle from there.

So we know as to the payment decision, at a minimum, you would apply this FAA test, and there's a bunch of law around that that, you know, every court confronts all the time when there's an arbitration award being challenged. I believe the Plaintiff's position, as I read it, is that as to eligibility, it's sort of unlimited de novo review of that decision with no limits. I don't believe that's right in addition to just what the plain language of the law says and the structure of it.

I think there are a few other ways you get to that. One of them is that when you read the full statute -- so there's

multiple sections -- it indicates that that jurisdiction strip applies to the notification, which is the request for arbitration, it applies to the parties, and it applies to the decision. Now, that language appears in 112, which is the section about air ambulance claims. But when you read it -- and if it's helpful to look at these, I have a copy of them I could hand up to look at them altogether. Would that -- is that useful or --

THE COURT: I -- however you --

MR. KNOWLES: Okay.

THE COURT: -- prefer.

MR. KNOWLES: This is nothing more than the statutory text.

THE COURT: You can come into the well if you need to, either way.

MR. MAYER: And, Your Honor, I'll --

THE COURT: We're not in criminal court, so I'm a little less worried about it today.

(Laughter)

MR. MAYER: Your Honor, I'll just object to relevance. I'll note that this is the -- there's portions here that are referencing the air ambulance statute, which we're happy to address.

MR. KNOWLES: That's true, and I'll explain exactly why it's relevant. This is all from the statute, not from

regulations or anything else. So --

THE COURT: Okay.

MR. KNOWLES: -- the first paragraph is prefatory. It explains what a "notification" is. The second paragraph is the jurisdiction strip in 111, which is the hospital claims that are at issue as to my clients. That's the language the Court has looked at. And then the third paragraph is the jurisdiction strip that is in the air ambulance section, 112. And so rather than just reciting the same language, what Congress said there is that the provisions of 111(c)(5)(e), the jurisdiction strip in the second paragraph, shall apply with respect to the determination of a certified IDR entity under Subparagraph A, the notification, the parties, to the same extent they apply under 111.

So, in other words, Congress is saying here, under both 111 and 112, the jurisdiction strip in 111 applies to the notification, the parties. It applies to everyone. That's a clear expression of congressional intent.

There's a fourth factor here, though, which is, even if Anthem were right on all of this, that the jurisdiction strip only applied to the payment decision, the selection of the two payment offers, there is controlling law from the Ninth Circuit that would say that they -- the same analysis would follow under the FAA. So we've cited the Sander case, which bars these sort of collateral attacks on arbitration awards by

invoking other statutes, the same way it does without a jurisdiction strip. So anyone who invokes RICO or a securities fraud claim to try and attack their loss in arbitration has to wrestle with this precedent from Sander.

What the Ninth Circuit said in the Sander case, and it's Sander vs. Weyerhaeuser, 966 F.2d at 501. I believe all the parties have cited it. The Court said -- and I'm going to quote from the Ninth Circuit's opinion. It says, "This Court has been extremely unwilling to upset the streamlined nature of arbitration by permitting the launching of collateral attacks." Anthem's point -- as I understand it, the only response on this is, "IDRE arbitration is very streamlined." The Court took that into account in Sander where it said, "You can't evoke securities fraud law" -- here, it's RICO -- "to attack an arbitration award, unless you can prevail on that FAA test."

So that's our view as to the scope of the jurisdiction strip. We all agree that if they could meet the FAA test, then there would be review. So the second question is, "Do they meet that?" Anthem relies on two of the four prongs, as I understand it. They rely on fraud, and they rely on an argument that the arbitrators exceeded their authority. So let me start with "fraud" because the word "fraud" in the context of an FAA review is used in a -- I would say a narrower and a more restrictive or more rigorous way than it is in the False Claims Act or in a fraud claim or a RICO claim.

What the Ninth Circuit says is that you have to show fraud, first, by clear and convincing evidence, second, you have to show that the fraud was not -- and I'm quoting from the Pacific & Arctic Railway case, "Not discoverable upon the exercise of due diligence prior or during the arbitration." That's where Anthem has pleaded itself out of Court because as to all of the IDREs it points to, certainly as to the four points to -- as to my clients, it has said, "We believe these claims were ineligible. We objected. We lost. The arbitrator ruled against us." That cannot be fraud, at least for the purposes of this FAA analysis.

If you know about it at the time, you raise it with the arbitrator and you lose, it is, by definition, not fraud. What the Ninth Circuit said in A.G. Edwards was, "If fraud is {quote} 'discovered and brought to the attention of the arbitrators,' a disappointed party will not be given a second bite at the apple." That's the reason there is no fraud review under the FAA here just based on the facts in the complaint.

As to exceeding authority -- so as I understand Anthem's arguments, essentially, that it's the arbitrators erred on eligibility. They said it's eligible, and it's not. Therefore, everything they did later, like, deciding between the two payment offers, they had no authority to do. The problem is that's not the test for exceeding authority, right? There's -- it's commonplace. I'd say it's, like, the millrun

of arbitration cases. The arbitrator decides arbitrability. Obviously, one side disagrees. They lose. They go to arbitration. They lose. They can't come back to Court and say, "The arbitrator made that threshold decision wrong, so everything that came later, there was -- that arbitrator had no authority to do, so we start over."

THE COURT: In that context, typically, the Court would construe, like, an arbitration contract to see if it indeed granted authority to determine arbitrability to the arbitrator. If we were making an analogy from that situation to this situation, it would be the Court looking at the No Surprises Act and the implementing regulations and seeing if they grant authority to the IDRE to determine eligibility, right?

MR. KNOWLES: I think that's exactly right. And the answer is, first, if they do, Anthem loses. It can't meet that "exceeds-authority test." And, second, it does. So in -- first, we've cited the CMS regulations that establish the Rules. They expressly require -- and this is 45-CFR-149.510(c)(1) {Roman} at (v), "The certified IDR entity must -- selected must review the information submitted in the Notice of IDR Arbitration to determine whether the federal IDR process applies. If the federal IDR process does not apply, the certified IDR entity must notify the secretary and the parties." And it's not a Loper Bright situation where we would

be concerned, "Did they have authority to do that?" because the statute itself -- and this is in 111(c)(2)(a) -- says, "The secretary shall establish, by regulation, this process." So they were expressly authorized to make those rules.

THE COURT: Is it problematic that the regulation tells the IDRE to look at the information in the Notice and not information that may have been submitted by the other party disputing what's in the Notice?

MR. KNOWLES: It certainly doesn't strip the IDRE of the ability to make -- or the right to make that decision. Obviously, I don't think there's a dispute that the opposing party has the opportunity to make its own submission. And the question whether Congress should structure that process differently is a question for Congress and maybe a question for CMS and its regulations. But as a matter of law, the IDRE has the authority to make the decision on eligibility. And therefore, whether it's right or wrong, it's not subject to judicial review under the FAA.

THE COURT: And the IDREs do, in fact, dismiss some of these based on a finding that they're not eligible?

MR. KNOWLES: They do. They do. I'm sorry. One of my co-counsel (inaudible).

MR. RETZINGER: I apologize.

MR. KNOWLES: Yeah.

MR. RETZINGER: Your question, Your Honor, about the

regulatory language, I just want to point you to -- and I can pull it up right now. But the guidance documents themselves provide that the IDRE is to review the information, not just in the Notice of IDRE Initiation Form but also all of the information that's submitted by the parties. And I don't think it's material at all that one of the requirements is in the regulation versus one of the requirements being in the guidance document, nor do I know, frankly, why Anthem would take the position that the agency itself did not have the authority to set forth in a guidance document what the obligations were on the part of the IDRE.

I don't think they would assert that type of APA challenge because, presumably, they want the IDRE, right, to be doing this. I think the, you know, less than -- I became aware of this over the weekend, Your Honor. But I think less than three months ago, the Court dealt -- in Savalia, right, with -- also with this judicial review prohibition in the NSA. And Anthem was on our side, right, of the table, where a provider at sought to compel Anthem, right, to ultimately pay the IDR award.

And I think the Court looked at it in the right way, consistent with how every other Court has looked at the judicial review prohibition around the country. But it -- I just -- I don't see the argument as to why the guidance document alone -- like, why the requirements set forth in the

guidance document otherwise is material at all.

MR. KNOWLES: So I think I should stop here, Your Honor, because this is the reason that we -- essentially, we think the Court should reach this conclusion and stop for a lack of subject-matter jurisdiction and give our colleagues a chance to respond because our position is, if there's no review under this FAA prong, there's no vacatur because they failed. They don't succeed on any of those four parts, right? They don't go any further, and they can't use collateral attacks per Sander to get around the FAA and plead using, whether it's RICO, ERISA, state law claims, what have you. That's the end of the review. So I think I should stop there and give the other side a chance to respond, unless you have any more questions on this issue.

THE COURT: No. I think that sounds like a good plan.

MR. KNOWLES: Thank you.

MR. MAYER: Your Honor, if I may, we prepared a presentation that discussed the facts of this case. I have never litigated a Motion to Dismiss where I've had so many disputes over the facts and requests to dismiss the case to, basically, ignore the facts that are pled in the pleading. And so, Your Honor, I'm happy to address the -- our position on the judicial review provision. But also, you know, we did prepare a presentation about what this case is actually about. And I

don't know if Your Honor wants us to provide that now, if Your Honor is not interested in it. But I think it's certainly relevant to Your Honor's consideration of the motions.

THE COURT: I'm happy to hear what counsel thinks is important for me to hear. My only concern is that we try and divide time fairly. So I don't know how long you're talking about spending on the facts. But you can try and keep your remarks to about the same time the other side used, maybe we can kind of keep some parody here in terms of time. That's my only concern.

MR. MAYER: Okay. Our factual presentation was going to be about 15 minutes. So --

(Pause in proceedings)

THE COURT: If you want to maybe try and breeze through that in 10 minutes and maybe spend --

MR. MAYER: Sure.

THE COURT: -- spend some, you know, 10 minutes then on jurisdiction?

MR. MAYER: Sure.

THE COURT: Okay.

MR. MAYER: Yeah. That works, Your Honor. Thank you. Okay.

(Pause in proceedings)

MR. MAYER: Your Honor, Anthem filed this action to seek damages and declaratory and injunctive relief due to the

Defendants' NSA scheme. Next slide. Their NSA scheme involves three components. First, the Defendants commit fraud by making false attestations and representations of eligibility that they know are ineligible for the IDRE process. These --

THE COURT: And the reason that you think they know that is because, A, you've told them, and, B, you think, in some of these instances, like, where the California law applies, the Knox-Cortese Act -- I think I'm saying that right -- or Knox-Keene Act, that that should be so clear that it's really not something that reasonable people could dispute?

MR. MAYER: Could we go to the next slide real quick? This is how the Defendants know, Your Honor.

THE COURT: Okay.

MR. MAYER: The IDR process is only available for a qualified IDR item or service. Your Honor, there's been a lot of rhetoric about that there's going to -- this is going to somehow chill the access to the IDR process. The Government expected that parties would seldomly use IDR. And only as a matter of last resort, it imposed very strict procedural requirements, specific deadlines, and limits on the types of plans and services that are eligible for IDR. The Government estimated that there would only be 22,000 disputes nationally. There's more than a hundred times those.

Here's how Defendants know that services are eligible or ineligible for IDR. They know from the explanations of

payment. And, Your Honor, we have up there disclosure that is required by regulation to be included when an item or service is eligible for IDR. It notifies the party of the 30-day open negotiation period. It provides an e-mail address for the party to reach out to initiate open negotiations. And, Your Honor, if there are questions about whether or not a plan is eligible, the provider can certainly reach out. This is the key language to informing the providers whether or not a dispute is eligible.

If this language is noted in the explanation of payment, it's eligible. The plan and the service is eligible. If this language is not there, the item or service is not eligible. It's very simple.

THE COURT: Well, I mean, if you're on the other side, though, and you get one of these explanations of payments and you think that the insurance network or health plan just made a mistake. They have to -- you know, they have to do thousands and thousands of these, and somehow, they made a mistake, do they have some opportunity? You were saying that they should reach out to you in the 30-day -- even though you didn't give them this notice?

MR. MAYER: Yes.

THE COURT: Okay.

MR. MAYER: Yes. And the regulations, I believe, also require the plans to, essentially, invite the outreach if

there are questions about how the claim was processed. But this is the key to notifying parties whether or not an item or service is eligible. If this is in the EOP for the service, then it's eligible. That type of plan, that type of service, is eligible. If it's not, it is not eligible. Or, again, as Your Honor pointed out, the provider can follow up if they have questions.

The second reason that Defendants know about whether or not a dispute is eligible is during the open negotiations period. Parties will initiate open negotiations. And when a party -- when a provider or an agent incorrectly sends an open-negotiation notice to Anthem seeking to negotiate an ineligible service, Anthem will typically respond by notifying the provider that the service isn't eligible for IDR. That happened in every single dispute example from our complaint.

THE COURT: Every single one?

MR. MAYER: Yes.

THE COURT: Okay.

MR. MAYER: Except for -- I apologize, except for one, because our client did not have a record of open negotiations for that originally because the provider submitted 88 -- they sought to {quote} {unquote} "negotiate" 88 items and services all at once. That is -- I believe that's the only one. That was a Medicaid claim. So -- and that's part of the second part of the scheme, which we'll talk about in a moment,

which is how they conceal their fraud.

The third reason that Defendants know --

THE COURT: And just before we go on, I'm looking at the screen, and I see the little green check in the box saying the claim is not governed by the federal No Surprises Act. Is that the only information that's given? If you've made a determination that it's a Medicare claim or that it's governed by the Knox-Keene Act, do you tell them that?

MR. MAYER: In most instances, yes. They will -- there are different boxes that are to be checked where, if there's a Medicare or Medicaid claim, there's a box for that. There's a box for -- and this also applies to their objections, too. There's a box that they didn't negotiate the 30-day open negotiation period. There's a box that it's subject to specified state law. You know, sometimes, there's a response like this that's a little bit more generic. But there are boxes that are specific to each circumstance as well.

THE COURT: Okay.

MR. MAYER: And then the third reason that Defendants know that the services, whether or not they're eligible, is through the IDR portal. Next slide. The IDR portal is designed to notify initiating parties of ineligible disputes, and we allege all of this in the complaint. Providers and their agents have to answer qualifications questions. And at the end of the qualifications questions, the providers and/or

their agents submit and affirmative attestation that the dispute is over qualified items and/or services within the scope of the IDR process.

Now, there's been a lot of talk about what this attestation means. There's a reason why the Government put in these qualifications questions and required parties who are initiating disputes to affirmatively attest to eligibility. They need to do their due diligence. With this affirmative attestation requirement, providers and their agents have the duty and the responsibility to confirm eligibility before initiating the IDR process. This is the check that the departments put in place to control what has become an overwhelming amount of volume of disputes. Again, they only estimated that there would be one percent of the amount of disputes that were actually filed here.

And the Defendants here, when they knowingly initiate the IDR process for ineligible items and services, they commit fraud. And they know from Anthem's explanations of payment their responses to the ineligible open negotiation notices and the IDR portal when disputes are eligible and when they are not.

THE COURT: And it's fraud on your client or fraud on the IDRE or both?

MR. MAYER: I would argue it's fraud on the Government. I would argue on the IDREs. You know, again, the

Government acts in a ministerial capacity here. They are not actually exercising discretion. They have set up this system to, essentially, police whether or not disputes are going to go through to the IDR process. And by lying to the system, they are defrauding -- we would argue that they're defrauding the Government and the Government's system, the system that the Government set up.

THE COURT: I --

MR. MAYER: So --

THE COURT: -- I can understand the portal, through which you input information, is not exercising discretion. It's a computer program, and it's acting in the manner in which it was programmed to act. But once a person receives the information that is entered into the portal, is it your position that they don't exercise discretion either?

MR. MAYER: Well, Your Honor, our position is that the IDREs -- that that's part of the problem with the system. So -- and I'm happy to sort of jump to that, I guess, real briefly. Let's go to next slide, next slide, next slide, sorry, next slide, next slide, next slide.

So, Your Honor, we go through the different ineligible claims here. I want to note, for the open negotiations, the Defendants would've had to put in a fake date and upload fictitious documentation to bypass the qualifications questions and initiate IDR. Again, that's fraud.

THE COURT: And let me ask about that. Supposing that there was never any open negotiation, the provider would know that because --

MR. MAYER: Yes.

THE COURT: -- they'd be a party to the open negotiation. And when you say that they have to upload false documentation, what is the documentation that is requested? Is it, like, some sort of e-mail exchange where you say, "Look, this is when I e-mailed them and initiated the discussion period for 30 days" but, in fact, no such e-mail was ever sent?

MR. MAYER: Yes. And you could -- I believe -- my understanding is you can upload any documentation. So you can upload a blank Word document and proceed. But you have to upload something.

THE COURT: Okay.

MR. MAYER: This is an ineligible Medicaid claim. There is no realm in which anybody would think that a Medicaid claim is eligible for IDR. It says "Medi-Cal," which is California's Medicaid claim in three different places on the face of the explanation of payment that we highlight. This, obviously, did not have the disclosure that stated that the item or service is eligible for IDR because it's a Medicaid claim. It's not eligible. Let's go to the next slide. Let's go to Slide 15 because this goes to Your Honor's question.

And, Your Honor, this really gets to why their fraudulent

schemes are so successful. The first reason is volume, and that is a key component of their scheme. They submit an avalanche of disputes, strategically all at once, to overwhelm the system. They're overwhelming Anthem, and they're overwhelming the IDR system and the IDREs that are tasked with making these eligibility nominally and payment determinations.

The second reason is that IDR is a limited, informal, highly streamlined process that lacks procedural safeguards to detect and prevent fraud. Congress designed IDR to resolve relatively low-value disputes based on the submission of blind offers. IDR has no discovery, no evidentiary requirements, no hearings, no testimony. There's nothing submitted under penalty of perjury, and no procedures to view, much less rebut, the other side's evidence. So when the parties are submitting evidence of eligibility, they don't get to see -- I -- my understanding is they don't get to see what the other side submits.

THE COURT: Let me just ask. You know, I'm familiar with private arbitration firms. And if the parties engaged JAMS or Judicate West and they had a terrible experience with an arbitrator, right, they could potentially complain to the company that hires them. If the person is a lawyer, they could potentially complain to the state bar, and they could complain to professional colleagues that they might network with at the Bar Association. And I suspect that that arbitrator would then

have difficulty getting new work.

In this setting, is there some mechanism by which someone could complain to someone who oversees the IDREs or the Government agencies involved that are supposed to be exercising oversight here if -- you know, and, again, you may not be able to compel them to do anything. But is there some mechanism for raising complaints if you really think that an IDRE is not engaging with the facts and making reasonable determinations?

MR. MAYER: If -- parties may submit a petition to decertify an individual IDRE, yes. There's a mechanism for that. But the problem, Your Honor, is that this is largely a system-wide problem. And --

THE COURT: But you couldn't write a letter to the Medicaid services offices, for example, and say, "We had a terrible experience with IDR Smith. We're urging you to investigate, and don't assign any more cases to him or her?"

MR. MAYER: I -- if you're asking whether or not a party can do that, I'm sure that they can, yes. There's a process for submitting complaints.

THE COURT: Okay.

MR. MAYER: Yes. But the issue here is that it's the nature of the process but also the fact that IDREs have a direct financial stake in the eligibility decisions. They are not paid unless they issue a payment determination. And I want to be clear about something. This is not like a judge who is

paid on a salary or an arbitrator who gets paid for the actual work that they do. Even an arbitrator, if there's an objection to the arbitration, the arbitrator is going to get paid for every minute that the arbitrator spends evaluating whether or not that arbitration is eligible up to the point of dismissal.

IDREs do not get paid for doing these eligibility decisions. They don't get paid anything. They only get paid if they proceed to a payment determination. So the only way that a dispute is going to be dismissed is if the IDRE spends uncompensated time to dig in and really understand whether or not the dispute is eligible and makes the decision to forgo any compensation for its work whatsoever. It gets paid nothing.

THE COURT: Well, I understand opposing counsel to be saying, "That's true, but that's how Congress designed the system. And if someone's going to change it, it needs to be Congress." How would you respond to that?

MR. MAYER: That is not how Congress designed the system respectfully, Your Honor.

THE COURT: Okay.

MR. MAYER: Congress did not state in any statute that IDREs should be reviewing eligibility decisions. They didn't decide that. That wasn't a decision by Congress. So, respectfully, there's nothing that suggests that Congress intended for this sort of perverse incentive to, you know, infect eligibility decisions. It was the departments that did

that, the same departments who set up the IDR portal as sort of -- as we explained, the honor system to -- and the gate-keeping function to determining whether or not eligible disputes would move forward. Congress did not decide this.

THE COURT: So when you used the term "honor system," what you mean by that is that Congress expected that people would, for the most part, provide accurate and truthful information about eligibility in the portal?

MR. MAYER: I think that's what the departments expected, yes.

THE COURT: Okay.

MR. MAYER: Right. Yeah. So -- but just Congress did not design this -- a system where IDREs were making eligibility determinations and were not going to be compensated for them whatsoever. There's nothing in the statute that says that or supports it. I want to turn, I think, now -- and I apologize for bearing the lead -- to the judicial review provision. So can we go to the next two slides?

So, Your Honor, there's several reasons why the judicial review provision does not apply here. And I was actually the one who argued the Savalia case before Your Honor. That was Blue Shield. That involved an effort to seek judicial review of a payment determination, as Your Honor may recall. This is not that case. This is about a fraudulent scheme to exploit the IDR process through the submission of ineligible disputes.

The standard of review counsels against the Defendants' position, as we'll go talk about in a minute. The NSA itself does not support the Defendants' position. The NSA's regulations actually refute the Defendants' position, and Congress' legislation in other contexts, which I know Your Honor referenced in the Savalia case, refutes Defendants' position here as well. Next slide.

Your Honor, just a few notes that I think are really critical about the standard of review here. There is -- and this is from the Supreme Court. There is a strong presumption in favor of judicial review, which can only be overcome by clear and convincing indications that Congress meant to foreclose judicial review. If there is ambiguity, the Court must resolve the ambiguity in favor of providing for judicial review. And even where a statute expressly precludes judicial review, the preclusion must be read narrowly. Next slide.

So this is what the NSA states, Your Honor. It states, "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." The Defendants conspicuously omitted that under Subparagraph A in their briefing. I believe the MPOWERHealth Defendants did.

If you look at Subparagraph A, which we also have on the screen, it states, "The only determination that is contemplated

in Subparagraph A is the payment determination in which the IDRE selects one of the parties' offers as the payment determination. Thus, the NSA limits judicial review of the IDRE selection of one of the two offers as the payment determination, except in one of the circumstances provided in the FAA."

And, Your Honor, there's a lot of talk about the different cases that have come up in the context of trying to enforce payment determinations or vacate payment determinations. All of those cases pertain to the IDRE's actual payment determination, not an issue that dealt with fraudulent -- the fraudulent submission of ineligible disputes, which does not go to the payment determination. Next slide.

The NSA regulations also refute the Defendants' position. Now, the NSA regulations are what delegate eligibility to decisions to the IDREs. And if you look at the regulations, they specifically follow the statute and cabin the prohibition on judicial review to the payment determination. It states, "A determination made by a certified IDR entity under Paragraph(c)(4)(2)." And then we have (c)(4)(2) below it, which mirrors the language in the statute about selecting one of the offers as the payment determination. Eligibility is discussed in an entirely different provision of the regulations. It's in (c)(1)(5). Next slide.

And, Your Honor, Congress' legislation and other conducts

-- in other contexts also refutes the Defendants' position. So we have a comparison here on the left is the No Surprises Act. There's a limit of judicial review for a determination of a certified IDR entity under Subparagraph A. And then some of the cases that the Sound Defendants cited cited to this statute on the right, the Congressional Review Act, which says, "No determination, finding, action, or omission under this chapter shall be subject to judicial review." Congress could've used that language. It did not. It specifically cabined the limit on judicial review to payment determinations. Next slide.

And we provided another comparison here as well. You know, there was an argument by the Defendants that there's some implicit intention by Congress to also include things that happened prior to the payment determination. That's completely unsupported, but we think that this comparison provides an apt example as well. The Veterans' Judicial Review Act, this states, "The Secretary shall decide all questions of law and fact necessary to a decision by the Secretary under a law that affects the provision of benefits by the Secretary to veterans or dependents or survivors of veterans.

Subject to Subsection B, the decision of the Secretary as to any such question shall be final and conclusive and may not be reviewed by any other official or by any court, whether by an action or the nature of mandamus, or otherwise." This is the language that Congress uses when it tends to preclude any

decision by the Secretary or an IDR entity. It is noticeably absent here. And the standards of review counsel that the Court must review the judicial review provision narrowly. And so it doesn't apply to this scheme because this scheme is not about payment determinations.

THE COURT: If the IDRE came back and said, "The payment due is zero," would the parties have some understanding about whether that was an eligibility determination or a determination about the reasonable value of the services provided? How would you know in that situation what kind of a determination that was if the availability of judicial review turns on it being an eligibility determination versus a payment determination?

MR. MAYER: Sure. I think Your Honor is talking about the Avraham case.

THE COURT: I was just imagining a hypothetical.

MR. MAYER: Okay. Well, there was a case that discussed that.

THE COURT: Okay.

MR. MAYER: That's the Avraham case out in New York. And that was an instance where the provider specifically sought vacatur of the payment determination of $0. So I think that if there's a question that the IDRE -- I mean, I'm not sure who would bring that kind of an action, frankly, Your Honor. The provider may dispute the actual payment determination itself,

which is what happened in the Avraham case. I'm not sure that the plan would bring a dispute, and I'm not sure that the provider would argue that the dispute is ineligible because the provider brought that dispute in the first instance. But certainly, if a party is seeking to vacate that payment determination of $0, then I think that that would implicate the judicial review provision, yes.

And so I know that we pled "vacatur" in the alternative. That was in the event that the Court decides to read the judicial review provision very broadly, which, again, we don't believe is supported by the standards of review or the statute itself. But we don't actually believe that this case implicates the vacatur provision in the No Surprises Act.

Just briefly on collateral attack, "collateral attack" is a doctrine that prevents parties from circumventing exclusive remedies for challenging a judgment or an arbitrability award. So it happens with courts. You cannot collaterally attack a final and binding judgment. You have to appeal it. It happens as was in the cases from -- cited by the Defendants with FAA arbitrations. You cannot collaterally attack a final and binding arbitration award subject to the FAA. You have to use the FAA's procedures.

This case does not implicate -- it doesn't limit judicial review of their fraudulent scheme. And so this doctrine does not apply. It is also known as an "exclusive-remedy

provision." If there is an exclusive remedy for challenging something, then it applies. And that is clear from the cases that were set forth. The Sander case that the Sound -- Mr. Knowles cited, that contained the language -- that was about an FAA arbitrage that said the three-month limitation is meaningless if a party to the arbitration proceedings may bring an independent direct action asserting such claims outside of the statutory period. So it was about not bringing a claim for -- that was a collateral attack on an FAA arbitration award that was subject to the FAA's procedures.

This case does not implicate the judicial review provision. There's nothing limiting judicial review, so it cannot be a collateral attack. But as we also explained, the NSA does not provide procedures for even challenging individual payment determinations. And that was set forth in the Med-Trans Corp. case. So for the reasons -- for those reasons and the reasons we discussed in the brief, we don't believe that that doctrine applies here.

THE COURT: If the Court did find that it applied and was looking to see if these claims, nevertheless, were qualified for vacatur, you've heard the argument that the fraud has to be, you know, discovered and brought up to the arbitrator in order to qualify under that provision. Do you disagree that that's the test, or do you agree that that's the test and argue that you meet it?

MR. MAYER: Are you -- Your Honor, are you talking specifically about 10(a)(4)?

THE COURT: Yes.

MR. MAYER: Well, the --

THE COURT: Well, I guess 10(a)(1) or (4).

MR. MAYER: Sure. I'll start with 10(a)(4), I guess. The test -- and this is in the EHM Products, Inc., case. And, again, I do want to make clear, we don't think that this is applicable to this case. But it is whether an entity is purporting to exercise powers that parties did not intend them to possess. Congress only intended by statute that IDREs would issue payment determinations for qualified IDR items or services. That's clear in Subsection 5(a). Now, the departments have also sort of foisted on this eligibility determination. But Congress was clear in the statute that IDREs do not have the authority to issue payment determinations for non-qualified IDR items or services.

And, Your Honor, there's not even a close question about whether any of the dispute examples in the complaint are qualified IDR items or services. We're talking about Medicaid claims. We're talking about claims that are clearly subject to specified state laws. We're talking about claims where there's no actual proof of open negotiations. It never happened. So there's not even an arguable -- I don't think that the Defendants could even argue that taking those facts as true

that an IDRE had the authority to issue a payment determination in those situations.

So if you look at -- so if Your Honor were to look at what Congress stated and what Congress limited, we think that it's clear that they did exceed their authority by issuing payment determinations on those.

THE COURT: Okay.

MR. MAYER: And the other point I would say in terms of 10(a)(1), and we explained this in our brief, 10(a)(1) can apply where there's, essentially, no indication that the arbitrator -- or, here, the IDRE -- meaningfully considered the evidence and the objection. There is no way that an IDRE would've meaningfully considered Anthem's evidence and found that these dispute examples are qualified and can -- and that there can be a payment determination issued on that. And so, for that reason, we also believe that it's subject to -- it could be subject to vacatur under Section 10(a)(1).

THE COURT: Okay. All right, thank you.

MR. MAYER: Thank you.

MR. RETZINGER: Your Honor, a couple of preliminary comments. I'm going to quote Your Honor in Savalia when you said, "Courts should avoid writing something into a statute which Congress so plainly left out. Congress says in a statute what it means and means in a statute what it says there." That was from the Savalia decision three months ago.

The judicial review prohibition in the NSA is very, very clear. There is no bifurcation of eligibility versus payment determinations. No court around the country has ever said that that is okay. It is an unreasonable reading of the statute. It would undermine the entire NSA statutory and regulatory framework. It's not supported by the textual language. It is -- it's -- I don't know how to frame it other than it is somewhat nonsensical.

THE COURT: Well, how would you respond? I hear the other side arguing, "Look, you got to interpret limitations on judicial review narrowly." And, here, they could've just said, "No determination by the IDRE is subject to review." And, instead, they said, "No determination by the IDRE under Subparagraph A." And is there some meaning that I should subscribe to the -- under Subparagraph A that's just different from any determination?

MR. RETZINGER: I think it's -- I think you framed it in Savalia. It's plain language, Your Honor.

THE COURT: Okay.

MR. RETZINGER: Right? That's what it is. And we -- I can pull up -- we have a slide, right, that actually has the language of it.

THE COURT: I think it's on the screen right now, even if that's not your slide.

MR. RETZINGER: I can't see it. The font is very

tiny.

(Laughter)

THE COURT: It's a little small. All right.

MR. RETZINGER: But it's very plain language. There's nothing in the NSA regulations that bifurcate -- right, that -- and say that judicial review is ultimately okay. The other practical reality of something like that is the judiciary would be absolutely overwhelmed. You have amici. You have Anthem who have talked all about volume here and how volume is, apparently, a problem.

What they are effectively advocating is that the judiciary now has -- statutorily is able to review an eligibility determination in which the IDR makes in every single IDR proceeding, right? So I think I'll -- just on the eligibility front, I just think it's not supported by the language of the statute to begin with.

But I think Your Honor made a very, very good point a couple moments ago when you asked about -- we had taken the position in our papers that this is not Capitol Hill, right? And much of what counsel just argued was his dissatisfaction. It is indisputable that, I think, Anthem is unhappy, right, with both the legislation and the rulemaking, right, that have implemented the IDR process. But your points about legislation applies equally to regulation. The guidance documents and the regulations themselves impose that eligibility determination

upon the IDRE.

And Anthem -- if Anthem thinks that otherwise has created some substantive legal standard that is otherwise incompatible with the No Surprises Act, there are many channels and avenues that Anthem can pursue to try to make that claim via the Administrative Procedure Act or otherwise. This is not -- this is a RICO action, Your Honor. This is a fraud action. And so simply because they dislike the process or that they otherwise think that federal agencies aren't doing a good job does not mean that they can plausibly assert a fraud claim.

MR. KNOWLES: I think -- Your Honor, I agree with -- excuse me. I agree with all that. And I would only note, too, that in the spirit of taking the allegations in the complaint as true, to the extent they're factual, and we have to look at what Anthem actually says. I mean, the first page of Anthem's brief and opposition to our Motion to Dismiss, in the first paragraph, it says {quote} that -- I'm sorry. Before I quote, they say that Anthem {quote} "'seeks to hold Defendants liable' {close quote} for among other things {quote} 'requesting payment at rates vastly beyond what the market provides'" {close quote}. That's Docket 93, the first paragraph of the first page.

So, clearly, payment is part of it. And I think what we have to understand is that you can't tease these things apart. They're two sides of the same coin. You can't tease the

analysis, or put differently, you couldn't get to do the analysis that we would have to do if we went to discovery and summary judgment and trial here without looking at both things. What is it they request in damages? It's the damages from the awards that they disagree with, the payments they say that we asked for too much, the IDRE erred in agreeing that our offer was more reasonable. It doesn't work to bifurcate them.

And then I think the second point I emphasize is, if we did bifurcate them, what's the standard? Is it -- would it be unlimited judicial de novo review of every -- of thousands or hundreds of thousands or maybe even millions of IDREs? That cannot possibly be consistent with Congress' scheme and its plain words -- plain language.

I would -- if this is a right point, I have about five minutes of, you know -- specific to my two clients that I think are important because we're being accused of fraud here. My colleague on the other side notes they pleaded a complaint. We have to accept the factual allegations as true. We certainly do. Here are the factual allegations as to the two Sound Defendants. So one is Sound Physicians, does physician services in hospitals. Sound Anesthesia does anesthesia services. The first thing the complaint says is that we are big. So we have over 4,000 providers. We're about 6% of all acute medical hospitalizations. That's Paragraph 25 of the amended complaint.

Anthem is also very large. Paragraph 30 notes that they processed tens of millions of healthcare claims annually. So Sound submits thousands and thousands of claims, thousands of IDRs. Why does that matter here? Well, the reason it matters here is that what's pleaded in the complaint as to Sound Anesthesia is one IDR that they say is ineligible, one. As to Sound Physicians, it's three. The Sound Anesthesia one is under the -- they say it should've been under the California statute. Obviously, I don't, in any way, concede that we made a mistake, but we have to accept the factual allegation here as true that it should -- that it was a state law claim.

Under Twombly and Iqbal, the Plaintiffs have to plead facts that rule out a plausible legal explanation for the conduct. If you have thousands and thousands of claims, thousands of IDRs, and one example where they -- where it was ineligible and it went through, that is entirely consistent with a mistake. And I'm not conceding there was a mistake, but that's entirely consistent with a mistake. They haven't pleaded facts that give rise to fraud.

I think the other thing that's important to emphasize is what's not pleaded. So my clients, as alleged in the complaint at Paragraph 8 and 88, we used HaloMD to process these IDR claims for a period of time. There's no allegation here that our relationship with HaloMD was anything more than arm's-length commercial contractual -- in other words, as to sound,

no allegations about shared directors or shared websites or overlap and then no allegations about a connection between sound and the other two Defendants or the other Defendants.

This all, of course, ties to 9(b), Your Honor, and we've raised a 9(b) argument. The Ninth Circuit has held that in certain instances of very complex fraud schemes, 9(b) is relaxed when the facts are in the exclusive possession of the Defendant. So the common example is a qui tam relator who just doesn't have access to all the claims and says, you know, "Here's what I know. These are enough facts to show fraud. That's why it survived the Motion to Dismiss. But I can't list every claim for you because I just don't know. They know." This is the opposite of that case.

I think it is fair to say that Anthem knows better than anyone what kind of health insurance plan each of their members have. And in this back and forth of large batched claims and thousands of claims flowing back and forth, they know. There's no reason they couldn't. I also can't tell you which IDRs are in dispute here because I don't know. They haven't listed them. They of course know that it started as thousands, it became hundreds in the amended complaint. They know what they are, I don't. They pointed to one. That does not comply with a 9(b). There is no basis under Ninth Circuit law to relax 9(b) in that way in these circumstances.

THE COURT: So the vision would be if they amended

the complaint that they should attach like a spreadsheet that lists all of the IDR numbers that they contend fall into what they're calling the scheme.

MR. KNOWLES: So if we got there, if the Court had jurisdiction --

THE COURT: Right.

MR. KNOWLES: -- which, you know, again --

THE COURT: Right.

MR. KNOWLES: -- we would disagree with, but they also would fail under 9(b). They would have to plead facts that are consistent. If you assume the facts to be true, only consistent with fraud. And they'd have to identify the claims and they have to satisfy 9(b) as to why each of them is fraud. The last point from me, Your Honor, is on this open negotiation issue. So there were allegations in the initial complaint, the first complaint, Docket #1, that my client committed fraud because it requested IDR without completing open negotiations. We sent a Rule 11 letter to the other side, said here's the emails. They properly amended their complaint to correct, because those allegations were wrong. But I think it highlights the broader point here that this is a big, complex system with a lot of claims flowing back and forth. There are mistakes along the way; that doesn't make them fraud. That doesn't give -- that doesn't mean that RICO is the right remedy to correct them. There are no open negotiations allegations

against my clients. So I'll stop there, Your Honor.

THE COURT: All right.

MR. RETZINGER: Could I just say two more comments --

THE COURT: Sure.

MR. RETZINGER: -- Your Honor?

THE COURT: Sure.

MR. RETZINGER: The first is when the Court held recently that there was no express or implied private right of action, right, in the No Surprises Act, it referenced the existing enforcement regime, right, for the agencies. What the agencies -- essentially penalty positions that they can do. And I think you had asked counsel, right, that question, to the extent that a initiating party does something wrong, right, can CMS otherwise take some sort of enforcement action against them. We certainly would say that they could. But independent of that, you also just had counsel argue that fraud, right, that this is fraud upon the Government. There are many, many authorities, right, that the Government could otherwise leverage to the extent that it believes that it has been defrauded in any way. So I don't know how, you know, Plaintiff could take the position that otherwise there isn't an existing enforcement regime or mechanism that the agency could rely upon.

And then just very quickly, Your Honor, on the 9(b) argument, there is certain case law and precedent in the Ninth

Circuit that provides that in the context of a fraud claim, sometimes representative pleading is okay. But that's in the context, usually, of when a Plaintiff is not in possession of the information, right, and the specific information that needs to be pleaded with particularity is exclusively in the possession of the Defendant. This type of argument comes up all the time in the False Claims Act context, right. Here we have the opposite circumstance. Presumably the only party that actually knows why it -- why Anthem is contending that a particular claim is ineligible is Anthem. So I don't think representative pleadings should be -- to the extent that any claim survives, and I don't -- certainly don't think that any claim should, but certainly they would have the obligation to plead each, you know, one of the alleged IDR proceedings that they sought to vacate, right, with particularity.

One -- just one more point. In the Avraham decision that Counsel referenced on Anthem's side shortly ago, there were 108 proceedings that were at issue in that case, and Counsel took the position on the behalf Blue Cross Blue Shield Association that those 108 claims should be severed into separate actions, right. Whereas --

MR. MAYER: That was not the position that we took.

MR. RETZINGER: That's the position that they took. I've read the briefs.

MR. MAYER: I know what the position we took.

THE COURT: Okay.

MR. RETZINGER: But so I think it's somewhat disingenuous, right, to claim in this other action that 108 claims should be severed, yet there is an indeterminable number of IDR proceedings here that are at issue. There's no parameters surrounding it, but they think that they can proceed, right, with respect to vacatur for those unspecified actions.

THE COURT: So we've got about a half hour left so I'm going to give you --

MR. MAYER: Okay.

THE COURT: -- 15 minutes, and since you're the moving parties, you can have the last word with the last 15 minutes.

MR. MAYER: Your Honor, briefly, we're not asking this Court to review eligibility on any claim. We're asking the Court -- our position is that the NSA's judicial review provision does not limit Anthem's action which is seeking to hold Defendants liable for a fraudulent scheme that's actionable under RICO. This is not going to open up the flood gates to a party petitioning the Court and saying hey, this particular example is wrong. We are just stating that the NSA's judicial review provision does not limit this action or the relief that is being sought. Anthem is seeking a declaration, it's seeking an injunction, and it's seeking

damages for the harm. There is no reason for the Court to have to actually revisit any of the IDRE's selection of any of the payment offers.

THE COURT: Well, the injunction provision, if I remember right, asked the Court to enjoin them from submitting ineligible claims to the IDRE process. And so if I sort of play that out, if I entered that injunction and then you thought they had submitted an ineligible claim, right, you would come back to me and say, Your Honor, they violated your injunction; this claim is really not eligible, and then I would have to decide eligibility, right?

MR. MAYER: Well, I guess in that hypothetical scenario that -- to enforce the Court's order, yes. But again, there is nothing about the NSA's judicial review provision that limits that. And certainly the Court can fashion whatever order it believes would be appropriate to end this fraudulent scheme.

There were questions -- I want -- there has been a conflation in the briefing about relaxed pleadings standards. That pertains to pleading the who, what, when, where, why, and that is when the information is not in the parties' possession. We pled a 371-paragraph complaint. I'm not sure if the Defendants are asking us to plead every single dispute example and show every single one that's fraud. I don't believe that that is necessary under the pleading rules. They also want a

list, that certainly that they can request in discovery. And this actually came up in the context of the ERISA arguments. They -- you know, they stated that we needed to identify the specific health plans. You know, the Courts that have dealt with those questions have stated that, you know, the party can just produce the relevant documents in the normal course of discovery. That's the UnitedHealthCare Services vs. Team Health case from the Eastern District of Tennessee that we cite. It's also the Nutrishare, Inc. vs. Connecticut General Life Insurance Company case out of the Eastern District of California. We have met -- our position is that we have met the requirements under Rule 9(b) to plead a fraudulent scheme with specific representative examples. That is all that Rule 9(b) requires. And these questions about, well, we need a spreadsheet, or we need to have more dispute examples, if Your Honor believes that, that's fine, but we don't believe that it's necessary under the Federal Rules of Civil Procedure.

THE COURT: Yeah, I did understand their arguments as making a distinction between identifying the particular IDRE determinations that are alleged to be the product of fraud versus -- you know, we recognized it on your side, if you see that someone using a particular username or email address entered data into the portal, you don't know the person behind that, and that's fine, you wouldn't know that.

MR. MAYER: Your Honor, I sort of want to -- you

know, I want to use my time wisely. I'm curious about what questions you have.

THE COURT: Let me ask, you mentioned the ERISA claim, and there was an argument in the other side's brief that said, look, the portions of ERISA under which you're trying to get equitable relief are just portions of ERISA that were added by the No Surprises Act, and so the same jurisdiction-stripping statutes -- you know, the same provisions within the No Surprises Act should apply to some claim for equitable relief under ERISA, that's one argument that I'd be interested in hearing your response to.

MR. MAYER: Sure.

THE COURT: The other was, you argue that you're a fiduciary under ERISA because of certain self-funded plans, but then there was no allegation that those self-funded plans were among the plans that lost money as a result of the fraud scheme that is alleged here, and so the other side is saying there's a link missing in your allegations of causation.

MR. MAYER: Sure, both great questions. So first, as we've explained, the judicial review provision does not apply to this action. And §1132(a)(3) broadly authorizes any action to address conduct that violates any provision of the subchapter, and we identified them in our brief. There are no exceptions to that authorization. And so there is no rational basis, from Anthem's position, for -- to suggest that Congress

intended to limit actionable ERISA claims, especially for prospective injunctive relief that is not available in IDR proceedings. I'll also note, Your Honor, that the judicial review provision -- again, it's about decisions under subparagraph (a). That's the IDRE's payment determination. That's retrospective, so that's looking at what happened in the past. (a)(3) is about prospective relief, and so there's nothing that limits a party in -- from Congress' legislation, from seeking prospective relief. Even if the Court were to determine that the judicial review provision somehow applied to this entire action with respect to retrospective relief that Anthem is seeking.

As to the plans, I'll just quote paragraph 30. We plead Anthem {quote} "is authorized to undertake efforts to safeguard and protect itself, its members and insureds, and the various employer group health plans it administers, from fraud, waste and abuse, like the fraud Defendants are perpetuating here." I think this is a very nit-picky reading of this argument, but Your Honor, if Your Honor believes that it seems ambiguous, and after construing all of the allegations in Anthem's favor that we either need to identify the specific plans or state that those specific plans were the ones that delegated the authority that's discussed in the complaint, we can certainly do that on a re-pleading. So again, we think that the inferences -- we believe the inferences make that clear, but we can allege that

more specifically as well, if Your Honor would like.

THE COURT: With regard to the claims for -- at the very end of the complaint there's just a claim for declaratory relief, injunctive relief, I think it's kind of a free-standing claim --

MR. MAYER: Sure.

THE COURT: -- is that something that is alleged under Federal law or State law?

MR. MAYER: Federal law.

THE COURT: Okay. I can look at my notes and see if I have any other --

MR. MAYER: Sure.

THE COURT: -- questions.

MR. MAYER: I do have one more point that I do want to raise for Your Honor --

THE COURT: Okay.

MR. MAYER: -- about the Litigation Activities Doctrine, and maybe one brief point on Noerr-Pennington and RICO. But I do want to answer Your Honor's questions first.

THE COURT: Well, I think that's fair. If the Court does get to RICO, there's been arguments that the type of wire fraud and mail fraud alleged here can't be predicate acts because they are really petitioning activity, and so if you -- or either that or they fall into the sham litigation exception. So if you want to address either of those, that would be fine.

MR. MAYER: Sure, so that's Noerr-Pennington, I believe, Your Honor. Defendants are not engaged in First Amendment petitioning activity when they commit -- when they engage in a fraudulent scheme to flood the IDR process with knowingly ineligible disputes. We explained first that it's inappropriate to make these factual decisions at the motion to dismiss stage, and we believe that we've adequately pled and argued that this is a purely private process. And Noerr-Pennington immunity does not apply to IDR proceedings, which are purely private commercial disputes. They do not apply to disputes before private organizations. That's what IDR is. IDRs are payment disputes that proceed before private entities. The entire process is closed -- private and closed to the public. The public cannot view or scrutinize the evidence or representations of the parties. The public cannot view or scrutinize the decision making of the IDREs. There is no publicly available opinions or precedent. We explain that the Government's role is ministerial. Again, it's -- they don't actually engage in any decision making. All of the decision making for these disputes is made by the IDREs. So there's no indication of Government action or Government discretion that is implicated as part of the IDR process disputes. Private IDREs have the authority to issue binding payment determinations with no agency review or Government input. IDR does not have any of the characteristics of Government action.

It's an entirely private process.

There's a -- there were questions about the sham exception which deals with misrepresentations, which is what we raised for Your Honor. I think the argument was that these misrepresentations do not deprive the proceedings of their legitimacy. This fraud goes to jurisdiction. It is essentially a fraud that is committed to bypass the gate-keeping that the Government has set up to police and ensure that disputes that go through are eligible disputes. And this scheme pushes patently ineligible disputes to payment determinations where the IDRE clearly has no jurisdiction under the statute. There's -- there were questions about reliance. We believe that the case law shows that the Government does rely on these false attestations, even though they're not acting by way of the system that they say that's set off. There is an indirect reliance. The IDREs are also relying on the Defendants' false attestations of eligibility, and we believe that that's clear from the complaint. By regulation, they can solely rely on the IDR initiation form. They're not compensated for evaluating eligibility. And the IDREs in these dispute examples had to have relied on the fraud from the Defendants. Otherwise how would these determinations, these disputes had gone to a payment determination in spite of Anthem's objection? Of course they were relying on the Defendants' fraud. So we think that it's very clear that that

question should not be decided on a motion to dismiss. IDR is a purely private process that does not implicate petitioning activity, and their misrepresentations also render Noerr-Pennington inapplicable.

And just briefly on litigation activities, this is a policy-based doctrine. The Courts are very clear that they apply it on a case-by-case basis, based on the policies of the cases. Koziol made that very clear when it declined to apply the doctrine because {quote} "the policy concerns asserted in these cases" -- which had applied the doctrine -- "are not implicated. The policy reasons behind the Litigation Activities Doctrine is that Courts have time-tested procedures to produce reliable results, separating validity from invalidity, honesty from dishonesty." That's the Pendergraft case from the Eleventh Circuit. Courts -- there's attorney representation, there's rules of procedure, there's rules of evidence, there's penalty of perjury, there's the right to cross-examine. There's public proceedings, there's written and reasoned opinions, there's a right to appeal, there's malicious prosecution claims, there's the right to issue sanctions, and there's res judicata and collateral estoppel which, as we explained, do not apply.

IDR has none of these time-tested procedures. There's no requirement of attorney involvement. IDR is often initiated anonymously, including through AI. Attestations of eligibility

are not subject to penalties of perjury. IDR does not provide any opportunity for discovery or cross-examination. IDREs are not mutual parties when it comes to eligibility decisions. IDREs cannot issue sanctions. IDR cannot serve as a basis for malicious prosecution. Res judicata, collateral estoppel do not apply. And IDR is unreliable and it's been riddled with errors, and the Government has said that in the technical assistance as well. And so all of the reasons for Courts adopting that exception on a case-by-case basis with respect to civil litigation, none of those policy reasons are implicated in this case.

THE COURT: All right, thank you, Counsel.

MR. COPPER: Thank you, Your Honor. Just a few comments in response, particularly on the Noerr-Pennington Doctrine. And again, I'm Kurt Copper on behalf of the MPOWER Defendants. Earlier when asked who is defrauded under Anthem's theory of the case, Counsel answered, the Government, among other things. And yet now, when discussing Noerr-Pennington, it becomes we're going to characterize this process as purely a private process that doesn't involve the Government. That's -- there's a clear tension there in their position, and the reason is because this is not a purely private matter, when the only reason that Anthem is coming into arbitration is because the Government set up the arbitration process. The process was established via the No Surprises Act and is -- this is, in

fact, core petitioning activity to the Government when healthcare providers are pursuing their rights under the statute to try to seek recourse for what they believe to be under-payments. If Anthem is unhappy with that, they have a -- have multiple remedies that have been discussed thus far. Counsel tried -- argued that this is not suitable for adjudication at the motion to dismiss stage on the pleadings. We would cite the Court to -- or direct the Court to the B&G Foods case that we cited in the briefing, or the Ninth Circuit addressed Noerr-Pennington arguments on a motion to dismiss and granted a motion to dismiss.

I also would just point the Court more broadly to the statement and the recent decision from the Central District of California in the Ford vs. Knight case, where there was an attempt to try to hold the Defendants liable for supposed misstatements in petitions that were submitted, and --

THE COURT: The Lemon Law cases that we all know and love.

MR. COPPER: Indeed, indeed, Your Honor, yes. And there the Court recognized that one of the -- that the ultimate purpose of the Noerr-Pennington Doctrine is to {quote} "over protect potentially baseless petitions" {unquote}. And so the doctrine itself is there to try to protect against chilling of petitioning activity. These are, in fact, core litigation activities. The opposition from Anthem concedes that Courts

don't generally allow litigation activities to serve as a basis for predicate acts under RICO. Obviously this has been briefed heavily and I don't want to belabor the points, but happy to address any particular questions that the Court might have.

THE COURT: I appreciate those comments. I don't think I have any further questions specifically about Noerr-Pennington.

MR. COPPER: Okay, thank you.

MR. KNOWLES: And Your Honor, I'm going to address very briefly the injunction and declaratory relief point, and I -- in response to the floodgate concern, I heard a concession from the other side that I think may well substantially resolve or maybe completely resolve the issue. My colleague on the other side said that his client is not asking the Court to review eligibility in any IDR. They're just -- and I'm not quoting, you know, said something -- we won't address the fraud. We don't want to -- we are not asking the Court to review eligibility in any IDR. That's the end of the story here, because without showing that an IDR got something wrong on one of these, there's no claim here. There's no dispute, there's no violation, there's no standing, there's no harm other than the fact that they went to IDR. That would be an essential component of every part of the relief they seek, including the injunctive relief. So they would ask for injunction under -- sounds like it's a Federal injunction claim

under one of the statutes they have invoked. The problem is, there's got to be -- you can't just go to the Court and say hey, we have this other entity, we do a lot of business, we want you to enter a follow-the-law injunction so that they have to follow the law, and if they don't follow the law we'll come and we'll say it's contempt. There has to be an injunction that springs from a violation. In other words, they can't get to the injunction without showing that there has been all of the things they alleged to be true in the complaint. You don't get to go there. So if they're not going to review the outcome of eligibility or damages, they never get there.

The second problem with the injunction theory is there's just no support for it, Your Honor. They point you to a case from the Fifth Circuit, Gulf Petro Training, it's 512 F.3d 742. That case is squarely against them. It says that you cannot use this injunction approach to avoid all of the bars and obstacles we've talked about today, unless the injunction issue is "analytically different" -- that's a quote from the case -- from the things that were fought about. Here it would be in the IDR or in the arbitration. That's exactly the case. The reason they are asking the Court for an injunction is they are saying that the -- we -- that my clients asked the IDREs and they did something in arbitration that was wrong, and they're saying you have to do it differently in the future. The Court cannot -- there's no way to get there without doing exactly the

re-examination that is prohibited under those provisions. Thank you.

MR. RETZINGER: Am I the last one, Your Honor?

THE COURT: I think so. I might have one more question that I'll give both sides to talk about, and that question would be there was a discussion in the briefing that if the Court does find that these jurisdiction stripping statutes apply and that the Court doesn't have jurisdiction over the Federal claims, that the Court could exercise its discretion then to not exercise supplemental jurisdiction over the State law claims at which point the anti-SLAPP motions, which are only directed at the State law claims, would not need to be decided by the Court, and it seemed that the parties were agreeing that the Court had discretion to go either way on that, and so if the parties want to -- maybe after you've completed, the parties want to end by giving me your best pitch on why I should exercise discretion to either consider or not consider those motions if I find that there's otherwise a lack of jurisdiction.

MR. RETZINGER: Thank you, Your Honor. And I can just say very briefly in response to the question you just asked, our position is you do have discretion, but ultimately the anti-SLAPP law in California is designed to prevent litigation just like this. But with that said, the only other thing I would like to raise for the Court is -- because I think

it's indicative of what this case really is all about, and I really do appreciate the Court holding a hearing on this. We cited the number of other cases that Anthem's affiliates have brought around the country in other Districts, you know, that are going to be decided on the papers, but we appreciate the opportunity to actually be heard. But there -- we've talked about, I think, from our side at least, some of the things that we think are very egregious about the pleading. And counsel talked about, you know, the Rule 11 letter that was sent, you know, with respect to the first complaint that was filed, and the factual misrepresentations that were in that first complaint. You know, to the extent there is one thing in this case, Your Honor, that I think is particularly egregious, I represent not just HaloMD, but I represent Alla LaRoque and I represent Scott LaRoque, two individuals. The allegations in the pleading with respect to those individuals are they're married, they live in Texas, they founded and directed their companies. That's it. And upon just those allegations, you had Crowell & Moring and you had Anthem ultimately elect to name them as Defendants in a RICO lawsuit, right, RICO ultimately passed in the 1970s to dismantle organized crime syndicates. I think this is the exact -- we just talked about the anti-SLAPP and when that's applicable and what's that designed to prevent. I think this is exactly -- with respect to the LaRoques in their individual capacities, this is exactly

the type of circumstance. This is why Rule 8 and Rule 9(b) exist, right. Because you should not just be able to plead a RICO action or plead a claim sounding in fraud against an individual just because you feel like it will get you leverage, which is all that this is. There is no individualized particularized allegations against the individuals. They were lumped in with all of the other Defendants just because -- you know, I can only speculate why, Your Honor, right. But to the extent there's something egregious, I think it's that. Thank you.

THE COURT: Do you want to address the discretionary point? I'll let you do that and I'll let them conclude since it's their motions.

MR. MAYER: Sure. And Your Honor, just on the LaRoques, I'll point Your Honor to the Reves vs. Ernst & Young case, 507 U.S. 170 (1993). Defendant may be liable in a RICO enterprise if it had "some part" {quote} in directing the enterprise's affairs. Defendants who participate in the operation or management of the enterprise itself. And that case also says even lower rung participants in the enterprise may be liable if they played {quote} "some part" {end quote} in operating or management -- managing the affairs of the enterprise. We clearly pled that. And I'm happy to go through the allegations about Mr. and Ms. LaRoque, but Your Honor can review them in the pleading.

Do you want to take the -- yeah.

MR. ROBBINS: Okay. Your Honor, as to the -- I think the last question that you've raised, are you more interested in hearing about the question of whether to exercise discretion to hear the -- or to address the State law claims, or whether or not the State law -- the anti-SLAPP is appropriate and the State law claims can survive in light of that, because --

THE COURT: I think it was just -- there was a point that was raised that said if the Court finds that none of the Federal claims go forward, you know, in, for example, a civil rights case, if none of the §1983 claims survive, the Court is probably going to decline to exercise jurisdiction over, you know, an assault and battery State law claim that might be a tenet to that. So here, you know, that would, by analogy, be -- if the Court decides it simply isn't going to exercise supplemental jurisdiction over the State law claims, the other side has argued, well, I should nevertheless consider the anti-SLAPP motions and award them attorneys' fees because, as they contend, that would fulfill the purposes of the anti-SLAPP litigation. And I understand your side is saying that that would not be an appropriate exercise of discretion. And so the factors that cause you to feel that way, this is a chance for you to tell me those.

MR. ROBBINS: Yes, Your Honor. And to be candid, I think we had planned to address the substance of the anti-SLAPP

motions as opposed to that. I think the briefing does address some of the case law that says that in that -- in the scenario you're describing where the Federal claims are out and all that's left is State -- are State law claims, that it is not proper or not a good idea to exercise discretion to address the arguments about those State claims, if there is nothing left and if -- of jurisdiction with respect to those claims, just for purposes of hearing a motion to strike. So that -- I'd refer you back to the brief -- what we submitted on that in the briefing. I'm happy to address the substance of the motion to strike, but I'm conscious that I have five minutes and you may not want to hear that.

THE COURT: I'll -- you can use five minutes however you think best.

MR. ROBBINS: I'll use my five minutes, Your Honor -- well, I supposed 2.5 minutes, to be fair. Can we go to 41?

MR. MAYER: Yeah.

MR. ROBBINS: I'm just going to -- we're just going to focus on one point.

THE COURT: Okay.

MR. ROBBINS: I think that's all we have time for. Which is that this was actually at the end -- addressed at the end of our opposition at the end of their reply, and this is the point that anti-SLAPP -- after the Supreme's Court decision in January in Berk vs. Choy, anti-SLAPP can no longer be

addressed in Federal Court. I'm going to -- we cite the Miller vs. Gammie case, which is the Ninth Circuit case that says if there is an intervening decision of the Supreme Court that is clearly irreconcilable in its reasoning with existing Ninth Circuit precedent, then the District Court, this Court, has to follow the Supreme Court's reasoning and not that of the Ninth Circuit. The Ninth Circuit precedent really goes back to the Newsham case which is where they said that they were allowing anti-SLAPP motions to be brought in Federal Court. Go on to the next slide. So in Berk vs. Choy, as -- I assume you've read the case that it's -- it was a State -- it was a Delaware State law that said when you plead a malpractice case, you have to attach an affidavit in support -- I believe it's an affidavit from a doctor -- in support of that, and that's part of what's required or else the pleading doesn't survive. And what the Supreme Court said in January was -- well, the general rule is if there is a Federal Rule of Civil Procedure that answers the disputed question, then that governs, unless it exceeds statutory authorization or Congress' rule-making power, and there is no claim in this case, I think, that Rule 12 or Rule 8 exceed Congress' power or statutory authorization. What the Supreme Court said in that case, the disputed question was what information -- what the Plaintiff had to provide with their claim, with their complaint, in order to survive a pleading challenge, and that that issue was controlled directly

by Rules 8 and Rule 12. And in light of that, there was nothing left for -- there was no room for the State law to address that same issue, so it was displaced. The argument that the -- I guess the Defendants had made in that case was that you could simply just rewrite the statute, just take away the parts of the Delaware law that were not consistent with Rules 8 and 12 and save the statute that way, and the Supreme Court in Berk said no, that doesn't work, the statute is just displaced. We can go to the next slide. So in this case, if we go to the anti-SLAPP statute, subsection (b)(1), step 2 of anti-SLAPP that I know the Court is quite familiar with, the test that it uses is it puts the burden on the Plaintiff to show a probability of prevailing. Well, in the Twombly case that we all know about 12(b)(6), it expressly said there is no probability requirement; it's a plausibility requirement. So it specifically said that when you're deciding a pleading challenge on the face of the pleading, you don't look at -- you don't consider whether it's probable that the Plaintiff will prevail, it's just plausibility. So that's -- that is what's directly on point. That answers the question that we're addressing -- that is being addressed here, which is whether or not the anti -- the pleading is sufficient to survive the anti-SLAPP motion. The Ninth Circuit has, in the past, before Berk, has addressed that in the Planned Parenthood case by saying, well, we'll just use the 12(b)(6) standard instead of the anti-

SLAPP standard when it's an anti-SLAPP case in Federal Court, and that's how we'll reconcile them. But what Berk made clear is you can't do that. You can't just say, well, we'll have a modified version of the State law, in this case the anti-SLAPP law, and use that when it's in Federal Court, and then in State Court it will use the regular version. No, if you have a Rule of Federal Procedure -- sorry, Federal Rule of Civil Procedure that answers the question directly, which is what do you need to plead to survive a pleading challenge, then that's what applies, period. And so that is not reconcilable with the prior Ninth Circuit case law under Planned Parenthood and in other cases. And so in light of Berk vs. Choy, and Miller vs. Gammie, the Court really needs to follow the Supreme Court's directive from January on that point. So we think that's a really important threshold issue on the entire anti-SLAPP. I'd love to talk about more, but I don't think that would be allowed at this point.

THE COURT: All right, thank you. Is there anything further from the right side of the room?

MR. KNOWLES: I should just -- there's just a subtle issue, so let me just say -- put our point on the record clearly on this. So if the Court dismisses the Federal claims for want of jurisdiction, the Court has discretion as to whether to hear the State claims under supplemental jurisdiction. We agree with that, the Sound Defendants agree

with that. If the Court proceeds to consider the State law claims, we believe the Court is actually required to do the anti-SLAPP analysis if it does.

Could I impose on you, could you put your slide 42 back up, please? So it's the last part of this is -- if you reach anti-SLAPP, Your Honor, it's the last paragraph here is what we disagree with. This case, Berk, does not hold that Courts cannot rewrite the statute as a work-around. They say if you rewrite the statute as a work-around, you still have to comply with the Federal Rules. We agree with that. Our entire anti-SLAPP motion is premised on Rule 12(b)(6), the same analysis. So if you reach it, that would be the frame to apply. But that's it, and we thank you, Your Honor, for all your time.

THE COURT: All right, well, thank you, Counsel. I will say I read through the briefing and these were excellent briefs. The Court really appreciates that, and if it was counsel here or counsel back in the office who was working on that brief writing, if you can share that with them, it's very helpful to the Court who's trying to understand the law, understand the facts, apply the law to the facts correctly to get briefs where they're well organized and they are concise and easy-to-follow, and so I do appreciate the time that was spent on that briefing. The Court will take the matter under submission and will issue a written ruling.

ALL: Thank you, Your Honor.

THE CLERK: This Court is now adjourned.

(Proceeding adjourned at 12:01 p.m.)

CERTIFICATION

I certify that the foregoing is a correct transcript from the electronic sound recording of the proceedings in the above-entitled matter.



Signed **March 15, 2026**

Dated

TONI HUDSON, TRANSCRIBER

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES—GENERAL

Case No. 8:25-cv-01467-KES Date: February 9, 2026

Title: ANTHEM BLUE CROSS LIFE & HEALTH INS. CO., et al. v. HALOMD, LLC, et al.

PRESENT:

THE HONORABLE KAREN E. SCOTT, U.S. MAGISTRATE JUDGE

Jazmin Dorado	Not Present
Courtroom Clerk	Court Reporter
ATTORNEYS PRESENT FOR PLAINTIFFS: None Present	ATTORNEYS PRESENT FOR DEFENDANTS: None Present

PROCEEDINGS (IN CHAMBERS): **Order GRANTING Applications to File Amicus Brief (Dkt. 99, 101)**

Defendants have filed seven motions to dismiss or strike Plaintiffs' pleadings on various grounds. (Dkt. 68, 69, 72, 73, 76, 77, 78.) Plaintiffs filed consolidated oppositions to the motions on January 30, 2026. (Dkt. 92, 93.) These motions are set for hearing on March 10, 2026. Under the Central District of California Local Rules, replies in support of the motions are due by February 24, 2026. See L.R. 7-10.

On February 6, 2026, America's Health Insurance Plans, Inc., American Benefits Council, the ERISA Industry Committee, and the Business Group on Health applied for leave to file two amicus briefs in support of Plaintiffs' oppositions to Defendants' motions. (Dkt. 99, 101.)

"[I]t is solely within the discretion of the Court to determine the fact, extent, and manner of participation by the amicus." Cobell v. Norton, 246 F. Supp. 2d 59, 62 (D.D.C. 2003). "District courts frequently welcome amicus briefs from non-parties concerning legal issues that have potential ramifications beyond the parties directly involved or if the amicus has 'unique information or perspective that can help the court beyond the help that the lawyers for the parties are able to provide.'" NGV Gaming, Ltd. v. Upstream Point Molate, LLC, 355 F. Supp. 2d 1061, 1067 (N.D. Cal. 2005) (quoting Cobell v. Norton, 246 F.Supp.2d 59, 62 (D.D.C. 2003)). "[A]n amicus curiae is not a party and has no control over the litigation and no right to institute any proceedings in it, nor can it file any pleadings or motions in the case." NGV Gaming, 355

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES – GENERAL

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F.Supp.2d at 1068 (rejecting amicus's attempt to file "oppositions" to a party's briefs or refer to the amicus's "pleadings").

The Court finds that the proposed amicus briefs may be helpful and of interest to the Court in the instant litigation. If any party wishes to respond to the arguments or issues raised in the brief, they may do so in their normal briefing on the pending motions to dismiss or at the hearing on March 10.

IT IS THEREFORE ORDERED that the applications (Dkt. 99, 101) are **granted**. The Court will consider the briefs attached to the applications. (Dkt. 99, 101.)

Initials of Deputy Clerk jd

EXHIBIT A

HYLAND HUNT (*pro hac vice* pending)
DEUTSCH HUNT PLLC
300 New Jersey Ave. NW, Suite 300
Washington, DC 20001
Telephone: (202) 868-6915
Facsimile: (202) 609-8410
Email: hhunt@deuschhunt.com

ELI A. ALCARAZ (Cal. Bar No. 288594)
SPERTUS, JOSEPHS & MINNICK, LLP
617 W. 7th Street, Suite 200
Los Angeles, CA 90017
Telephone: (213) 205-6520
Facsimile: (213) 205-6521
Email: ealcaraz@spertuslaw.com

Attorneys for America's Health Insurance Plans, Inc.

IN THE UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

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

Plaintiffs,

v.

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

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

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

Judge: Hon. Karen E. Scott

PHYSICIANS ANESTHESIOLOGY OF CALIFORNIA, P.C.,

Defendants.

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INTEREST OF AMICUS CURIAE[1]

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

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

INTRODUCTION AND SUMMARY OF ARGUMENT

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

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

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

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

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

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

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

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

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

ARGUMENT

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

The Act establishes a dispute resolution process that encourages prompt,

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

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

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

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

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

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

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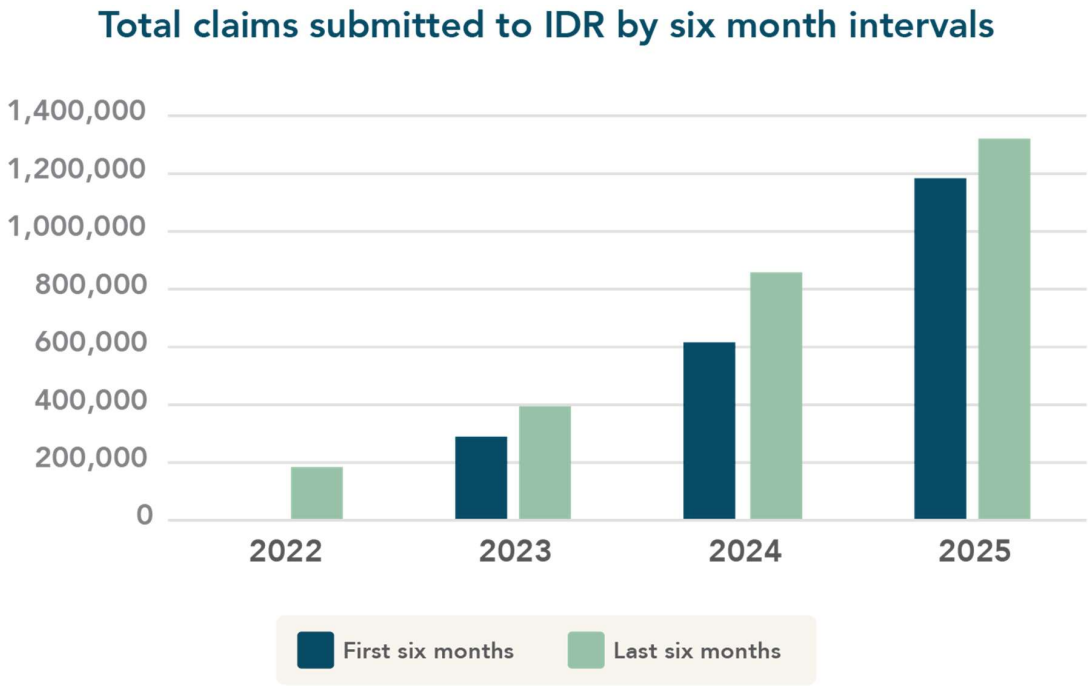
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II. Abuse of the IDR Process is Generating Billions in Unwarranted Costs.

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The system is buckling under the strain.

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

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

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

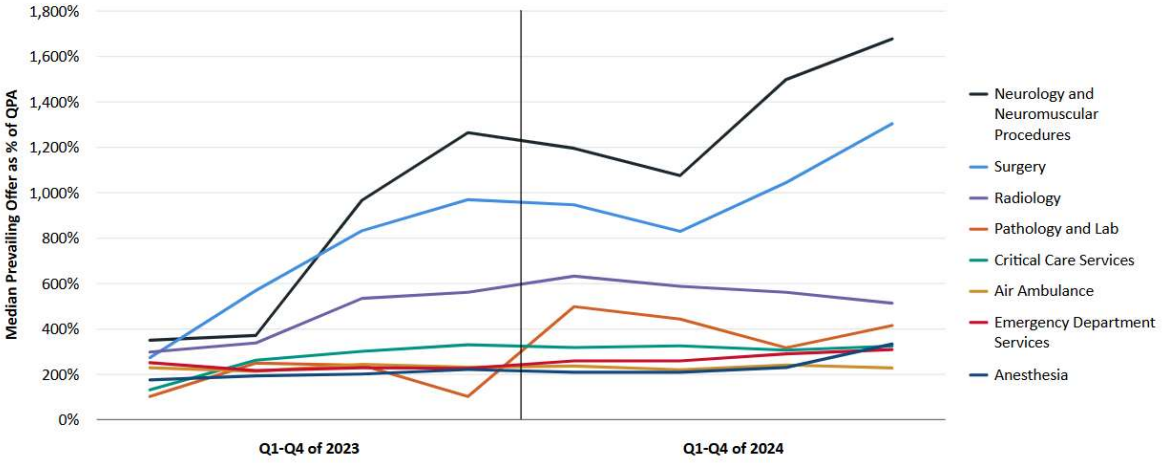
The negative consequences from abuse of the IDR system are immense. IDR is very costly, in terms of both administrative costs and IDR awards that far outpace negotiated market rates.

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

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

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

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



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

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

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

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

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

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

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

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///

CONCLUSION

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

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

By */s/Eli A. Alcaraz*
ELI A. ALCARAZ
Attorney for AMERICA'S HEALTH INSURANCE PLANS, INC.

Dated: February 6, 2026 DEUTSCH HUNT PLLC

By */s/Hyland Hunt*
HYLAND HUNT (*pro hac vice* pending)
Attorney for AMERICA'S HEALTH INSURANCE PLANS, INC.

CERTIFICATE OF COMPLIANCE

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

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

By */s/Eli A. Alcaraz*
ELI A. ALCARAZ
Attorney for AMERICA'S HEALTH INSURANCE PLANS, INC.

Dated: February 6, 2026 DEUTSCH HUNT PLLC

By */s/Hyland Hunt*
HYLAND HUNT (*pro hac vice* pending)
Attorney for AMERICA'S HEALTH INSURANCE PLANS, INC.

Amir Shlesinger (State Bar No. 204132)
ashlesinger@crowell.com
Jennie Wang VonCannon (State Bar No. 233392)
jvoncannon@crowell.com
Crowell & Moring LLP
515 South Flower Street, 41st Floor
Los Angeles, CA 90071
Tel: 213.622.4750

Joshua M. Robbins (State Bar No. 270553)
jrobbins@crowell.com
Crowell & Moring LLP
3 Park Plaza, 20th Floor
Irvine, CA 99614
Tel: 949.798.1325

Martin J. Bishop (pro hac vice)
mbishop@crowell.com
Alexandra M. Lucas (pro hac vice)
alucas@crowell.com
Jason T. Mayer (pro hac vice)
jmayer@crowell.com
Crowell & Moring LLP
300 N. LaSalle Drive, Suite 2500
Chicago, IL 60654
Tel: 312.321.4200

Jed Wulfekotte (pro hac vice)
jwulfekotte@crowell.com
Crowell & Moring LLP
1001 Pennsylvania Ave. NW
Washington, DC 20004
Tel: 202.624.2500

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
SOUTHERN DIVISION

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

Plaintiffs,

v.

HALOMD, LLC; ALLA LAROQUE; SCOTT LAROQUE; MPOWERHEALTH PRACTICE MANAGEMENT, LLC; BRUIN

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

Hon. Karen E. Scott

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTIONS TO DISMISS

NEUROPHYSIOLOGY, P.C.; iNEUROLOGY, PC; N EXPRESS, PC; NORTH AMERICAN NEUROLOGICAL ASSOCIATES, PC; SOUND PHYSICIANS EMERGENCY MEDICINE OF SOUTHERN CALIFORNIA, P.C.; and SOUND PHYSICIANS ANESTHESIOLOGY OF CALIFORNIA, P.C.,

Defendants.

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INTRODUCTION

The Amended Complaint ("AC," at ECF No. 50) seeks to hold Defendants liable[1] for filing millions of dollars' worth of fraudulent disputes against Anthem through the "independent dispute resolution" ("IDR") process created by the No Surprises Act ("NSA"). As part of their "NSA Scheme," Defendants: (1) submit hundreds of knowingly false attestations to federal agencies certifying that ineligible disputes involve "qualified" services within the scope of the IDR process; (2) employ artificial intelligence ("AI") to overwhelm the IDR system with hundreds of disputes at a time; and (3) request payment at rates vastly beyond what the market provides.

Defendants' NSA Schemes work by exploiting the NSA's honor system, under which providers and their IDR agents self-certify dispute eligibility. The Departments of Health and Human Services ("HHS"), Labor ("DOL"), and Treasury (collectively, the "Departments") built an online screening tool (the "IDR Portal") through which parties submit disputes and certify that they meet strict eligibility criteria. While this tool prevents parties from inadvertently submitting ineligible disputes, it cannot prevent fraud. There is no effective verification process; once Defendants make fraudulent submissions, the Departments automatically transmit the dispute to a certified IDR entity ("IDRE") tasked with making a payment determination.

Unlike court proceedings or commercial arbitrations, the IDR process contains no safeguards to prevent this type of fraud. The NSA itself does not delegate eligibility decisions to IDREs. Regulations direct IDREs to review eligibility, but

[1] "Defendants" include (1) HaloMD, LLC ("HaloMD"); (2) Alla LaRoque; (3) Scott LaRoque; (4) MPOWERHealth Practice Management, LLC ("MPOWERHealth"); (5) Bruin Neurophysiology, P.C. ("Bruin"), iNeurology, PC ("iNeurology"), N Express, PC ("N Express"), and North American Neurological Associates, PC ("NANA") (collectively, the "LaRoque Family Providers"); and (6) Sound Physicians Emergency Medicine of Southern California, P.C. ("SPEMSC") and Sound Physicians Anesthesiology of California, P.C. ("SPAC") (collectively, "Sound Physicians Providers"). The LaRoque Family Providers and the Sound Physicians Providers are collectively referred to as the "Provider Defendants." "Anthem" includes both Plaintiffs Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California d/b/a Anthem Blue Cross.

they (1) only require IDREs to consider the providers' unilateral attestation of eligibility, and (2) do not require that IDREs consider health plan objections or issue any written eligibility decisions. Making matters worse, IDREs only get paid if they find a dispute is eligible and proceed to make a payment determination. HaloMD alone submitted 134,318 disputes in the second half of 2024. The IDREs overseeing those disputes stood to earn tens of millions of dollars if, and only if, they decided eligibility in HaloMD's favor.

Defendants' motions[2] ignore the realities of the IDR process and Anthem's well-pleaded factual allegations. By misquoting the NSA and invoking inapplicable doctrines, Defendants claim that the Court is powerless to address their fraud. Accepting these misguided arguments would give Defendants' NSA Schemes a judicial seal of approval and invite similar bad actors to follow suit, with devastating consequences for health plans and American consumers. The Court should deny Defendants' motions in their entirety for the following reasons:

First, the jurisdictional arguments fail. Anthem has standing to recover millions of dollars in damages incurred as a direct result of Defendants' fraudulent NSA Schemes. And Defendants are subject to personal jurisdiction via the Racketeering Influenced and Corruption Organizations ("RICO") Act, Employee Retirement Income Security Act of 1974 ("ERISA"), and California long-arm statute.

Second, Defendants cannot avoid judicial review of their fraud. The NSA limits judicial review of individual IDRE payment determinations; it does not bar review of Defendants' NSA Scheme, through which they knowingly submitted hundreds of ineligible disputes. The *Noerr-Pennington* doctrine protects First Amendment activity, not fraudulent misrepresentations in private disputes. And

[2] This opposition responds to motions to dismiss the AC filed by (1) HaloMD ("HaloMD Br." at ECF No. 76-1), (2) MPOWERHealth and the LaRoque Family Providers ("MPOWER Br." at ECF No. 73-1); (3) MPOWER Health (as to jurisdiction) ("MPOWER 12(b)(2) Br." at ECF No 72-1); (4) Sound Physicians Providers ("Sound Br." at ECF No. 69-1); and (5) Alla LaRoque and Scott LaRoque ("LaRoque Br." at ECF No. 77-1).

collateral estoppel does not apply to eligibility "decisions," by partial IDREs who receive no compensation whatsoever if they find the dispute is ineligible.

Third, Anthem pleads all elements of its RICO claims. Moreover, the Ninth Circuit has not adopted the "litigation activities" exemption, which would not apply to IDR proceedings or Defendants' NSA Scheme in any event.

Fourth, the ERISA-governed plans at issue delegate to Anthem the authority to recover overpayments, and Anthem pleads violations of specific ERISA provisions and regulations.

Fifth, Anthem adequately pleads claims under California state law for the reasons stated in its accompanying Opposition to Defendants' Motions to Strike.

Sixth, Anthem adequately pleads all claims against Alla and Scott LaRoque, who are the central figures responsible for Defendants' wrongful conduct.

Finally, Anthem pleads viable claims for declaratory and injunctive relief to prevent future harm from Defendants' NSA Scheme.

BACKGROUND

Before the NSA, out-of-network providers engaged in the financially devastating practice of "surprise billing." AC, ¶ 39. Rather than go "in-network" and agree to reasonable rates with health plans, these providers exploited patients' inability to select an in-network provider in certain situations (*e.g.*, emergency care) to bill them at "inflated," "non-market-based rates" known as "billed charges." *Id.*; H.R. Rep. No. 116-615 (2020), at 52-53. Patients faced astronomical bills for the difference between the billed charges and the amounts covered by health plans. AC, ¶¶ 37-39.

Congress enacted the NSA (effective January 1, 2022) to protect patients from surprise bills and to bring down the cost of out-of-network care for specific types of plans and services. AC, ¶¶ 1, 42. If an out-of-network provider of NSA-covered services disagrees with the amount paid by a health plan, it has thirty business days

to provide a notice of "open negotiation." *Id.,* ¶¶ 45-47; 42 U.S.C. § 300gg-111(c)(1)(A). If the parties cannot reach a resolution in thirty days, and all other prerequisites are met, the provider may initiate IDR through the IDR Portal. AC, ¶ 46; *see* 42 U.S.C. § 300gg-111(c)(1)(B); 45 C.F.R. § 149.510(b)(2)(i).

Critically, a provider may only initiate IDR for a "qualified IDR item or service," subject to strict criteria. AC, ¶ 48; 42 U.S.C. § 300gg-111(c)(1); 45 C.F.R. § 149.510(a)(2)(xi), (b)(1), (b)(2). Among other requirements: (1) the patient must have coverage via a group health plan or health insurance issuer, and not a government plan like Medicare or Medicaid; (2) the dispute must not be governed by a state surprise billing law; and (3) the provider must have exhausted open negotiations and initiated the dispute in a timely manner. *See id.*

I. The NSA Employs an Honor System to Prevent Providers From Initiating IDR With Ineligible Disputes.

Because the NSA limits the IDR process to payment disputes over a "qualified IDR item or service" that meets strict eligibility criteria (AC, ¶ 48), HHS requires providers to initiate IDR though an eligibility screening tool on the IDR Portal (https://nsa-idr.cms.gov/paymentdisputes/s/). AC, ¶ 54. To initiate a dispute, the provider must answer "Qualification Questions," as well as submit an eligibility attestation, confirming that the eligibility criteria are met. *Id.*, ¶¶ 54-61. This self-certification, provided in a sworn statement to multiple government agencies, constitutes an honor system that safeguards against the filing of ineligible disputes. *See id.*

Through the Qualification Questions, the IDR Portal reminds providers of all eligibility criteria required to initiate a dispute. AC, ¶¶ 48, 55-59, 61. If the provider fills out any field with an answer that would render the dispute ineligible, the IDR Portal immediately advises them of ineligibility and prevents them from submitting the form altogether. *Id.*, ¶¶ 59-61.

For example, one of the Qualification Questions on the IDR Portal asks when the party began the open negotiation process. AC, ¶ 60. The Portal makes clear that "[t]he thirty business-day open negotiation period must elapse before starting the federal IDR process." *See id.* If the initiating submission is not made within four business days after the end of the open negotiation period, the initiating party must explain why it qualifies for an extension, along with supporting documentation. *Id.*, ¶¶ 61-62. Otherwise, the initiating party cannot proceed with initiation. *Id.*

After answering all Qualification Questions, the provider must complete a Notice of IDR Initiation form with a signed attestation that "to the best of my knowledge . . . the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) within the scope of the Federal IDR process." *Id.*, ¶¶ 63-64. By making that attestation and submitting the form, the provider causes a copy of the Notice of IDR Initiation, with the attestation, to be sent to the Departments, the IDRE, and the relevant health plan. *Id.*, ¶ 65. As soon as the Notice of IDR Initiation is submitted, both parties are responsible for paying a $115.00 administrative fee that will not be refunded, even if the dispute is later found to be ineligible for IDR. *Id.*, ¶ 79.

II. Unlike Court Proceedings or Commercial Arbitration, the IDR Process Lacks Safeguards to Protect Against Fraud.

Although sometimes referred to as arbitration, IDR bears no resemblance to the process that term commonly denotes. Congress designed IDR as a highly informal procedure to resolve relatively low-value disputes, without the need for legal counsel, based on the submission of blind "offers." *See* 42 U.S.C. § 300gg-111(c)(5). IDR has no discovery, no evidentiary requirements, no hearings, no testimony (live or written), and no procedures to even view—much less verify and rebut—an opposing party's offer. *See id*; AC, ¶ 290. Disputes are adjudicated by private entities (IDREs), not an identifiable judge or arbitrator. *See id.* IDRE payment determinations "include minimal justification or rationale," and there is "limited transparency into how

[IDREs] evaluate submissions." AC, ¶ 84; *No Surprises Act Arbitrators Vary Significantly in Their Payment Decision Making Patterns*, GEORGETOWN UNIV. CENTER ON HEALTH INS. REFORMS, http://bit.ly/4heOcWQ. These procedural shortcomings led the government to recently urge IDREs to "reduce errors" and institute "robust quality assurance (QA) programs to verify dispute eligibility and review payment determinations." *Federal IDR Technical Assistance for Certified IDR Entities and Disputing Parties* (June 2025), ECF No. 76-8, at 1.

A. IDR Provides No Meaningful Process to Dispute Providers' Misrepresentations of Eligibility.

Once a provider submits a dispute through the IDR Portal, there is no meaningful process for health plans to dispute eligibility. The NSA itself does not provide a process for addressing eligibility. *See* 42 U.S.C. § 300gg-111. Regulations state that a health plan may submit eligibility objections to HHS through the IDR Portal within three business days. 45 C.F.R. § 149.510(c)(1)(iii). The regulations do not require HHS to share these objections with the IDRE. *See id.* Instead, the regulations state that IDREs "must review the information submitted in the notice of IDR initiation"—which only contains the provider's attestation of eligibility—"to determine whether the Federal IDR process applies." AC, ¶ 116; 45 C.F.R. § 149.510(c)(1)(v). No law or regulation requires IDREs to consider information beyond the notice of IDR initiation with the provider's attestation. *See* 45 C.F.R. § 149.510(c)(1)(v). Moreover, the regulations do not require IDREs to conduct hearings or issue decisions (written or otherwise) addressing eligibility. *See id*.

B. IDREs Have a Financial Stake in Eligibility Decisions.

IDRE eligibility "decisions" are further compromised by a perverse economic incentive that would immediately disqualify a factfinder in any court or arbitration: IDREs are not paid unless they decide that a dispute is eligible for IDR. AC, ¶¶ 80, 116; 42 U.S.C. § 300gg-111(c)(5)(F); *see CALENDAR YEAR 2023 FEE GUIDANCE*

FOR THE FEDERAL INDEPENDENT DISPUTE RESOLUTION PROCESS UNDER THE NO SURPRISES ACT, CMS, http://bit.ly/48xP1Yc ("[C]ertified IDR entities may not collect fees for those cases that they ultimately determine are ineligible for the Federal IDR process."). This means that health plans can only prevail in their objections to eligibility if the IDRE both: (1) expends the resources necessary to appropriately evaluate eligibility (which the regulations do not require), and (2) reaches a decision requiring it to forego any compensation.

IDREs' fees range from several hundred to over a thousand dollars per dispute. AC, ¶ 79. HaloMD alone submitted 134,318 disputes in the second half of 2024. *Id.*, ¶ 110. The IDREs deciding those disputes stand to gain tens of millions of dollars if, and only if, they decide HaloMD's disputes are eligible for IDR and/or otherwise proceed to a payment determination.

C. The NSA Enables Providers to Obtain Radically Inflated Rates Through IDR Payment Determinations.

Unless the IDRE decides that a dispute is ineligible and that it will forego payment, the dispute proceeds to a payment determination. AC, ¶ 74. The payment determination process is often described as "baseball-style" or "final offer" dispute resolution. *Id.,* ¶ 75. The provider and health plan each submit payment offers to the IDRE, and the IDRE must select one of the two offers. *Id.* Neither the provider nor the payor gets to examine, contest, or rebut the other's offer. *Id.,* ¶ 290.

In choosing between offers, the NSA requires IDREs to consider the Qualifying Payment Amount ("QPA") (an approximation of the plan's in-network rate for that service) and several "additional circumstances," such as the provider's quality, market share, case mix, and scope of services. AC, ¶ 76; 42 U.S.C. § 300gg-111(c)(5)(C). Although IDREs must issue a written payment determination, the regulations do not require any specific explanation or reasoning. *See* 45 C.F.R. § 149.510(c)(4)(vi). In practice, IDREs typically provide threadbare decisions

containing the dollar amount selected for the dispute and a boilerplate list of statutory factors considered, with no explanation as to why those factors support the ultimate determination. AC, ¶ 84; *see No Surprises Act Arbitrators Vary Significantly in Their Decision Making Patterns*, HEALTH AFFAIRS, https://bit.ly/3XQUUcO.

IDR payment determinations overwhelmingly favor providers. In the most recent reporting period, providers prevailed in 85% of payment determinations. AC, ¶¶ 82-84. When providers prevail, they do so at a median rate that is over 4.5 times greater than the QPA. *Id.* In other words, by accessing the IDR system, providers recover a median rate over 459% higher than in-network market rates for identical services. *Id.* By flooding the NSA's IDR process with knowingly ineligible disputes, Defendants have secured some payments for ineligible Medicaid claims that are more than 4,200% higher than the applicable Medicaid rate. *See, e.g.*, *id.*, ¶ 235.

III. The Parties.

Plaintiff ABC is a health care service plan licensed by the California Department of Managed Health Care. Its principal place of business is in Woodland Hills, California. AC, ¶ 12. It offers and administers claims for several different types of health care plans for California residents and companies. AC, ¶¶ 30-35. Plaintiff ABCLH (together with ABC, "Anthem") is an insurance company regulated by the California Department of Insurance. Its principal place of business is in Woodland Hills, California. AC, ¶ 13.

MPOWERHealth is a Delaware limited liability company based in Texas; its founder, ultimate sole owner, and CEO is Defendant Scott LaRoque. AC, ¶¶ 17-18. Through total control of MPOWERHealth, Scott LaRoque exerts managerial and operational control over all of its subsidiaries. AC, ¶¶ 141-42. MPOWERHealth recruits physicians and technicians for its subsidiaries and provides and coordinates their clinical services and legal, billing, and IDR functions. AC, ¶¶ 136-38. Scott LaRoque's wife, Defendant Alla LaRoque, was MPOWERHealth's COO and is a

current board member. AC, ¶¶ 16, 148, 158-59.

HaloMD is a Delaware limited liability company based in Texas that bills itself as "the premier expert in Independent Dispute Resolution." AC, ¶¶ 14, 152. It is ultimately owned by Scott and Alla LaRoque, who exert managerial and operational control over the company. AC, ¶¶ 15, 148, 162-64. Alla LaRoque is the founder and President of HaloMD. AC, ¶ 16. HaloMD submits massive numbers of IDR disputes for all Provider Defendants and other providers using AI and other automated tools. AC, ¶¶ 151-54. HaloMD operates on a commission model, taking a portion of the amount recovered through IDR on behalf of providers. AC, ¶ 157.

Defendants Bruin, iNeurology, N Express, and NANA (*i.e.*, the "LaRoque Family Providers") are California professional corporations and provide interoperative neuromonitoring ("IONM") services, including to California residents, and are each subsidiaries of MPOWERHealth. AC, ¶¶ 19-22, 140.

HaloMD, MPOWERHealth, and the LaRoque Family Defendants share multiple overlapping business and mailing addresses. *See, e.g.*, AC, ¶¶ 14, 17, 19-22, 136, 143-44, 146-47, 161. Roxy LaRoque, MPOWERHealth's Director of Client Experience, is the Authorized Official for hundreds of provider entities, including each of the LaRoque Family Providers. AC, ¶¶ 139, 143-44, 146-47. Other key executives, such as Brenda Thiele (Senior Manager of Treasury at MPOWERHealth) and Megan Rausch (COO of HaloMD and previously Vice President of Revenue Cycle Management at MPOWERHealth), likewise hold official positions across related entities. AC, ¶¶ 47, 160.

The websites for HaloMD and MPOWERHealth are also nearly identical in design and structure, and their contact pages are directly linked. AC, ¶¶ 163. HaloMD's "Join Our Team" page directs applicants back to MPOWERHealth's domain. *Id*. Advertisements for jobs posted on the internet conflate the various entities. *Id*. For example, one advertisement for an "IDR Specialist" lists the

employer as MPOWERHealth, but the body of the description under the section "Who We Are" lists HaloMD as the employer and describes HaloMD. *Id.*

SPAC is a California professional corporation with its principal place of business in Brentwood, Tennessee. AC, ¶ 23. SPEMSC is a California professional corporation with its principal place of business also in Brentwood, Tennessee. AC, ¶ 24. Each of the Sound Physicians Providers contract with HaloMD to manage IDR disputes while also submitting a subset of their own disputes. AC, ¶¶ 215-219.

IV. Defendants' Fraudulent NSA Schemes.

Defendants launched their NSA Schemes to exploit the IDR process and defraud Anthem and other health plans on a massive scale. AC, ¶¶ 3-6, 92, 105-08, 110-11, 130, 206. To conduct their NSA Schemes, Defendants: (1) use interstate wires to make knowingly false attestations of eligibility to Anthem, the Departments, and IDREs; (2) strategically initiate massive numbers of IDR disputes simultaneously to overwhelm the system's minimal safeguards; and (3) submit wildly inflated demands for payment that they could never receive outside the IDR process. AC, ¶¶ 90-93. Defendants often prevail in these processes because there is no meaningful opportunity for Anthem to contest their fabrications, and IDREs are financially incentivized and permitted by regulation to simply accept Defendants' misrepresentations as true. AC, ¶¶ 73, 86, 116-17, 296.

Defendants formed two enterprises to carry out their NSA Schemes. AC, ¶¶ 87-88. Under the direction and control of Scott and Alla LaRoque, the HaloMD Defendants, MPOWERHealth Defendants, and the LaRoque Family Providers formed the LaRoque Family Enterprise. AC, ¶¶ 130-34, 164. Similarly, HaloMD and the Sound Physicians Providers formed the Sound Physicians Enterprise. AC, ¶¶ 206-09. Both enterprises rely on HaloMD to exploit the IDR process and defraud Anthem and other health plans on a massive scale. AC, ¶ 89.

Each defendant plays a role in the scheme. To advance the shared purpose of

the LaRoque Family Enterprise, the LaRoque Family Providers perform services and generate claims that MPOWERHealth and HaloMD use to flood the IDR system with ineligible disputes. *E.g.*, AC, ¶¶ 164, 168-205. MPOWERHealth coordinates, facilitates, and directs the LaRoque Family Providers' operations and funnels their claims into IDR through HaloMD. AC, ¶¶ 135-140. HaloMD takes the claims generated by the LaRoque Family Providers and, in coordination with MPOWERHealth, uses them to systematically submit fraudulent disputes. *See, e.g.*, AC, ¶¶ 164, 171-172, 175, 180, 184, 190, 196, 202. Scott and Alla LaRoque manage and coordinate each of the corporate Defendants and the overall scheme. AC, ¶¶ 134, 135, 148-50.

Similarly, to advance the shared purpose of the Sound Physicians Enterprise, the Sound Physicians Providers performs services and generate claims that they and HaloMD use to flood the IDR system with ineligible disputes. AC, ¶¶ 206-09, 148-50; *see also, e.g.*, AC, ¶¶ 224-48. HaloMD takes the claims generated by the Sound Physicians Providers and, in conjunction with claims it collects from the LaRoque Family Providers, uses them to systematically submit fraudulent disputes. AC, ¶¶ 210-214; *see also, e.g.*, AC, ¶¶ 224-248.

At the heart of their NSA Schemes, Defendants knowingly make false representations and attestations of eligibility in submissions to the IDR Portal. AC, ¶¶ 96-104. These false statements are necessary steps for accessing the IDR process. AC, ¶ 4. Their false representations include, for example, knowingly initiating disputes that are not ripe for the IDR process because no open negotiation occurred. AC, ¶ 99. Defendants also misrepresent that claims subject to the California Surprise Billing Law are not covered by the state law and eligible for the IDR process. AC, ¶¶ 100. 82, 90, 161-205. These are not isolated events; Anthem estimates that hundreds of Defendants' disputes, including almost half that reached a payment determination, are ineligible for IDR. AC, ¶¶ 90, 118. Defendants know that their

representations of eligibility are false when they make them because of, among other things, the nature of the claims, the timing of their dispute submissions, the warnings and screening mechanisms on the IDR Portal, and Anthem's direct and repeated notices to Defendants that their claims are ineligible for the IDR process. *E.g.*, AC, ¶¶ 96-104, 287, 303.

Defendants also exploit their volume of disputes to overcome the minimal safeguards in the IDR process. Before the NSA went into effect, the Centers for Medicare and Medicaid Services ("CMS") estimated that there would be about 22,000 IDR disputes annually, and health plans would need to devote several hours to manage each dispute. 86 Fed. Reg. 55,980, 56,067-70 (Oct. 7, 2021). Yet in 2024, almost 1,500,000 disputes were initiated. AC, ¶ 99. HaloMD is among the three most prolific filers of IDR disputes; it initiated 134,318 disputes against health plans in the second half of 2024. AC, ¶ 101.

In both NSA Schemes, Defendants strategically overwhelm IDR safeguards by using automated AI tools to submit massive numbers of disputes all at once. AC, ¶¶ 6, 92. For example, on May 3, 2024, Defendants initiated 126 separate IDR disputes against Anthem; Anthem's records show more than 75% were ineligible for IDR. AC, ¶ 112. Defendants know that Anthem has only three business days to respond to their IDR initiation with any eligibility objections. *See supra*. And they know that IDREs must complete the entire IDR process and issue payment determinations within thirty business days. *See supra*. Defendants thus strategically flood the system to (1) overwhelm health plans' ability to identify and object to ineligible disputes and (2) prevent IDREs from meaningfully scrutinizing their disputes. AC, ¶ 93, 105-118. The LaRoque Family Enterprise's scheme often succeeds despite Anthem's frequent objections to eligibility and/or notices of ineligibility. *E.g.*, AC, ¶¶ 118, 171, 176, 181, 187, 193, 199, 205. The Sound Physicians Enterprise's scheme also frequently succeeds despite Anthem's frequent

objections to eligibility. *E.g.*, AC, ¶¶ 118, 223, 228, 234, 240, 247.

The final element in Defendant's NSA Schemes is what makes it so lucrative: Defendants submit, and often prevail with, hugely inflated payment demands. AC, ¶ 119. These demands far exceed what Defendants could recover in a competitive market and often exceed even Defendants' "inflated," "non-market-based" billed charges. *E.g.*, AC, ¶ 124.

The LaRoque Family Enterprise has carried out the NSA scheme for hundreds of claims. For example, on March 11, 2024, NANA provided a health care service to a member of a health plan administered by ABCLH. AC, ¶ 178. ABCLH issued a payment to NANA for the service in the amount equal to the QPA for that service. *Id.,* ¶ 179. Because the claim was covered by the No Surprises Act, ABCLH informed NANA that "[i]f you disagree with our decision, you can initiate the 30-day open negotiation period[.]" *Id*. Nonetheless, neither NANA nor HaloMD initiated open negotiations. *Id.,* ¶ 180. Over three months later, HaloMD initiated IDR, falsely attesting that the service was a qualified item and that NANA complied with the NSA IDR requirements. *Id*. Before making this false attestation, HaloMD would have also entered fictitious open negotiation dates and/or uploaded fabricated supporting documents to the IDR Portal when answering the Qualifications Questions. *See id.,* ¶¶ 60-62. ABCLH responded with an objection of eligibility to the IDRE and sent to NANA, specifically noting that the dispute did not qualify for IDR. *Id.,* ¶ 181. Yet neither NANA nor HaloMD withdrew the dispute, purposefully evading the measures on the IDR Portal meant to prevent IDR payment determinations for patently ineligible claims. *Id.* As a result, the IDRE proceeded to make a payment determination anyway and awarded NANA $9,843.83. *Id.,* ¶ 182. Anthem also paid $512.00 in related IDR fees. *Id.* In short, NANA knowingly recovered nearly 45% more than NANA's original billed amount in a dispute that it knew was ineligible for the IDR process. *Id*.

The Sound Physicians Enterprise has carried out the NSA scheme for hundreds of claims as well. For example, on February 9, 2024, SPEMSC provided a health care service to a member of a Medicaid managed care plan administered by ABC. AC, ¶ 230. ABC paid the Medicaid rate of $44.60 for the service; no QPA applied. *Id*. Claims for services rendered pursuant to a Managed Medicaid plans are not eligible for the NSA's IDR process. *See supra.* SPEMSC and HaloMD knew this claim was ineligible because ABC's remittance specifically stated the member belonged to a Managed Medicaid plan. AC, ¶ 231. Nevertheless, on March 13, 2024, SPEMSC included this claim with about eighty-eight other individual claims in its request for open negotiation. *Id.,* ¶ 232. On October 23, 2024, HaloMD initiated IDR and falsely attested to IDR eligibility on behalf of and in coordination with SPEMSC. *Id.,* ¶ 233. Despite Anthem's timely objection to eligibility for IDR because the claim involved a "Medicare/Medicaid claim ineligible for NSA," neither Defendant withdrew the dispute. As result, ABC was ordered to pay $1,880.00, or about 42 times the Medicaid rate, as well as $915.00 in IDR-related fees. *Id.,* ¶ 235.

V. Defendants' NSA Schemes Damage Anthem in Multiple Respects.

Defendants' NSA Schemes damaged Anthem in multiple independent ways. First, every time Defendants submit one of their hundreds of fraudulent disputes against Anthem to the IDR Portal, Anthem must pay a $115.00 administrative fee to HHS, which Anthem cannot recover even if the dispute is deemed ineligible. AC, ¶ 79. Second, Anthem must spend enormous amounts of time and money to identify and contest Defendants' hundreds of fraudulent disputes. AC, ¶ 115. Third, through their fraudulent submissions, Defendants have (so far) obtained millions of dollars in improper IDR awards against Anthem. AC, ¶¶ 9, 118, 128, 253, 270, 116. Fourth, for each award in Defendants' favor, Anthem must also pay hundreds of dollars in fees to the IDRE. AC, ¶ 79. To date, Anthem has incurred hundreds of thousands of dollars in fees based on Defendants' fraudulent disputes, and it has been ordered to

pay millions of dollars in ineligible and/or inflated IDR payments based on Defendants' knowingly false statements. AC, ¶¶ 9, 112.

VI. Causes of Action.

Anthem asserts thirteen causes of action against both the LaRoque Family Enterprise Defendants and the Sound Physicians Enterprise Defendants for violations of federal RICO (Counts I, II, III, and IV); fraudulent misrepresentation (Counts V and VI); negligent misrepresentation (Counts VII and VIII); business acts or practices in violation of Cal. Bus. & Prof. Code §§ 17200 *et seq*. (Counts IX and X); vacatur of IDR Determinations (in the alternative) (Count XI); violations of ERISA (Count XII); and equitable declaratory and injunctive relief (Count XIII). *See* AC, ¶¶ 249-371.

LEGAL STANDARD

On a motion to dismiss, the court must "accept all factual allegations in the complaint as true and construe the pleadings in the light most favorable to the nonmoving party." *Knievel v. ESPN*, 393 F.3d 1068, 1072 (9th Cir. 2005). A plaintiff need only give a defendant fair notice of its claims and the grounds upon which they rest. *See Erickson v. Pardus*, 551 U.S. 89, 93 (2007). A complaint must allege facts sufficient "to raise a right to relief above the speculative level." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007).

Rule 9(b)'s pleading standard applies to claims of fraud. Where a plaintiff alleges a scheme involving "hundreds or thousands" of misrepresentation, Rule 9(b) requires only that the plaintiff plead "examples" of the fraud with the requisite particularity. *See Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, No. CV14-03053 MWF (VBKx), 2015 WL 12778048, at *8 (C.D. Cal. Oct. 23, 2015).

ARGUMENT

I. Defendants' Jurisdictional Arguments Fail.

A. Anthem Pleads Standing.

As a direct and immediate consequence of Defendants' NSA Scheme, Anthem incurred millions of dollars of liability for fees and awards based on ineligible disputes and the operational expenses and burden of responding to Defendants' fraud. *See supra* at 14-15. Anthem pleads standing because it alleges that it: (1) "suffered an injury in fact" that is (2) "fairly traceable to" Defendants' conduct, and (3) "is likely to be redressed by a favorable judicial decision." *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016).

Injury In Fact: Standing only requires "general factual allegations of injury." *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992). The AC alleges concrete injuries (with demonstrative examples) in the form of Anthem incurring (1) IDRE and administrative fees for ineligible disputes, (2) the operational burden and expense to address Defendants' false scheme, and (3) the liability for fraudulently procured IDR awards. *See supra* at 14-15.

The LaRoque Family Providers claim the AC fails to plead that Anthem ever paid any IDR awards. MPOWER Br. 15. But the AC identified numerous specific payments that Anthem was compelled to make on ineligible disputes due to their NSA Scheme. AC, ¶¶ 172, 177, 182, 188, 194, 200, 205, 229, 235, 241, 248.[3] Moreover, regardless of whether Anthem has paid each fraudulently procured IDR award to date, "a liability, including a contingent liability, may be a cognizable legal injury." *Carter v. HealthPort Techs., LLC*, 822 F.3d 47, 55 (2d Cir. 2016) (citing *Clinton v. City of New York*, 524 U.S. 417, 430–31 (1998)); *City of San Diego v.*

[3] Providers cite the inapposite decision in *Scheid v. Fanny Farmer Candy Shops, Inc.*, 859 F.2d 434, 437 (6th Cir. 1988), to suggest that the Court should draw inferences against Anthem based on the supposed omission of specific language in the AC. But the law requires the Court to "construe the complaint in the light most favorable to the plaintiff . . . and draw all reasonable inferences in favor of the plaintiff." *E.g.*, *Eastep v. City of Nashville, Tenn.*, 156 F. 4th 819, 826 (6th Cir. 2025) (internal quotation marks omitted).

Monsanto Co., 334 F. Supp. 3d 1072, 1082 (S.D. Cal. 2018) (same).

Traceability: "Article III requires no more than *de facto* causality," and "traceability is satisfied" if Anthem's injury was "likely attributable *at least in part*" to Defendants' actions. *Dep't of Com. v. New York*, 588 U.S. 752, 768 (2019) (emphases in original). As detailed in Argument, Section III.B.2 *infra*, Anthem easily pleads that Defendants' conduct is the proximate cause of its injuries. But for the purposes of standing, traceability "is less demanding than proximate causation, and the 'causation chain does not fail solely because there are several links' or because a single third party's actions intervened." *O'Handley v. Weber*, 62 F.4th 1145, 1161 (9th Cir. 2023) (internal citation omitted). The AC far exceeds the requirement to plead that Anthem's injuries are sufficiently attributable to Defendants' actions.

HaloMD incorrectly suggests that Anthem only alleges damages arising from IDR awards, and that IDREs break the causal chain between Defendants' fraud and Anthem's injury. HaloMD Br. 20. But as soon as Defendants submit a fraudulent dispute through the IDR Portal, Anthem must: (1) spend time and money to identify the fraud and submit an objection to eligibility (*e.g.*, AC, ¶¶ 115, 268, 279), and (2) pay a $115.00 administrative fee, which it cannot recover even if "the IDRE determines that the dispute does not qualify for IDR[.]" *Id.*, ¶ 79. Anthem incurs these damages even before an IDRE is selected.

As to actual awards, traceability does not require that "the defendant's actions are the very last step in the chain of causation." *Bennett v. Spear*, 520 U.S. 154, 169 (1997). IDR awards are only issued because of Defendants' misrepresentations. If Defendants accurately answered eligibility questions on the IDR Portal, the "federal IDR website [would] not permit the[m] . . . to proceed and seek payment for the service." AC, ¶¶ 61, 66. Absent Defendants' misrepresentations, IDREs would have no basis to resolve eligibility disputes and awards in their favor.

Redressability: Where, as here, a plaintiff seeks damages for past injuries,

"compensatory damages satisfy the redressability requirement for purposes of standing." *Clough v. Highway Auto. Pros LLC*, No. SACV2300107CJCJDEX, 2023 WL 4291826, at *4 (C.D. Cal. May 23, 2023). Anthem's injuries arise directly from Defendants' hundreds of fraudulent attestations. *See supra* at 14-15. And an order enjoining Defendants' NSA Schemes, as sought in the AC, will redress future injury so long as it "reduce[s] to some extent" the likelihood of future harm. *See Mass. v. EPA*, 549 U.S. 497, 526 (2007).[4] Anthem easily meets this standard.

B. Anthem Pleads Personal Jurisdiction Over HaloMD, MPOWERHealth and the LaRoques.[5]

The nationwide service of process provisions in both the ERISA and RICO statutes provide personal jurisdiction over HaloMD, MPOWERHealth, and the LaRoques (the "out-of-state Defendants"). And the out-of-state Defendants are each also subject to specific jurisdiction in California under the California long-arm statute, Cal. Civ. Proc. Code § 410.10.

1. ERISA Jurisdiction.

ERISA's nationwide service of process provision confers personal jurisdiction in any federal court over any defendant who has minimum contacts with the United States. *See Board of Directors of Motion Picture Indus. Pension Plan v. Lucky Foot Productions, Inc.*, No. CV 19-2263 DSF (JCX), 2019 WL 13063385, at *2 (C.D. Cal. June 27, 2019); *see also Jorgensen v. Scolari's of California, Inc.*, No. SACV1401211CJCRNBX, 2014 WL 12480261, at *2 (C.D. Cal. Nov. 12, 2014). The out-of-state Defendants do not contest that they have minimum contacts with the

[4] HaloMD claims that Anthem should have pursued a new process to petition to reopen each of their hundreds of IDR proceedings. HaloMD Br. 15. The cited guidance states this process "is not intended to have the force of law." (*Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties*, ECF No. 76-8, at 1. The new process also does not state that it provides an exclusive remedy, and it could not remedy or enjoin Defendants' NSA Schemes.

[5] The Defendants organized and operating in California—Bruin; iNeurology; N Express; NANA; SPAC; and SPEMC (collectively, the "in-state Defendants" or "California-based Defendants")—do not contest personal jurisdiction.

United States. Contrary to their arguments (MPOWERHealth Br. 3; LaRoque Br. 11; HaloMD Br. 19 n.14), Anthem alleges a viable ERISA claim (*see* Section IV). Because Defendants offer no other challenge to this basis for jurisdiction, they are all subject to personal jurisdiction under ERISA.

2. RICO Jurisdiction.

The "ends of justice" provision of the RICO statute (MPOWERHealth Br. 3; HaloMD Br. 19 n.14) provides a second independent basis for personal jurisdiction over the out-of-state Defendants because: (1) the Court has personal jurisdiction over at least one alleged participant in the conspiracy; and (2) there is no district in which a court would have personal jurisdiction over all defendants. *See Aych v. Univ. of Az.*, No. 24-4710, 2025 WL 1641876, at *1 (9th Cir. June 10, 2025). Defendants do not contest that the Court has jurisdiction over the in-state Defendants, satisfying the first requirement. *See* AC, ¶¶ 19-24 (alleging the in-state Defendants are California professional associations located and operating in California). And there is no other district in which a court will have personal jurisdiction over all of the alleged co-conspirators. *See* AC, ¶¶ 14, 17 (two of ten Defendants subject to jurisdiction in Delaware), ¶¶ 23, 24 (two of ten Defendants subject to jurisdiction in Tennessee), ¶¶ 14-24 (eight of ten Defendants subject to jurisdiction in Texas). Because Anthem alleged a viable RICO conspiracy involving the out-of-state Defendants, personal jurisdiction is proper over all Defendants under RICO.[6]

3. California's Long Arm Statute.

The Court's also has specific jurisdiction over the out-of-state Defendants under California's long-arm statute, which permits the exercise of personal jurisdiction consistent with federal due process. *Patrizzi v. Lam*, No. CV 08-0322 AHM (CTX), 2008 WL 11336134, at *3 (C.D. Cal. May 19, 2008). For specific

[6] The Court can exercise pendent personal jurisdiction over Anthem's state law claims, which arise from the same facts as Anthem's ERISA and RICO claims. *Action Embroidery Corp. v. Atlantic Embroidery, Inc.*, 368 F.3d 1174, 1181 (9th Cir. 2004).

jurisdiction, due process requires: (1) purposeful direction of activities toward or purposeful availment of the privilege of conducting activities in California by defendants; (2) the claim arises out of or relates to defendants' contacts with California; and (3) the exercise of jurisdiction comports with "fair play and substantial justice," *i.e.*, it is "reasonable." *Schwarzenegger v. Fred Martin Motor Co.*, 374 F.3d 797, 802 (9th Cir. 2004).

i. Purposeful Direction.

Defendants and Anthem agree that, because Anthem's claims sound in tort, the Court should apply the "purposeful direction" test. LaRoque Br. 9; *see Yahoo! Inc. v. La Ligue Contre Le Racisme Et L'Antisemitisme*, 433 F.3d 1199, 1206 (9th Cir. 2006). "Purposeful direction" is satisfied where defendant "(1) committed an intentional act, (2) expressly aimed at the forum state, (3) causing harm that the defendant knows is likely to be suffered in the forum state." *See Ayla, LLC v. Alya Skin Pty. Ltd.*, 11 F.4th 972, 980 (9th Cir. 2021). Courts focus "on the forum in which the defendant's actions were felt, whether or not the actions themselves occurred within the forum." *Yahoo! Inc.*, 433 F.3d at 1206.

Here, HaloMD solicited and represented California-based physician practices, including the in-state Defendants, in the intentional submission of fraudulent IDR claims against California-based Anthem. *See* AC, ¶¶ 6, 14, 103, 104, 132, 134, 151. MPOWERHealth acts as a physician management organization for the in-state Defendants (*i.e.*, California healthcare providers) and "centrally coordinates their IONM services and manages legal, billing, and *IDR functions*," which functions include coordinating the fraudulent IDR disputes. *See* AC, ¶¶ 135-40 (emphasis added). The intentional submission of fraudulent IDR disputes for the California-based Defendants against Anthem were intentional acts expressly aimed at a California business. *See id.,* ¶¶ 9-10, 12-13. These acts are also attributable to the LaRoques, *see* Section VI.

More importantly, Anthem felt the effects of the NSA Schemes in California, where it wasted resources responding to and paying meritless IDR awards as well as unnecessary IDRE and administrative fees. Taken together, these facts more than satisfy the purposeful direction test. *See, e.g.*, *Automattic Inc. v. Steiner*, 82 F. Supp. 3d 1011, 1025 (N.D Cal. 2015) (finding first prong met where "Plaintiffs allege that as a result of Defendant's fraudulent conduct, [plaintiff] spent substantial time and resources in dealing with the 'meritless' takedown notices and suffered reputational harm"); *see also AGA Serv. Corp. v. United Air Ambulance, LLC*, No. 16-CV-2663 W (WVG), 2017 WL 4271991, at *4-5 (S.D. Cal. Sept. 26, 2017) (finding purposeful availment where defendants wrongfully attempted to collect excessive additional payments for providers' services to California residents and filed appeals to California agencies).

ii. Defendants' Contacts with California.

The second prong requires that Anthem's claims arise out of or relate to the out-of-state Defendants' contacts with the forum. *Ford Motor Co. v. Montana Eighth Jud. Dist. Ct.*, 592 U.S. 351, 362 (2021) (holding that the "relate to" requirement does not require a causal connection). Anthem's claims arise from the out-of-state Defendants' NSA Schemes, which include hundreds of ineligible IDR proceedings submitted on behalf of the California-based Defendants for services provided in California, and to obtain additional payments from Anthem, a California business. *See Automattic*, 82 F. Supp. 3d at 1025 (claim arose from notices sent by defendant to plaintiff in California). The second prong is thus satisfied.

iii. Fair Play and Substantial Justice.

Defendants bear the burden on the third prong and must "present a compelling case" that the exercise of jurisdiction would not be reasonable. *Schwarzenegger*, 374 F.3d at 802; *see also AGA Serv. Corp.*, 2017 WL 4271991, at *5-6 (listing the seven factors courts consider). Here, HaloMD and MPOWERHealth offer no case, and the

LaRoques' case is not compelling. LaRoque Br. 10.

The LaRoques incorrectly argue there is "no personal conduct directed at California." *Id.* The LaRoques are involved in the fraudulent NSA Schemes using California companies to target California victims. *See supra* at Argument, Section VI. The out-of-state Defendants thus fail to meet their burden to show jurisdiction would be unreasonable.

Finally, the LaRoque's reliance on the fiduciary shield doctrine does not change the analysis. *See* LaRoque Br. 10. First, courts apply the traditional minimum contacts analysis, not the fiduciary shield doctrine, where the state long-arm statute extends to the limit of constitutional due process, as in California. *See Davis v. Metro Prods., Inc.*, 885 F.2d 515, 522 (9th Cir. 1989); *Harris v. Chroma Cars, LLC*, No. EDCV 21-1492 JGB (SPX), 2022 WL 1844116, at *13 (C.D. Cal. Feb. 25, 2022). Second, the fiduciary shield doctrine does not apply when jurisdiction is based on the RICO or ERISA statutes. *See Davis*, 885 F.2d at 522. And third, the LaRoques are the driving force behind and directly control their fraudulent NSA Schemes. *See supra* at Argument, Section VI; *see also ProSource Discounts, Inc. v. Dye*, No. 2:19-CV-00489-AB-JC, 2019 WL 6729702, at *4 (C.D. Cal. July 23, 2019) (fiduciary shield doctrine did not protect defendant because his alleged tortious conduct "was the moving force behind the corporation's tortious conduct"); *Sihler v. Fulfillment Lab, Inc.*, No. 3:20-CV-01528-H-MSB, 2020 WL 7226436, at *5 (S.D. Cal. Dec. 2020) ("[T]he fiduciary shield doctrine may be ignored . . . by virtue of the individual's control of, and direct participation in the alleged activities.") (citation omitted).

II. Defendants Cannot Avoid Judicial Review of Their Fraud.

Defendants seek dismissal based on plainly inapplicable statutory and doctrinal grounds. Defendants: (1) misquote the NSA's "Judicial Review Provision" (42 U.S.C. § 300gg-111(c)(5)(E)(i)(II)) to argue that Anthem may only file a petition

to vacate IDR awards via the Federal Arbitration Act ("FAA"), which is not true; (2) claim they are immune from liability under *Noerr-Pennington*, which does not apply to IDR proceedings or to factual misrepresentations; and (3) raise the affirmative defense of collateral estoppel without the necessary supporting proof or the ability to meet its elements. None of these arguments immunize Defendants' NSA Scheme.

A. The NSA's Judicial Review Provision Does Not Apply to Anthem's Claims.

Defendants' arguments that the NSA's Judicial Review Provision bars Anthem's claims fail for three independent reasons. First, the Judicial Review Provision applies solely to a payment determination from an IDRE; it does not apply to Defendants' NSA Schemes, through which they knowingly submitted hundreds of ineligible disputes. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). Second, the NSA does not incorporate the FAA's procedures—much less impose them as an exclusive remedy—and Anthem has pleaded "a case described in" 9 U.S.C. § 10(a)(1) and (a)(4) to support "judicial review." Third, Anthem's claims are not a collateral attack on IDR payment determinations; Anthem asserts the disputes should never have taken place in the first instance and seeks, *inter alia*, prospective injunctive relief to prevent future submission of fraudulent disputes.

1. The Judicial Review Provision Does Not Apply to the NSA Scheme.

The plain language of the Judicial Review Provision applies solely to an IDRE payment determination. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). It does not limit judicial review of Defendants' NSA Schemes, through which they knowingly submitted hundreds of ineligible disputes. *See id.*[7]

[7] None of Defendants' authorities addressing the NSA involved a claim challenging IDR eligibility, much less a widespread scheme to knowingly initiate hundreds of ineligible disputes. *See Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 275 (5th Cir. 2025) (holding only that the NSA "contains no express right of action to enforce or confirm an IDR award"); *Mod.Orthopaedics of N.J., v. Premera Blue Cross.*, 2:25-cv-01087 (BRM) (JSA), 2025 WL 3063648, at *14 (D.N.J. Nov. 3, 2025) (same); *Guardian Flight, L.L.C. v. Med. Evaluators of Tex. ASO, L.L.C.*, 140 F.4th

To determine the scope of review under a statute, "we begin with the strong presumption in favor of judicial review," which can only be overcome by "clear and convincing indications that Congress meant to foreclose review." *SAS Inst., Inc. v. Iancu*, 584 U.S. 357, 370 (2018) (internal citation omitted); *see also Guerrero-Lasprilla v. Barr*, 589 U.S. 221, 229 (2020) (collecting cases). "To the extent there is ambiguity in the [provision] it must be resolved in [] favor" of providing for judicial review. *Salinas v. United States R.R. Ret. Bd.*, 592 U.S. 188, 196 (2021) (internal quotation and citation omitted); *McLaughlin Chiropractic Assocs., Inc. v. McKesson Corp.*, 606 U.S. 146, 162 (2025) ("[A]mbiguity does not suffice to deprive a party of that judicial review."). This presumption applies even when reviewing "statutes that [expressly] limit or preclude review." *Cuozzo Speed Techs. v. Com. for Intell. Prop.*, 579 U.S. 261, 273 (2016). "[I]n other words, the presumption dictates that such provisions must be read narrowly." *El Paso Natural Gas Co. v. United States*, 632 F.3d 1272, 1276 (D.C. Cir. 2011).

There is no indication—much less "clear and convincing indications"—that Congress intended to bar judicial review of Defendants' NSA Schemes. The NSA 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." 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). The only "determination" an IDRE makes under subparagraph (A) is its decision to "select one of the offers submitted . . . to be the amount of payment." *Id.* § 300gg-111(c)(5)(A). The text of the Judicial Review Provision thus only precludes review of an individual "Payment Determination." *See id.* Defendants simply ignore this narrowing language. HaloMD Br. 15; MPOWER Br. 5. Nothing in the NSA suggests determinations concerning IDR eligibility are barred from review; it certainly does not state that a scheme involving hundreds of ineligible disputes is immune from

613, 620 (5th Cir. 2025) (dismissing claim by plaintiff who disputed payment determination, not eligibility).

judicial review.

The Departments' NSA-implementing regulations confirm that the Judicial Review Provision is strictly limited to an IDRE payment determination, and there is no limitation that applies to the NSA Schemes.[8] Under 45 C.F.R. § 149.510(c)(4)(vii) ("Effects of Determination"), HHS specified that "[a] determination made by a certified IDR entity under paragraph (c)(4)(ii) of this section . . . is not subject to judicial review[.]" The sole determination described under (c)(4)(ii) is the IDRE's decision to "[s]elect as the out-of-network rate for the qualified IDR item or service one of the offers submitted" by the parties. The regulatory language addressing IDRE decisions on eligibility appears in a different provision: paragraph (c)(1)(v) ("[T]he certified IDR entity selected must . . . determine whether the Federal IDR process applies."). Like the NSA itself, these regulations confirm the limitation on judicial review does not apply to any decisions regarding eligibility, which is at the heart of Defendants' fraud.

Congress has created an extremely narrow restriction on judicial review that applies exclusively to an IDRE's payment determinations "under subparagraph (A)." 42 U.S.C. § 300gg-111(c)(5)(E). Had Congress intended to broadly preclude judicial review of all decisions by an IDRE under the NSA, it would have done so. This is evident in Sound Physicians Providers' cited case law (Sound Br. 7), which addresses expansive judicial review provisions providing that "[n]o determination, finding, action, or omission under this chapter shall be subject to judicial review." *Ctr. for Biological Diversity v. Bernhardt*, 946 F.3d 553, 561 (9th Cir. 2019) (applying provision of the Congressional Review Act); *Montanans For Multiple Use v. Barbouletos*, 568 F.3d 225, 229 (D.C. Cir. 2009) (applying identical provision of

[8] HHS could not use a regulation to expand a statutory bar on judicial review. *See Kucana v. Holder*, 558 U.S. 223, 248 (2010) ("If Congress wanted the jurisdictional bar to encompass decisions specified . . . by regulation along with those [specified] by statute . . . Congress could easily have said so.").

National Forest Management Act).[9] Congress could have insulated any decision by an IDRE from judicial review. Instead, it limited review only for determinations "under subparagraph (A)."[10]

Congress's decision to limit judicial review solely to an IDRE's payment determination—and not issues involving eligibility—is both common sense and consistent with a long line of precedent. Even for contractual arbitration—where, unlike here, the parties have consented to the process—the question of arbitrability is still "undeniably an issue for judicial determination. Unless the parties clearly and unmistakably provide otherwise, the question of whether [and what] the parties agreed to arbitrate is to be decided by the court, not the arbitrator." *See AT&T Techs., Inc. v. Commc'ns Workers of Am.*, 475 U.S. 643, 649 (1986). Consistent with this principle, the NSA does not prevent this Court from reviewing Defendants' NSA Schemes involving hundreds of fraudulent misrepresentations as to eligibility.

2. The NSA Does Not Incorporate the FAA's Procedures, Much Less Impose Them as an Exclusive Remedy.

Defendants' Judicial Review Provision arguments fail for a second independent reason: the NSA does not incorporate any of the FAA's procedural provisions, much less impose them as exclusive remedies. *See Med-Trans Corp. v. Cap. Health Plan, Inc.*, 700 F. Supp. 3d 1076, 1082 (M.D. Fla. 2023) ("The FAA's procedural law does not govern appeals of NSA IDR awards.").

The NSA provides that "[a] determination of a certified IDR entity under subparagraph (A) . . . shall not be subject to judicial review, except in a case described

[9] MPOWER Providers cite a series of inapposite cases addressing an unrelated issue: whether certain preconditions for seeking judicial review under other statutes constitute "a jurisdictional requirement" or "simply a mandatory claim-processing rule." *Riley v. Bondi*, 606 U.S. 259, 263 (2025) ("30-day filing deadline" under the INA was not jurisdictional); *Santos-Zacaria v. Garland*, 598 U.S. 411, 431 (2023) (exhaustion requirement under INA not a jurisdictional precondition to judicial review); *Pakootas v. Teck Cominco Metals, Ltd.*, 646 F.3d 1214, 1219 (9th Cir. 2011) (rejecting argument that "statute merely regulates timing, and is not a true jurisdictional statute").

[10] *Acker v. Tarr* is inapposite. That case simply applied a narrow bar on judicial review of discretionary military classification decisions because the plaintiff challenged precisely such a classification. 486 F.2d 654, 656 (7th Cir. 1973).

in any of paragraphs (1) through (4) of section 10(a) of title 9 [*i.e.*, the FAA]." 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). The cited paragraphs outline four circumstances in which a party may challenge an arbitration award. *See* 9 U.S.C. § 10(a)(1)-(4). As the court in *Med-Trans* noted:

> Although this explains the grounds upon which a party may challenge an award, it does not discuss how to raise this challenge. In the FAA, those rules are found in other sections, such as §§ 6, 9, and 12 of the FAA. But the NSA does not invoke or discuss §§ 6, 9, 12, or any other sections of the FAA . . . . [C]ourts must presume that a legislature says in a statute what it means and means in a statute what it says there. Congress invoked four paragraphs of the FAA to describe "cases" where an IDR decision may be "subject to judicial review"—nothing more. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). The FAA's procedural requirements for vacating an award . . . are not incorporated.

700 F. Supp. 3d at 1083 (internal citations omitted); *see also Guardian Flight*, 140 F.4th at 276 ("Congress chose not to incorporate § 9 [governing award confirmation] into the NSA.").

In contrast to the NSA, Congress has expressly incorporated FAA procedures into multiple other statutes, either by listing out each provision or incorporating all of Title 9. *See, e.g.*, 5 U.S.C. § 580(c) (government employment disputes) ("A final award . . . may be enforced pursuant to sections 9 through 13 of title 9."); 29 U.S.C. § 1401 (ERISA) (awards shall be enforced "under Title 9"); 35 U.S.C. § 294 (patent disputes) ("[A]wards by arbitrators and confirmation of awards shall be governed by title 9 . . . ."); 41 U.S.C. § 7107 (agency contract disputes) ("[C]onfirmation of

awards shall be governed by title 9.").

Defendants' request to read the FAA's procedures into the NSA violates fundamental principles of statutory interpretation:

> It is a fundamental principle of statutory interpretation that absent provision[s] cannot be supplied by the courts. To do so is not a construction of a statute, but, in effect, an enlargement of it by the court. Atextual judicial supplementation is particularly inappropriate when, as here, Congress has shown that it knows how to adopt the omitted language or provision.

Rotkiske v. Klemm, 589 U.S. 8, 14 (2019) (citations and internal quotations omitted); *accord Turtle Island Restoration Network v. Evans*, 284 F.3d 1282, 1296 (Fed. Cir. 2002) ("When Congress omits from a statute a provision found in similar statutes, the omission is typically thought deliberate.").

None of Defendants' authorities support the proposition that "the exclusive means to challenge an IDR award is to seek vacatur under the FAA." MPOWER Br. 8. Some simply held that the NSA "contains no express right of action to enforce or confirm an IDR award." *Guardian Flight*, 140 F.4th at 275; *Mod. Orthopedics of NJ*, 2025 WL 3063648, at *5 (holding that IDR awards are not subject to confirmation under FAA Section 9 because "[t]he NSA is not arbitration and there is no enforceable arbitration award"). Others denied petitions to vacate IDR payment determinations pursuant to the FAA where: (1) the petitioner did not assert any other claims; (2) the petitioner did not dispute that the IDR payment determination at issue involved a qualified IDR service; and thus (3) the court had no reason to consider the scope of the NSA's Judicial Review Provision or whether it applies to conduct like the NSA Scheme. *See Aetna*, 140 F.4th at 620 (denying vacatur because petitioner failed to adequately plead fraud); *Worldwide Aircraft Servs. Inc. v. Worldwide Ins.*

Servs., LLC, No: 8:24-cv-840-TPB-CPT, 2024 WL 4226799, at *3 (M.D. Fla. Sept. 18, 2024) (denying vacatur because undisputed record evidence rendered allegations implausible); *Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc.*, 160 F.4th 1110, 1114 (11th Cir. 2025) (denying vacatur because IDRE's reasoning for payment determination is not subject to judicial review); *see also, e.g.*, *Avraham Plastic Surgery LLC v. Aetna, Inc.*, No. 25-cv-784 (OEM) (SDE), 2025 WL 3779084, at *1, 3, 7 (E.D.N.Y. Dec. 30, 2025) (denying petition to vacate IDR payment determinations under the FAA because "Petitioners thus fail to demonstrate that a zero-dollar award is a violation of [the IDRE's] duties under the NSA[.]"). The alleged facts and relief sought in those actions are not relevant to the AC.

Under the NSA's plain language, Anthem may seek "judicial review" of an IDRE's payment determination in any "case described in any of paragraphs (1) through (4) of section 10(a) of title 9." 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). Anthem is seeking judicial review of Defendants' NSA Schemes, and not any individual IDRE payment determination. *See supra*. But to the extent the Court finds the Judicial Review Provision applies, Anthem is entitled to judicial review where, as here, the IDREs "exceeded their powers" by issuing payment determinations on disputes that were ineligible for IDR.[11] 9 U.S.C. § 10(a)(4).

The NSA only permits IDREs to issue a payment determination for a "qualified IDR item or service." 42 U.S.C. § 300gg-111(c)(5)(A). Anthem pleads that IDREs issued hundreds of payment determinations for services that were not a "qualified IDR item or service." *E.g.* AC, ¶ 128. As contemplated by the Judicial Review Provision, this is a "case described in" 9 U.S.C. § 10(a)(4) because the IDREs

[11] *Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc.* is inapposite. The plaintiff in *Reach Air* argued that an IDRE exceeded its authority by applying an improper presumption in favor of the plan's (misstated) QPA when making a payment determination. 160 F.4th 1110, 1117 (11th Cir. 2025). The court noted that "an arbitrator's actual reasoning" for a payment determination was irrelevant to 9 U.S.C. 10(a)(4) because the sole question is whether "the arbitrator (even arguably) performed the assigned task." *Id*. at 1120. Here, Anthem argues that IDREs issuing awards for ***ineligible*** claims and thus strayed from their "assigned task." *See id*.

exceeded their authority by "purport[ing] to exercise powers that the parties did not intend [them] to possess." *EHM Prods., Inc. v. Starline Tours of Hollywood, Inc.*, 1 F.4th 1164, 1174 (9th Cir. 2021) (internal citation omitted).[12]

Anthem may also seek "judicial review" of IDR payment determinations because "the award was procured by . . . fraud" (9 U.S.C. § 10(a)(1)) through Defendants' false attestations of eligibility. "[P]erjury materially related to an issue in the arbitration" is sufficient to meet this standard. *See Bonar v. Dean Witter Reynolds, Inc.*, 835 F.2d 1378, 1383-84 (11th Cir. 1988).[13]

Defendants cite authorities like *A.G. Edwards & Sons* v. *McCollough* for the proposition that if fraud is "discovered and brought to the attention of the arbitrators, a disappointed party will not be given a second bite at the apple." 967 F.2d 1401, 1404. (9th Cir. 1992). But this principle presumes the existence of an opportunity to litigate the alleged fraud "at a confrontational, adversarial hearing[.]" *Pour Le Bebe, Inc. v. Guess? Inc.*, 112 Cal. App. 4th 810, 833 (2003) (cited with approval by *Mohazzabi v. Wells Fargo Bank, N.A.*, No. 22-15357, 2023 WL 4449179, at *1 (9th Cir. July 11, 2023)). Here, there was no such "confrontational, adversarial hearing" on eligibility. *See supra* at 5-8. While Anthem did often object to eligibility, there is no indication that "the arbitrators had all the material information before them" and actually addressed the disputed misrepresentation. *Scott v. Prudential Sec., Inc.*, 141 F.3d 1007, 1015, n.16 (11th Cir. 1998); *see supra* at 5-8. Defendants have overwhelmed the IDR system as part of their NSA Schemes to push ineligible disputes through to payment determinations. *See supra* at 10-14. The IDREs

[12] Defendants cite *Schoenduve Corp. v. Lucent Techs., Inc.*, 442 F.3d 727, 733 (9th Cir. 2006) to suggest that courts must defer to an arbitrator's determination that a dispute is subject to arbitration. But that case involved an arbitrator's interpretation of a "submission agreement" purporting to define the scope of a dispute that undisputedly was encompassed within a contractual arbitration agreement. *Id*. The law is clear that "the question of whether the parties agreed to arbitrate" an issue in the first place "is to be decided by the court, not the arbitrator." *See AT&T Techs., Inc. v. Commc'ns Workers of Am.*, 475 U.S. 643, 649 (1986).

[13] Defendants' citation to other cases involving fraud in IDR proceedings are inapposite. *See Guardian Flight*, 140 F.4th at 622 (plaintiff failed to plead any specific misrepresentation about QPA in single IDR proceeding); *Reach Air*, 160 F.4th at 1122 (same).

generally issue no written eligibility decisions at all, much less decisions addressing any claims of fraud. *See id.* at 5-8.

In any event, "[f]raud properly embraces a situation in which the supposedly neutral arbitrator exhibits a complete unwillingness to respond . . . to any evidence or argument in support of one of the parties' positions." *Pac. & Arctic Ry. & Nav. Co. v. United Transp. Union*, 952 F.2d 1144, 1148 (9th Cir. 1991). This is precisely what has occurred in the underlying IDR proceedings, in which IDREs are not required to consider Anthem's objections and are financially incentivized to disregard them. *See* AC, ¶ 116.

B. Anthem's Claims Are Not a Collateral Attack on IDR Determinations.

Because the NSA does not incorporate the FAA's procedural provisions, Defendants' arguments about "collateral attacks" on IDR determinations are inapposite. In *Sander v. Weyerhaeuser Co.*, the Ninth Circuit reasoned that the bar on collateral attacks was necessary because the three-month notice requirement in FAA § 12 for a motion to vacate would be "meaningless if a party to the arbitration proceedings may bring an independent direct action asserting such claims outside of the statutory time period provided for in section 12." 966 F.2d 501, 503 (9th Cir. 1992) (citing *Corey v. New York Stock Exchange*, 691 F.2d 1205, 1213 (6th Cir. 1982)); *see also Bachman Sunny Hill Fruit Farms, Inc. v. Producers Agric. Ins. Co.*, 57 F.4th 536, 541 (6th Cir. 2023) ("The holdings of *Decker* and *Corey* follow from the FAA's exclusive remedies."); *Nickoloff v. Wolpoff & Abramson, L.L.P.*, 511 F. Supp. 2d 1043, 1044 (C.D. Cal. 2007) (disallowing collateral attack on contractual debt collection arbitration pursuant to National Arbitration Forum "National Arbitration Code of Procedure" and subject to all FAA procedural limitations); *Credit Suisse AG v. Graham*, 533 F. Supp. 3d 122, 133 (S.D.N.Y. 2021) (bar on collateral attacks rooted in § 12 time limitations). The principle has no bearing here

given that "the NSA does not invoke or discuss §§ 6, 9, 12, or any other sections of the FAA." *Med-Trans*, 700 F. Supp. 3d at 1083.

Moreover, regardless of whether the FAA's procedures apply (they do not), Anthem seeks injunctive and other relief that cannot possibly be construed as a collateral attack on any prior IDR award. To decide whether a claim constitutes a collateral attack, courts "look to the requested relief and its relationship to the alleged wrongdoing and purported harm." *Tex. Brine Co., L.L.C. v. Am. Arb. Ass'n, Inc.*, 955 F.3d 482, 489 (5th Cir. 2020). If the plaintiff's damages are simply the "award it believes it should have received," it is a collateral attack. *Gulf Petro Trading Co., Inc. v. Nigerian Nat. Petroleum Corp.*, 512 F.3d 742, 750 (5th Cir. 2008); *see also Decker v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 205 F.3d 906, 910 (6th Cir. 2000) (plaintiff sought only to "rectify the alleged harm she suffered by receiving a smaller arbitration award than she would have received"); *Wachovia Sec., LLC, v. Wiegand*, No. 07CV243 IEG (BLM), 2007 WL 9776732, at *5 (S.D. Cal. Apr. 16, 2007) ("Unlike *Decker*, Wiegand did not allege that Wachovia's wrongful conduct in terminating his employment harmed him only by its impact on the Rooney award . . . Wiegand's statement of claim, taken on its face, is not a collateral attack on the Rooney award.").

Anthem is not seeking damages that it sought and failed to procure in the underlying IDR proceedings. Instead, Anthem is challenging Defendants' NSA Schemes—which are far broader than any individual IDR proceeding—and seeks relief that it could not have obtained either in the IDR proceedings or via its alternative claim for vacatur (Count XI).

First, Anthem seeks "[i]njunctive relief prohibiting the Provider Defendants and HaloMD from continuing to submit false attestations and initiate IDR for items or services that are not qualified for IDR" to prevent future injury from the NSA Scheme. AC, ¶ 369. Defendants cite no authority that could possibly preclude

prospective relief, which is not available in IDR or through vacatur.[14]

Second, Anthem seeks categories of damages that were neither recoverable in the IDR process nor the result of any IDR determination. These include: (1) time and money spent addressing Defendants' fraudulent submissions, and (2) IDR administrative fees paid to HHS, which are not refundable. *See supra* at Argument, Section I.A. Anthem incurs these damages even in the IDR proceedings in which it prevails. Anthem could not recover either category of damages in IDR or through vacatur, and thus they cannot possibly be construed as providing Anthem with the "award it believes it should have received." *Gulf Petro Trading Co., Inc.*, 512 F.3d at 750.

C. The *Noerr-Pennington* Doctrine Does Not Immunize Defendants From Liability for Their Fraudulent NSA Scheme.

Defendants defrauded Anthem by initiating hundreds of IDR proceedings with knowingly false attestations of eligibility to obtain millions of dollars in payment determinations for patently ineligible disputes. Defendants claim that they were engaging in "core petitioning activity protected by the First Amendment," and their fraudulent NSA Schemes should therefore be immune to liability under the *Noerr-Pennington* doctrine. *E.g.*, HaloMD Br. 17.

Defendants' argument is inappropriate at the motion to dismiss stage. The question of whether "something is a genuine effort to influence government action, or a mere sham is a question of fact." *Clipper Exxpress v. Rocky Mountain Motor Tariff Bureau, Inc.*, 690 F.2d 1240, 1253-54 (9th Cir. 1982). Courts thus "rarely award *Noerr-Pennington* immunity at the motion to dismiss stage, where the Court must accept as true the nonmoving party's well-pleaded allegations." *Sonus Networks, Inc. v. Inventergy, Inc.*, No. C-15-0322 EMC, 2015 WL 4539814, at *2 (N.D. Cal. July 27, 2015); *see also In re Xyrem (Sodium Oxybate) Antitrust Litig.*,

[14] In *Texas Brine*, the plaintiff's only "equitable" relief was "disgorge[ment]" of amounts paid during the arbitration," not injunctive relief. 955 F.3d at 489.

555 F. Supp. 3d 829, 877 (N.D. Cal. 2021) (same).

In any event, Defendants' argument fails as a matter of law for at least two additional reasons. First, IDR disputes "before a private organization do not implicate the First Amendment," such that applying *Noerr* immunity would be "far-removed from the constitutional foundation for the doctrine." *Ford Motor Co. v. Nat'l Indem. Co.*, 972 F. Supp. 2d 862, 868-69 (E.D. Va. 2013). Second, even in public court proceedings, "if the alleged anticompetitive behavior consists of making intentional misrepresentations to the court," it is not entitled to *Noerr* immunity. *Kottle v. Nw. Kidney Ctrs.*, 146 F.3d 1056, 1060 (9th Cir. 1998) (internal citation omitted).

1. *Noerr* Immunity Does Not Apply in a Private Commercial Dispute.

Noerr immunity does not apply to Defendants' false statements made as part of a private payment dispute before private companies (IDREs). *Ford Motor Co.*, 972 F. Supp. 2d at 868-69.

Noerr immunity is premised on the First Amendment's Petition Clause, which "guarantees the right 'to petition the Government for a redress of grievances.'" *Kottle*, 146 F.3d at 1059 (quoting U.S. Const. amend. I, cl. 6). The doctrine protects "conduct (including litigation) aimed at influencing decision making by the government." *Octane Fitness, LLC v. ICON Health & Fitness, Inc.*, 572 U.S. 545, 556 (2014) (applying *Noerr* immunity to statement sin public court litigation). The Supreme Court created the doctrine to immunize legitimate efforts to lobby the government. *See, e.g.*, *BE & K Constr. Co. v. N.L.R.B.*, 536 U.S. 516, 525-27 (2002). The Ninth Circuit has consistently applied it only to actions that seek relief from a defendant's petitioning of the government. *See*, *e.g.*, *Sosa v. DIRECTV, Inc.*, 437 F.3d 923, 929 (9th Cir. 2006) ("Under the *Noerr–Pennington* doctrine, those who petition any department of the government for redress are generally immune from statutory liability for their petitioning conduct."); *B&G Foods N. Am., Inc. v. Embry*,

29 F.4th 527, 535 (9th Cir. 2022) ("The doctrine immunizes petitions directed at any branch of government, including the executive, legislative, judicial and administrative agencies.") (quoting *Manistee Town Ctr. v. City of Glendale*, 227 F.3d 1090, 1092 (9th Cir. 2000)).

The AC alleges that Defendants submit false attestations of eligibility in non-public IDR proceedings before private IDREs. AC, ¶ 96. Such statements "before a private organization do not implicate the First Amendment." *Ford Motor Co.*, 972 F. Supp. 2d at 868-69. Because "the First Amendment only protects citizens from government conduct infringing on free speech," *Noerr* does not protect petitions to private companies, such as the IDREs. *Golden Eye Media USA, Inc. v. Trolley Bags UK Ltd.*, 525 F. Supp. 3d 1145, 1240–41 (S.D. Cal. 2021).

There is no precedent from the Supreme Court, the Ninth Circuit, or any other U.S. Court of Appeals to support applying *Noerr* immunity to petitioning directed to non-governmental bodies. Defendants can therefore cite only inapt, distinguishable, and unpersuasive decisions in their effort to stretch *Noerr* beyond its recognized scope. The MPOWERHealth Defendants assert that *Noerr* applies to IDR because "the IDR procedure has the character of an agency adjudication." MPOWERHealth Br. 15-16. But the only authority they cite for that proposition is *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, which held that *Noerr* immunity applies only where the harm at issue "is the result of valid *governmental* action, as opposed to private action." 486 U.S. 492, 499 (1998) (emphasis added); *see Cal. Motor Transp. Co. v. Trucking Unlimited*, 404 U.S. 508, 510 (1972); (*Noerr* arises from "the right to petition . . . the Government" and applies only to allegations of harm to the plaintiff resulting directly from action by government officials); *see also Entrepreneur Media, Inc. v. Dermer*, No. SACV181562JVSKESX, 2019 WL 4187466, at *3 (C.D. Cal. July 22, 2019) (applying *Noerr* to conduct directed at the United States Patent and

Trademark Office, a federal government agency).[15]

HaloMD's and the Sound Physicians Providers' citation to *Viriyapanthu v. California*, No. SACV172266JVSDFMX, 2018 WL 6136150 (C.D. Cal. Sept. 24, 2018), also does not support application of *Noerr* to IDR. In that case, the plaintiff's claims arose from Mandatory Fee Arbitration Act ("MFAA") proceedings before the Orange County Bar Association ("OCBA"). *Id.* at *1. The district court dismissed the claims based on application of *Noerr* among other grounds. *Id.* at *7-*10.

At the outset, unlike IDR, there is a direct relationship between MFAA proceedings and litigation in the public courts because, by statute, "MFAA arbitration rulings are reviewable via a trial de novo in superior court." *Dorit v. Noe*, 49 Cal. App. 5th 458, 470 (2020). Moreover, the plaintiff in *Viriyapanthu* never disputed that petitions to the OCBA constituted First Amendment petitioning. To the contrary, he alleged "that OCBA acts with governmental authority," and "that the OCBA arbitrators who decided the arbitration award are actually government officials . . . ." *Id.* at *10 (internal quotation marks omitted). The issue of whether *Noerr* applies to non-government arbitral bodies was, therefore, never litigated. And on appeal, the Ninth Circuit affirmed on alternative grounds (failure to comply with Rule 9(b)), finding it unnecessary to address *Noerr* at all. 813 F. App'x 312, 313 (9th Cir. 2020).

Sound Physicians Providers' reliance on *Eurotech, Inc. v. Cosmos Eur. Travels Aktiengesellschaft*, is likewise misplaced. 189 F. Supp. 2d 385, 392 (E.D. Va. 2002). *Eurotech* applied *Noerr* to an action arising from a single dispute brought under the World Intellectual Property Organization's ("WIPO") Uniform Domain Name Dispute Resolution ("UDRP") Policy. The court described WIPO as a "quasi-public organization that is an integral part of the United Nations." 189 F. Supp. 2d at 392.

[15] Defendants make false statements to HHS to access the IDR process, but *Noerr* does not apply if "the government acts in a [] ministerial or non-discretionary capacity in direct reliance on the representations made by private parties." *In re Buspirone Pat. Litig.*, 185 F. Supp. 2d 363, 369 (S.D.N.Y. 2002); *see also Staley v. Gilead Sciences, Inc.*, No. 19-cv-02573-EMC, 2020 WL 5507555, at *16 (N.D. Cal. July 29, 2020) (finding that *Buspirone*'s holding against applying *Noerr* to such requests for ministerial action "provide[s] an accurate framework of analysis . . . .").

WIPO UDRP proceedings involve disputes over the public registration of Internet domain names; such proceedings involve formal complaints, arbitration records, and published reasoned decisions. *See id.*; *WIPO Guide to the UDRP*, WIPO, *available at* https://www.wipo.int/amc/en/domains/decisions.html.

WIPO UDRP proceedings bear no resemblance to IDR. IDREs are not a "quasi-public organization that is an integral part of" a public government agency. Unlike WIPO, Congress has not delegated authority directly to any of the private entities that serve as IDREs; rather, these private entities apply to the Departments to serve as IDREs and function as private contractors. These IDREs are faceless private companies who process thousands of IDR disputes each day. Moreover, IDR proceedings do not involve matters of public concern (*e.g.*, public registration of Internet domain names) or result in published reasoned decisions; they are purely private commercial disputes resulting in privately issued payment determinations with minimal justification or rationale. Because IDR proceedings do not implicate First Amendment concerns, *Noerr* does not apply.

2. *Noerr* Does Not Immunize Fraud in Adjudicatory Proceedings.

Noerr does not apply to Defendants' NSA Schemes for a second, independent reason: Defendants' intentional misrepresentations of fact do not give rise to *Noerr* immunity as a matter of law. *See Trucking Unlimited*, 404 U.S. at 513 ("Misrepresentations . . . are not immunized when used in the adjudicatory process."); *Clipper Exxpress*, 690 F.2d at 1261 ("There is no first amendment protection for furnishing with predatory intent false information to an administrative or adjudicatory body.").

The Ninth Circuit recognizes three circumstances in which the sham litigation exception to *Noerr* may apply. Anthem relies on one, in which the "allegedly unlawful conduct consists of making intentional misrepresentations" in an

adjudicatory proceeding.[16] *Sosa*, 437 F.3d at 938 (quoting *Liberty Lake*, 12 F.3d at 159) (internal quotes omitted); *see also Freeman v. Lasky, Haas & Cohler*, 410 F.3d 1180, 1184 (9th Cir. 2005). Defendants' cited authorities confirm this principle exempts their NSA Schemes from *Noerr* immunity. *See Kottle*, 146 F.3d at 1063 (discussing misrepresentation exception but finding it inapplicable because plaintiff failed to plead any misrepresentations); *see also NM LLC v. Keller*, No. 3:24-cv-05181-TMC, 2024 WL 4336428, at *5 (W.D. Wash. Sept. 27, 2024) (explaining requirements for misrepresentation exception) (internal citation omitted); *U.S. Futures Exch., L.L.C. v. Bd. of Trade of the City of Chicago, Inc.*, 953 F.3d 955, 960 (7th Cir. 2020) (finding fraud exception inapplicable because agency was involved in legislative rule making, not adjudication.

Defendants contend that "Anthem's Amended Complaint does not plausibly allege that . . . [they] knowingly made any false attestations" (HaloMD Br. 18), but this argument fails for the reasons discussed in Section III.B. The AC unquestionably alleges that Defendants' false attestations "deprived the [IDR proceedings] of [their] legitimacy" by allowing initiation of IDR for disputes that were statutorily ineligible. *See Sosa*, 437 F.3d at 938. In the absence of Defendants' misrepresentation, there would have been no IDR proceedings at all. *Cf. Ford Motor Co. v. Knight L. Grp.*, No. 2:25-CV-04550-MWC-PVC, 2025 WL 3306280, at *11 (C.D. Cal. Nov. 24, 2025) (finding defendants' requests for allegedly inflated attorney's fees did not deprive proceeding of legitimacy because plaintiff conceded defendants were entitled to some portion of the requested fees).

D. Collateral Estoppel Does Not Apply to Anthem's Claims.

[16] Defendants' arguments and authorities addressing the other two exceptions—in which plaintiffs are not actually trying to prevail in the underlying proceeding—are inapposite. *See, e.g.*, *Octane Fitness, LLC v. ICON Health & Fitness, Inc.*, 572 U.S. 545, 555-56 (2014); *Pro. Real Estate Inv., Inc. v. Columbia Pictures, Indus.*, 508 U.S. 49, 60 n.5 (1993); *City of Columbia v. Omni Outdoor Advert., Inc.*, 499 U.S. 365, 380 (1991) *B&G Foods N. Am., Inc. v. Embry*, 29 F.4th 527, 538 (9th Cir. 2022); *Manistee Town Ctr. v. City of Glendale*, 227 F.3d 1090, 1095 (9th Cir. 2000); *Boulware v. State of Nev., Dep't of Hum. Res.*, 960 F.2d 793,798 (9th Cir. 1992); *Relevant Grp., LLC v. Nourmand*, 116 F.4th 917, 927-28 (9th Cir. 2024).

Defendants cannot invoke collateral estoppel because it is incompatible with IDR procedures and Anthem's well-pleaded factual allegations. No IDRE has (or can) evaluate Anthem's allegations regarding Defendants' scheme to submit hundreds of knowingly ineligible IDR disputes against Anthem. Nor did Congress (or even the Departments) dictate meaningful procedures in any law or regulation addressing eligibility for any individual IDR proceeding.

In the NSA, Congress did not address, much less delegate, eligibility decision making to IDREs. *See* 42 U.S.C. § 300gg-111. And the regulations simply state that for each individual IDR proceeding, an IDRE "must review the information submitted in the notice of IDR initiation to determine whether the Federal IDR process applies," which only includes information provided by the initiating party (*i.e.*, Defendants). AC, ¶ 73; 45 C.F.R. § 149.510(c)(1)(v). The eligibility decision-making process is "a cursory review by the IDRE based on incomplete, one-sided information." AC, ¶ 73. Nothing in the regulations requires an IDRE to conduct hearings, consider a health plan's factual objections, or issue decisions (written or otherwise) describing their rationale. *See* 45 C.F.R. § 149.510(c)(1)(v); AC, ¶ 84. IDREs also have a vested financial interest in finding a dispute eligible because "they only receive compensation if a dispute reaches a payment determination." *Id.*, ¶ 116.

The Court should disregard Defendants' reliance on nonbinding guidance to dispute the well-pleaded facts in the AC and the plain language of the NSA and its implementing regulations. *See* Regulations, ECF Nos. 76-4 through 76-8. "[C]ourts may judicially notice that statements in public records were made, without noticing the correctness of those statements." *CrossFirst Bank v. Vieste SPE, LLC*, No. 24-7605, 2025 WL 3633294, at *2 (9th Cir. Dec. 15, 2025); *Khoja v. Orexigen Therapeutics, Inc.*, 899 F.3d 988, 999 (9th Cir. 2018) ("a court cannot take judicial notice of disputed facts contained in such public records").[17] Defendants cite

[17] *See also Romero v. Securus Techs., Inc.*, 216 F. Supp. 3d 1078, 1085 (S.D. Cal. 2016) ("While matters of public record are proper subjects of judicial notice, a court may take notice only of the

nonbinding guidance documents to argue that IDREs "must review the information submitted in . . . the notification from the non-initiating party claiming the Federal IDR Process is inapplicable . . . to determine whether the Federal IDR process applies." HaloMD Br. 14 (quoting ECF No. 76-5). But that is not evidence of a full and fair process. In fact, following the nonbinding guidance, the Departments admonished IDREs to "reduce errors" and institute "robust quality assurance (QA) programs to verify dispute eligibility[.]" ECF No. 76-8, at 1. Defendants cannot rely on nonbinding guidance to contradict the plain language of the NSA[18] and controlling regulations, which do not require a meaningful eligibility evaluation process.

Collateral estoppel is an affirmative defense, and "[t]he party asserting preclusion bears the burden of showing with clarity and certainty what was determined by the prior judgment. It is not enough that the party introduce the decision of the prior court; rather, the party must introduce a sufficient record of the prior proceeding to enable the trial court to pinpoint the exact issues previously litigated." *Clark v. Bear Stearns & Co.*, 966 F.2d 1318, 1321 (9th Cir. 1992). As a result, "collateral estoppel cannot apply without a record showing the specific issues litigated in arbitration." *Crafty Prods., Inc. v. Fuqing Sanxing Crafts Co.*, 839 F. App'x 95, 98 n. 2 (9th Cir. 2020). Here, Defendants do not and cannot submit a record of any underlying eligibility "decision" to support their assertion of collateral estoppel for any IDR proceedings. Thus, their argument fails at the outset.

Defendants also cannot establish the elements of collateral estoppel. The doctrine requires Defendants to show that: "(1) the issue at stake was identical in both

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existence and authenticity of an item, not the truth of its contents.") (*citing Lee v. City of Los Angeles*, 250 F.3d 668, 689–90 (9th Cir. 2001)); *California Sportfishing Prot. All. v. Shiloh Grp., LLC*, 268 F. Supp. 3d 1029, 1038 (N.D. Cal. 2017) ("when courts take judicial notice of administrative records, only the existence of the documents themselves including the findings therein are judicially noticeable, and not the contents of the documents for the truth of the matters asserted").

[18] Even if the NSA were ambiguous (it is not), courts "may not defer to an agency interpretation of the law simply because a statute is ambiguous." *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 413 (2025).

proceedings; (2) the issue was actually litigated and decided in the prior proceedings; (3) there was a full and fair opportunity to litigate the issue; and (4) the issue was necessary to decide the merits." *Hansen v. Musk*, 122 F.4th 1162, 1172 (9th Cir. 2024). Defendants have not and cannot meet at least the first three elements.

1. IDREs Did Not Determine Whether Defendants Engaged in Fraud, and the Issues Are Not Identical.

IDREs' eligibility "decisions" are limited in scope. Regulations only require IDREs to "review[] the notice of IDR initiation" with the provider's attestation of eligibility "to determine whether the Federal IDR process applies." AC, ¶ 73; 45 C.F.R. § 149.510(c)(1)(v). The issue before this Court is categorically different: whether Defendants made hundreds of fraudulent attestations of eligibility to the IDR Portal as part of a scheme to defraud Anthem in violation of RICO, ERISA, and California statutes and torts. These are "two, quite separate inquiries." *See United States v. Carpentieri*, 23 F. Supp. 2d 433, 435–36 (S.D.N.Y. 1998) (distinguishing, for the purposes of a statute barring judicial review, between two questions: (1) "whether [defendant] falsified his initial employment papers and his claim forms for FECA" and (2) whether the defendant's "submission, if not fraudulent, establishes eligibility for benefits").

1. Defendants' Fraud Was Neither Litigated Nor Necessary.

IDREs have no obligation to consider Anthem's objections and rarely, if ever, issue written decisions addressing those objections. Accordingly, Anthem's challenges to eligibility were "not 'actually litigated' and could not possibly have been 'critical and necessary' to the judgment." *CSX Transp., Inc. v. Bhd. of Maint. of Way Emps.*, 327 F.3d 1309, 1318 (11th Cir. 2003). Moreover, no IDRE has the authority to review Defendants' fraudulent NSA Schemes involving hundreds of ineligible disputes.

2. Anthem Did Not Have a Full and Fair Opportunity.

Collateral estoppel also does not apply where, as here, "there is reason to doubt the quality, extensiveness, or fairness of the procedures followed in prior litigation." *Kremer v. Chem. Constr. Corp.*, 456 U.S. 461, 481 (1982); *Clements v. Airport Auth. of Washoe Cnty.*, 69 F.3d 321, 328 (9th Cir. 1995) ("[W]e do not give preclusive effect to judgments rendered in proceedings that fail to comply with the minimum standards of due process"); *see Bravo-Fernandez v. United States*, 580 U.S. 5, 10 (2016) (preclusion requires "confidence that the result achieved in the initial litigation was substantially correct").

"When determining whether a party received a full and fair opportunity to litigate an issue, the inquiry is whether the minimum due process requirements guaranteed by the fourteenth amendment are satisfied." *Caldeira v. Cnty. of Kauai*, 866 F.2d 1175, 1180 (9th Cir. 1989). And "[a]t a minimum, Due Process requires a hearing before an impartial tribunal." *Clements*, 69 F.3d at 333; *see also Collier v. Reliastar Life Ins. Co.*, 589 F. App'x 821, 823 (9th Cir. 2014) (collateral estoppel requires "a hearing before an impartial decision maker") (applying California law).

Under the NSA, however, IDRE eligibility "decisions" are not impartial. Under the "the judicial-impartiality requirement," "a judge's income can't directly depend on how he decides matters before him." *Harper v. Pro. Prob. Servs. Inc.*, 976 F.3d 1236, 1241, 1243-44 (11th Cir. 2020) (because defendant received a "$40 monthly fee only as long as a probationer remained on probation . . . it couldn't determine probation sentencing matters impartially"); *Caliste v. Cantrell*, 937 F.3d 525, 530 (5th Cir. 2019) ("[i]ncentives that most obviously violate the right to an impartial magistrate are those that . . . put money directly into a judge's pocket"); *Alpha Epsilon Phi Tau Chapter Hous. Ass'n v. City of Berkeley*, 114 F.3d 840, 844 (9th Cir. 1997) ("due process is violated if a decisionmaker has a 'direct, personal, substantial pecuniary interest' in the proceedings) (quoting *Tumey v. Ohio*, 273 U.S.

510, 523 (1927)); *Brewster v. City of Los Angeles*, 672 F. Supp. 3d 872, 965 (C.D. Cal. 2023) ("When procedures already lack avenues for a meaningful hearing, as do the procedures here, a potentially biased hearing officer serves to increase the chances of an erroneous deprivation of property."); *McNeil v. Cmty. Prob. Servs., LLC*, No. 1:18-cv-00033, 2021 WL 366776, at *18 (M.D. Tenn. Feb. 3, 2021) (collecting cases). IDREs only receive payment if they agree that a dispute is eligible. AC, ¶¶ 80, 116. This financial incentive flunks the judicial-impartiality requirement.

Indeed, HaloMD submitted 134,318 disputes in the second half of 2024. AC, ¶ 110. The IDREs deciding those disputes stood to earn tens of millions of dollars if, and only if, they decided eligibility in HaloMD's favor. AC, ¶ 80; 42 U.S.C. § 300gg-111(c)(5)(F). Judges are typically compensated with a salary, and arbitrators are paid for all their work on a case up through the point of dismissal. But per the NSA, an IDRE who dismisses a dispute as ineligible forfeits the right to any compensation at all. *Id*. Because IDREs have an immediate financial stake in the outcome of their eligibility "decisions," they are not impartial fact finders to whom collateral estoppel applies.

Separate from partiality, the "claim preclusive effect . . . does not hold universally" to non-judicial proceedings. *Littlejohn v. United States*, 321 F.3d 915, 921 (9th Cir. 2003). The law is clear that estoppel cannot apply where the procedures in the prior proceeding "provided [a party] with neither the tools nor the opportunity to fully litigate" the relevant issues. *Id*.; *see also Maciel v. Comm'r*, 489 F.3d 1018, 1023 (9th Cir. 2007) (If "procedural opportunities unavailable in the first action could readily cause a different result in the second action, then the results of the first action generally should not be given preclusive effect.") (internal punctuation omitted).

Collateral estoppel especially does not apply where, as here, the procedures in the prior proceeding were "tailored to the prompt, inexpensive determination of small claims" that would be "wholly inappropriate to the determination of the same issues

when presented in the context of a much larger claim." Restatement (Second) of Judgments § 28 (1982);[19] *Staub v. Nietzel*, No. 22-5384, 2023 WL 3059081, at *6 (6th Cir. Apr. 24, 2023) (courts may refuse to apply estoppel where "an earlier action involved relaxed rules of evidence, a system to quickly determine [claims], and concerned minimal amounts of damages"); *see Parklane Hosiery Co. v. Shore*, 439 U.S. 322, 332 (1979) (collateral estoppel should not apply if there are "procedural opportunities available" in the second suit "that were unavailable in the first . . . [and] might be likely to cause a different result"); *Grimes v. BNSF Ry. Co.*, 746 F.3d 184, 188 (5th Cir. 2014) ("If the procedural differences might be likely to cause a different result, then collateral estoppel is inappropriate.").[20]

MPOWERHealth and the LaRoque Family Providers generalize that "[i]ssue preclusion includes administrative determinations and arbitration awards." MPOWER Br. 11. But their cited authorities confirm that courts must carefully consider the adequacy of procedures in prior proceedings. *See B & B Hardware, Inc.*, 575 U.S. at 158 (courts must ask "whether the procedures used in the first proceeding were fundamentally poor, cursory, or unfair"); *Hansen v. Musk*, 653 F. Supp. 3d 832, 835 (D. Nev. 2023), *aff'd*, 122 F.4th 1162 (9th Cir. 2024) ("[T]he parties exchanged pre-trial briefing and then participated in a three-day hearing, where several witnesses testified and were subject to direct examination, cross-examination, re-direct examination, and re-cross examination . . . The hearing was followed by an additional round of briefing.").

Here, Congress deliberately created IDR as an informal process to efficiently

[19] In deciding whether to apply collateral estoppel, the Supreme Court "regularly turns to the Restatement (Second) of Judgments." *B & B Hardware, Inc. v. Hargis Indus., Inc.*, 575 U.S. 138, 148 (2015).

[20] *See also Helfrich v. Lehigh Valley Hosp.*, No. 03-cv-05793, 2005 WL 1715689, at *19 (E.D. Pa. July 21, 2005) ("[P]rocedural and economic disparities between unemployment compensation proceedings and later civil proceedings negate the preclusive effect of a Referee's factual findings."); *Cold Springs Farm Dev., Inc. v. Ball*, 661 A.2d 89, 91–92 (Vt. 1995) (informality of small claims court procedures render estoppel inapplicable); *Clusiau v. Clusiau Enters., Inc.*, 236 P.3d 1194, 1198–99 (Az. Ct. App. 2010) (collecting cases).

resolve what were expected to be relatively low-value payment disputes without the need for legal counsel. IDR "is not an arbitration"; rather, "IDR is—by statute—a highly-restricted process." *Mod. Orthopaedics of NJ v. Premera Blue Cross*, No. 2:25-CV-01087 (BRM) (JSA), 2025 WL 3063648, at *6 (D.N.J. Nov. 3, 2025) (explaining the "differences [that] pervade the IDR and arbitration processes"). The parties are given a single opportunity to provide the referee with supporting documents and evidence . . . there is no opportunity for briefing, hearing, or appeal." *Id.* There is also no discovery, no evidentiary requirements, and no procedures to even view—much less verify or rebut—an opposing party's submission. AC, ¶ 290; *supra* at 5-8. And there is no requirement for IDREs to provide a reasoned decision. IDR is precisely the kind of "prompt, inexpensive determination of small claims" for which collateral estoppel is "wholly inappropriate." *See Staub*, 2023 WL 3059081, at *6.

In any event, district courts have discretion "to 'determine when [offensive collateral estoppel] should be applied' . . . [and] [o]ne of the most important considerations is whether the application would be unfair[.]" *Sec. & Exch. Comm'n v. Stuart Frost & Frost Mgmt. Co., LLC*, No. 8:19-CV-01559-JLS-JDE, 2021 WL 6103552, at *7 (C.D. Cal. Oct. 12, 2021) (quoting *Parklane Hosiery Co.*, 439 U.S. at 331)); *PenneCom B.V. v. Merrill Lynch & Co., Inc.*, 372 F.3d 488, 493 (2d Cir. 2004) (invocation of collateral estoppel "is influenced by considerations of fairness in the individual case"). Where, as here, a party alleges that the outcome of a prior proceeding resulted from a "fraudulent scheme to dupe" the finders of fact, a court should not apply collateral estoppel without the benefit of discovery. *See PenneCom*, 372 F.3d at 493.

E. In the Alternative, Anthem Pleads a Claim for Vacatur (Count XI).

In the alternative to its common law and statutory claims, Anthem has also asserted a claim for vacatur. AC, ¶¶ 355-59 (Count XI). Defendants argue that

Anthem's grounds for vacatur do not satisfy the substantive requirements of 9 U.S.C. § 10(a). HaloMD Br. 24; MPOWER Br. 18; Sound Br. 7. For the reasons stated in Section II.A.2, those arguments fail.

In addition, Defendants suggest that Anthem "cannot plead a claim for vacatur across an indeterminate universe of IDR awards and otherwise satisfy Fed. R. Civ. P. 8 and 9(b)." Halo Br. 24; MPOWER Br. 20 ("Anthem cannot plead vacatur en masse."). Defendants cite no authority for this proposition, nor do they provide any reasoned basis for imposing the various procedural requirements set forth "[u]nder 9 U.S.C. § 12" and other inapplicable provisions of the FAA. Sound Br. 9-10.[21] Defendants' argument might have merit in a vacatur action governed by the procedures of the FAA, but as detailed in Section II.A.2, "the NSA does not invoke or discuss §§ 6, 9, 12, or any other sections of the FAA" other than § 10. *Med-Trans*, 700 F. Supp. 3d at 1083. There is no basis to impose FAA procedural requirements on a complaint that brings a claim for vacatur under the NSA.

III. Anthem States Claims for Violations of RICO (Counts I-IV).

Defendants have committed extensive RICO violations, employing interstate wires to submit hundreds of fraudulent IDR submissions to Anthem, the Departments, and IDREs. AC, ¶¶ 3-11, 165, 221. Defendants' motions categorically ignore the AC's allegations and misconstrue applicable law. But as detailed below: (1) the litigation activities exemption does not apply; and (2) Anthem pleads (a) predicate acts of wire fraud, (b) an enterprise, (c) a pattern of racketeering activity, and (d) conspiracy.

A. The "Litigation Activities" Exemption Does Not Apply.

In another attempt to immunize their fraud, Defendants invoke the so-called RICO "litigation activities" exemption, a judge-made doctrine under which courts

[21] Anthem need not "particularly allege the error infecting *each* challenged award under Rule 9(b)." MPOWER Br. 20. Defendants cite *Semegen v. Weidner*, 780 F.2d 727, 731 (9th Cir. 1985), which does not address arbitral awards at all.

generally do not allow litigation filings to serve a basis for RICO predicate acts. *Kim v. Kimm*, 884 F.3d 98, 103-04 (2d Cir. 2018). The Ninth Circuit has not adopted the litigation activities doctrine. *See United States v. Koziol*, 993 F.3d 1160, 1174 (9th Cir. 2021) (acknowledging doctrine and declining to apply it to Hobbes Act claim). And this Court has at least two independent additional reasons not to apply it to Defendants' NSA Schemes. First, the policy reasons behind the doctrine do not apply to IDR. Second, in addition to deceiving the IDREs, Defendants' "litigation activities" here are also intended to deceive third parties (*i.e.*, the Departments), and their NSA Schemes target insurers other than Anthem.

1. RICO Does Not Exempt Fraud in IDR Proceedings.

As part of the NSA Scheme, Defendants used false attestations of eligibility to initiate hundreds of ineligible IDR proceedings against Anthem. AC, ¶¶ 86-95. No court has exempted IDR from RICO liability, and this Court should decline Defendants' invitation to do so. Indeed, the policy reasons warranting trust of the litigation process are notably absent from the IDR process—which is precisely why Defendants' NSA Schemes have succeeded.

The policy rationale for the litigation activities doctrine is rooted in the courts' extensive procedures and mechanisms for policing fraudulent filings, including rules of procedure, rules of evidence, the right to cross-examination, and penalties for perjury. *See United States v. Pendergraft*, 297 F.3d 1198, 1206-07 (11th Cir. 2002). Where parties and their counsel submit fraudulent filings, they may be subject to sanctions, disbarment, or state law remedies like malicious prosecution. *See id.* ("We trust the courts, and their time-tested procedures, to produce reliable results, separating validity from invalidity, honesty from dishonesty.").

When declining to apply the exemption in *Koziol*, the Ninth Circuit similarly observed that the doctrine was rooted in the procedural safeguards of litigation, including that the "the rigors of cross-examination and the penalty of perjury

sufficiently protect the reliability of witnesses," 993 F.3d at 1175, and the fact that litigants have "remedies and protections in state tort law through claims of malicious prosecution[.]" *Id.* at n.15.

The exemption has no place in the context of IDR proceedings. Unlike court litigation, IDR proceedings do not use "time-tested procedures[] to produce reliable results, separating validity from invalidity, honesty from dishonesty." *See Pendergraft*, 297 F.3d at 1206. In IDR, attestations of eligibility are not filed by attorneys who are bound by ethical obligations and subject to court and professional sanctions. *Cf. id.* IDR does not provide any opportunity for discovery, "the rigors of cross-examination," or "the penalty of perjury [to] sufficiently protect the reliability of witnesses." *Koziol*, 993 F.3d at 1175; *supra* at 5-8. IDREs are not neutral parties when evaluating eligibility; they have a direct financial incentive to find that disputes are eligible or else they receive no compensation. *Supra* at 6-7; *see Harper*, 976 F.3d at 1241. IDR also cannot serve as the basis for a malicious prosecution claim.[22] *Compare with Koziol*, 993 F.3d at 1175, n.15 (civil litigants have "remedies and protections in state tort law through claims of malicious prosecution[.]").

Moreover, principles of res judicata and collateral estoppel do not apply to IDR proceedings. *Compare supra* at 5-8, *with Kim*, 884 F.3d at 104 (RICO claims based on litigation activities "erode the principles . . . of res judicata and collateral estoppel"). IDR proceedings are not open to the public, and a disproportionately small number of providers initiate the overwhelming majority of IDR disputes. AC, ¶¶ 109-10 (ten companies initiated 71% of all disputes). Permitting claims based on fraudulent IDR submissions has no potential to chill "open access to the courts" or "inundate the federal courts" with RICO cases. *Cf. Kim*, 884 F.3d at 104.

[22] *Cf., e.g.*, *Brennan v. Tremco Inc.*, 25 Cal. 4th 310, 317 (2001) ("[T]ermination by contractual arbitration is simply not the sort of favorable termination needed to support a malicious prosecution action."); *Whitney v. J.M. Scott Assocs., Inc.*, 09-cv-5007099S 2012 WL 4747476, at *9 (Conn. Super. Ct. Sept. 7, 2012) (same); *Diamond, Resorts Int'l, Inc. v. Aaronson*, No. 6:17-CV-1394-ORL-37DCI, 2018 WL 735627, at *10 (M.D. Fla. Jan. 26, 2018) (predicting "Florida Supreme Court" would reject malicious prosecution claim premised on the outcome of an arbitration).

As recently as June 2025, the Departments urged IDREs to "reduce errors" and institute "robust quality assurance (QA) programs to verify dispute eligibility and review payment determinations." ECF No. 76-8, at 1. While judges and the courts "produce reliable results, separating validity from invalidity, honesty from dishonesty," those overseeing the IDR process do not believe the same is true of IDREs. *Compare id.*, *with Pendergraft*, 297 F.3d at 1206.

That two out-of-circuit district courts[23] have applied the "litigation activities" exemption "to arbitration proceedings" (Sound Br. Br 22) is inconsequential. "[T]he IDR process is not an arbitration[.]" *Mod. Orthopaedics*, 2025 WL 3063648, at *5; *see id.* at *6-7 (explaining the "differences [that] pervade the IDR and arbitration processes"). It is a "highly-restricted process" in which there is "no opportunity for briefing, hearing, or appeal," whereas it is "far more common for arbitration to be a robust process, involving discovery, hearings and a limited possibility for appeal." *Id.* at 6.

2. The Exemption Does Not Apply Because Defendants Intentionally Deceive HHS and Target Other Insurers.

The RICO litigation activities exemption does not apply here for a separate, independent reason. Courts outside the Ninth Circuit that have adopted the exemption have nevertheless rejected its application to schemes that either: (1) seek to deceive a third party, and not simply the court itself; or (2) target victims who were not party to the underlying proceeding. *See United States v. Lee*, 427 F.3d 881, 890 (11th Cir. 2005); *Carroll v. United States Equities Corp.*, No. 1:18-cv-667, 2020 WL 11563716, at *9 (N.D.N.Y. Nov. 30, 2020). Here, Defendants' NSA Schemes (i) seek

[23] Neither of Defendants' cited authorities considered whether the rule *should* apply to arbitration (much less IDR). *Republic of Kazakhstan v. Stati* dismissed a wire fraud claim premised on public litigation to enforce an arbitral award, 380 F. Supp. 3d 55, 61 (D.D.C. 2019), and, on appeal, the D.C. Circuit affirmed on alternate grounds, 801 F. App'x 780 (D.C. Cir. 2020). In *Diamond Resorts Int'l, Inc. v. Aaronson*, the court simply assumed without analysis that the rule applied to an arbitration demand. 2018 WL 735627, at *5-6 (M.D. Fla. Jan. 26, 2018). The issue was also immaterial; the plaintiff did not allege the arbitration contained false statements. *Id.* at *5-6, n.5.

to deceive the Departments, and not simply the IDREs; and (ii) target numerous other insurers in addition to Anthem.

As articulated by the Eleventh Circuit, the fact that a document is prepared for or used in litigation is not, by itself, sufficient to invoke the litigation activities exemption. *Lee*, 427 F.3d at 890. Rather, litigation activities may form the basis for wire fraud where the defendant intends for litigation materials to deceive someone other than the court itself. *Id.* In *Lee*, the defendants were convicted of mail fraud based on having served a "motion to dismiss" containing false affidavits on opposing counsel in a foreclosure action. The defendants appealed their conviction on this count, invoking the exemption for litigation activities. In affirming the conviction, the Eleventh Circuit rejected a categorical bar against premising wire fraud on litigation activities. The court held that the exemption would apply only if the relevant scheme was intended solely to deceive the court. *Id.* In contrast, the defendants in *Lee* committed wire fraud because they used litigation documents to mislead "the lender and its counsel," rather than simply "influencing the court." *Id.*

Even though the IDR process does not qualify as a "litigation" activity, the reasoning of *Lee* is instructive. Before Defendants can deceive the IDREs, they must first deceive the Departments. Before an IDRE is selected, Defendants must unlock the IDR process by deceiving HHS with false attestations of eligibility. 45 C.F.R. § 149.510(b)(2)(iii)(C) (the initiating party will "furnish the notice of IDR initiation to the Secretary [of HHS] by submitting the notice through the Federal IDR portal"). As explained by Sound Physicians Providers, "[t]he attestation is the gateway to the proceeding and payment determination." ECF No. 68-1 at 18. For this additional reason, the litigation activities exemption does not apply.

The exemption also does not apply because the NSA Schemes involve hundreds of different proceedings and targets Anthem in addition to other health plans. Courts have limited application of the exemption to cases in which a plaintiff

alleges wire fraud based on materials from "a single frivolous, fraudulent, or baseless lawsuit." *Kim*, 884 F.3d at 105. The decision in *Kim* is a leading authority on this doctrine. And "*Kim* leaves open the door for RICO claims premised on abusive litigation activities involving conduct beyond a single lawsuit." *Carroll*, 2020 WL 11563716, at *9 (allowing RICO claim based on false filings in thousands of cases);[24] *cf. Dees v. Zurlo*, 1:24-cv-1, 2024 WL 2291701, at *2, 5 (N.D.N.Y. May 21, 2024) (*Kim* did "not automatically preclude" a RICO claim that sought "to overturn state-court custody and support decisions" "related to the custody and supervision of [plaintiff's] children" but concluding that the "reasons" and "principle[s]" behind the doctrine supported its application under those facts).

Finally, Defendants resort to comparing (1) their systematic submission of hundreds of knowingly false eligibility attestations to (2) Anthem making minor, inadvertent factual mistakes in its original complaint that did not impact the viability of its claims and were subsequently corrected in the AC. Sound Br. 2, 23; HaloMD Br. 21.[25] This false equivalence demonstrates the difference between court proceedings, in which counsel function as officers of the court and correct even minor factual errors, and IDR proceedings, in which Defendants systematically make misrepresentations to initiate the IDR process for ineligible disputes and the victim

[24] *Cf. Acres Bonusing, Inc. v. Ramsey,* No. 19-CV-05418-WHO, 2022 WL 17170856, at *11 (N.D. Cal. Nov. 22, 2022) (applying exemption to RICO claim premised "on payment of the billing invoices and substitution of counsel and Frank's verification of discovery responses and submission of declarations" in a single litigation); *Pompy v. Moore,* No. 19-10334, 2024 WL 845859, at *16 (E.D. Mich. Feb. 28, 2024) (dismissing RICO claims on multiple grounds and noting in *dicta* that litigation materials exception likely applied to court ordered transmission of search warrants in single criminal proceeding); *Snow Ingredients, Inc. v. SnoWizard, Inc.*, 833 F.3d 512, 524 (5th Cir. 2016) (holding that plaintiff who *did not* plead mail or wire fraud could not sustain a RICO claim premised on unsupported argument that "bad faith litigation tactics alone constitute witness tampering").

[25] For example, Anthem amended its description of DISP-1289721 to address the Sound Physicians Providers' factual complaints, but the South Physicians Providers did not and cannot dispute that the IDR proceeding involved a knowingly ineligible dispute for a Medicaid claim for which they received payment in excess of billed charges and at 42 times the Medicaid rate due to their fraudulent NSA Scheme. *See* AC at ¶¶ 230-35. The Sound Physicians Providers also quibbled over the header – but not the substance – of the description of DISP-2639953, which Anthem corrected in the AC. *See id.* at ¶¶ 242-48.

of Defendants' schemes have no recourse other than to seek court intervention.

B. Anthem Pleads Predicate Acts of Wire Fraud.

Anthem has supported its wire fraud claim by identifying the precise misrepresentations that Defendants must make to initiate an ineligible dispute on the IDR Portal (AC, ¶¶ 54-67), and by setting forth the specific time, date, source, and content of demonstrative misrepresentations constituting wire fraud. *E.g.*, AC, ¶¶ 171, 175, 180, 204, 227, 233, 240, 246. Anthem also pleads clear allegations tying Defendants' conduct to its injuries, including millions of dollars in IDR fees and payment determinations and operational expenses to combat Defendants' fraud. Defendants do not and cannot meaningfully dispute that the AC pleads the elements of wire fraud, including causation.[26]

1. The Wire Fraud Allegations Satisfy Rule 9(b).

Anthem's allegations easily satisfy Rule 9(b). First, the Sound Physicians Providers erroneously contend that Anthem was required to plead the time, place, and contents for each of Defendants' hundreds of misrepresentations. Sound Br. 20. But where a plaintiff alleges a scheme involving "hundreds or thousands" of misrepresentations, Rule 9(b) requires only that the plaintiff plead "examples" of the fraud with the requisite particularity. *See Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, No. CV14-03053 MWF (VBKx), 2015 WL 12778048, at *8 (C.D. Cal. Oct. 23, 2015); *Leprino Foods Co. v. Avani Outpatient Surgical Ctr., Inc.*, No. CV 22-7434 DSF (JEMX), 2023 WL 11066072, at *3 (C.D. Cal. Apr. 26, 2023) (where plaintiffs allege "'hundreds' of instances of fraud," Rule 9(b) is satisfied by pleading "examples of the fraud[.]"). Here, Anthem alleges that Defendants engaged in "hundreds" of instances of fraud (*e.g.*, AC, ¶¶ 286, 307, 340) and pleads representative instances of fraud with particularity (*see id.*, ¶¶ 168–205,

[26] Anthem does not assert that the number of Defendants' IDR disputes, their inflated demands for payment, or their overall bad faith are additional "theories" of wire fraud. Sound Br. 22. Rather, these are attributes of the NSA Schemes that conceal their fraud and increase the schemes' effectiveness and profitability.

224–248).[27]

Second, Defendants argue that Anthem has failed to adequately plead fraudulent intent. HaloMD Br. 23; MPOWER Br. 13. But under Rule 9(b), "intent, knowledge, and other conditions of a person's mind may be alleged generally." Fed. R. Civ. P. 9(b). Indeed, "the Ninth Circuit has held that a general allegation of scienter, including a simple allegation that the defendants had the requisite scienter, satisfies Rule 9(b)." *Grimes v. Ralphs Grocery Co.*, No. CV 23-9086 TJH (PDX), 2024 WL 5470432, at *4 (C.D. Cal. Aug. 9, 2024) (citing *In re GlenFed, Inc. Sec. Litig.*, 42 F.3d 1541, 1547 (9th Cir. 1994)); *see also SPS Techs., LLC v. Briles Aerospace, Inc.*, No. CV 18-9536-MWF (ASX), 2020 WL 12740596, at *17 (C.D. Cal. Jan. 17, 2020) ("'[P]laintiffs may aver scienter generally, just as the rule states—that is, simply by saying that scienter existed.'") (internal citation omitted).

Here, Anthem does not simply plead that Defendants knew the certifications of eligibility were fraudulent "without any stated factual basis." *Swartz v. KPMG LLP*, 476 F.3d 756, 765 (9th Cir. 2007); MPOWER Br. 22. Anthem alleges that Defendants knew their representations were false and sets forth facts demonstrating how and why they knew disputes were ineligible, including (i) specific communications from Anthem advising them that disputes were ineligible (*e.g.*, AC, ¶¶ 171, 176, 181, 187) and (ii) readily accessible information confirming disputes were ineligible. *See, e.g.*, *id.* at ¶ 287 (Defendants had access to, among other things, "patient's insurance cards, Anthem's EOPs, the plain text of federal laws and regulations, [and] CMS publications and resources[.]"). These allegations far exceed the requirement for pleading knowledge.[28]

[27] When a plaintiff asserts fraud against a corporate entity, the failure to identify the specific employees responsible for each individual misrepresentation is immaterial where, as here, plaintiffs plead sufficient information "so that the defendant can prepare an adequate answer from the allegations." *Odom v. Microsoft Corp.*, 486 F.3d 541, 555 (9th Cir. 2007) (internal citation omitted)

[28] The LaRoque Family Providers' citation to *Nuñag-Tanedo v. E. Baton Rouge Par. Sch. Bd.*, 790 F. Supp. 2d 1134, 1148-49 (C.D. Cal. 2011), is inapposite. *See* MPOWER Br. 13. That decision simply noted that intent was an element of mail and wire fraud but dismissed the underlying claim

Nor is there any merit to Provider Defendants' argument that Anthem has failed to plead their roles in their fraudulent NSA Schemes. Sound Br. 20, MPOWER Br. 12, 17. To be liable for mail or wire fraud, "[t]he defendant need not personally have mailed the letter or made the telephone call; the offense may be established where one acts with the knowledge that the prohibited actions will follow in the ordinary course of business or where the prohibited acts can reasonably be foreseen." *United States v. Johnson*, 297 F.3d 845, 870 (9th Cir. 2002).

This is not a heavy burden. For example, in *United States v. Crossley*, an insider at an insurance company submitted fabricated claims on behalf of co-conspirators, who would then cash insurance checks and share them with the insider. 224 F.3d 847, 856 (6th Cir. 2000). After all members of the conspiracy were convicted of wire fraud, one of the co-conspirators appealed on the grounds that his sole conduct involved (1) giving the insider their names and mailing addresses and (2) receiving and cashing the checks. *Id*. The Sixth Circuit affirmed their conviction, holding that a wire fraud plaintiff is "not required to prove that each member of a conspiracy knew every detail" of the scheme, and that it was sufficient to show that the defendant "knew the check was for an insurance claim to which she was not entitled." *Id.*

The allegations of the AC far exceed the allegations deemed sufficient in *Crossley*. Unlike the unsophisticated defendants in *Crossley*, who simply provided names and deposited checks, Provider Defendants are sophisticated businesses that engage in open negotiation with Anthem and utilize HaloMD as their agent to submit millions of dollars of ineligible disputes to IDR. Provider Defendants are the source of the underlying services and all information submitted for these disputes and authorize their submission after being expressly advised by Anthem that they are ineligible for IDR. *E.g.*, AC, ¶¶ 168-172 (MPOWERHealth & Bruin), 173-182

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for failure to allege any "specific mailings or wire usage by Defendants." *Nuñag-Tanedo*, 790 F. Supp. 2d at 1149.

(MPOWERHealth & NANA), 183-200 (MPOWERHealth & N. Express); 201-205 (MPOWERHealth & iNeurology); 224-241 (SPEMSC); 242-248 (SPAC). And Provider Defendants (along with HaloMD) receive the fruits of their fraudulent NSA Schemes: millions of dollars in payments based on disputes that they knew were ineligible. *Id.*, ¶118.[29]

Finally, Defendants' arguments that that the AC constitutes a shotgun pleading also fail. *See* Sound Br. 20; HaloMD Br. 23, n.17. "There is no flaw in a pleading . . . where collective allegations are used to describe the actions of multiple defendants who are alleged to have engaged in precisely the same conduct." *Blue Cross & Blue Shield Oklahoma v. S. Coast Behav. Health LLC*, No. 2:24-CV-10683 MWC (AJRX), 2025 WL 2004500, at *9 (C.D. Cal. June 20, 2025) (quoting *United Healthcare*, 848 F.3d at 1184). Anthem pleads specific facts as to each defendant's role in the NSA Schemes, representative examples of fraudulent disputes involving each defendant, and separate claims against each enterprise. *See* AC, ¶¶ 130-354.

2. Anthem Pleads Causation.

The AC plainly alleges that Defendants' NSA Schemes proximately caused Anthem's injuries. Defendants seek to blame others for Anthem's injuries, arguing they cannot be liable because IDREs failed to detect their fraud or Anthem failed to adequately object. Defendants' argument contradicts both the law and the well-pleaded facts in Anthem's AC. *See* HaloMD Br. 20-21; MPOWER Br. 13-15. Courts consider three factors to assess proximate cause:

> (1) whether there are more direct victims of the alleged wrongful conduct who can be counted on to vindicate the law as private attorneys general; (2) whether it will be difficult to ascertain the amount of the plaintiff's damages

[29] MPOWERHealth's and the LaRoque Family Providers' citation to *In re Pac One, Inc.* is thus inapposite. No. 01-85027 MGD, 2007 WL 2083817, at *8 (N.D. Ga. July 17, 2007) (dismissing fraud claim where only allegation of conduct was that "Defendants, jointly and severally, engaged in activities and transactions in the name of 'Pac One, Inc.'").

> attributable to defendant's wrongful conduct; and (3) whether the courts will have to adopt complicated rules apportioning damages to obviate the risk of multiple recoveries."

Newcal Industries, Inc. v. Ikon Office Solution, 513 F. 3d 1038, 1055 (9th Cir. 2008) (reversing dismissal and holding that proximate causation under RICO is a fact-based issue that cannot be resolved on a Rule 12(b)(6) motion).

Defendants do not and cannot dispute that the AC pleads proximate causation under these factors. Defendants' fraudulent submissions in disputes with Anthem are intended to harm Anthem and Anthem alone. There are no more "direct victims of [Defendant's] fraud [who] would be likely to sue [Defendant]" and thus no victims whose "existence . . . would make it difficult to apportion damages" or "create a risk of multiple recovery against [Defendants]." *Newcal*, 513 F. 3d at 1055.

The fact that the IDREs are a necessary part of the scheme does not negate proximate causation. Halo Br. 20; MPOWER Br. 14. Under controlling Supreme Court law, the fact that a representation is made to and relied upon by IDREs does not constitute an "independent factor" that breaks the chain. *See Bridge v. Phoenix Bond & Indem. Co.*, 553 U.S. 639, 656-59 (2008). It is sufficient to show that "someone relied on the defendant's misrepresentations" and, as a result, the plaintiffs were harmed. *Id.* at 658. A third party's conduct only breaks the causal chain if it was "a later cause of independent origin that was not foreseeable." *Painters & Allied Trades Dist. Council 82 Health Care Fund v. Takeda Pharm. Co. Ltd.*, 943 F. 3d 1243 (9th Cir. 2019) ("*Painters*").

In *Painters*, health insurers brought RICO claims against drug manufacturers for failing to disclose the risks of medications. The defendants sought dismissal on the grounds that physicians who prescribed the drug made independent medical decisions that constituted an intervening cause. *Id.* at 1257. The Ninth Circuit rejected

this argument, explaining that it was "perfectly foreseeable that physicians who prescribed [the drug] would play a causative role in Defendants' fraudulent scheme." *Id.* Similarly, here reliance by IDREs and the Departments was not only foreseeable but intended. *E.g.*, AC, ¶ 93.[30]

Defendants' arguments about causation are also premised on factual assertions that disregard Anthem's well-pleaded allegations. Defendants fail to address allegations that, as a result of Defendants overwhelming the IDR Portal with hundreds of fraudulent disputes, Anthem must (1) spend time and money to identify the fraud and submit an objection to eligibility (*e.g.*, AC, ¶¶ 115, 268, 279), and (2) pay a $115.00 administrative fee that it cannot recover even when "the IDRE determines that the dispute does not qualify for IDR[.]" *Id.*, ¶ 79. Anthem incurs these damages as an immediate result of Defendants' submissions, even before an IDRE is selected.

Finally, while Defendants claim that IDREs conduct eligibility assessments in each proceeding (HaloMD Br. 14), the AC alleges that (1) Defendants submit an avalanche of disputes simultaneously to overwhelm the IDR system, (2) IDREs often conduct only "a cursory review" of the "one-sided information" from Defendants, (3) IDREs "rely on Defendants' false attestations of eligibility," and (4) IDREs are financially incentivized to find that disputes are eligible for IDR or else forego any payment. AC, ¶¶ 73, 93, 79, 117. And as detailed in the AC, the only relevant language in the regulations directs IDREs to "review the information submitted in the notice of IDR initiation" "to determine whether the Federal IDR process applies."

[30] Defendants' cited authorities are inapposite. *See Galen v. Cnty. of Los Angeles,* 477 F. 3d 652, 663 (9th Cir. 2007) (granting summary judgment, not a motion to dismiss, on 42 U.S.C. § 1983 claim for violation of the Eighth Amendment); *De Los Angeles Aurora Gomez v. Bank of Am., N.A.*, No. CV 12-8704-GHK (SHX), 2013 WL 12165673, at *6 (C.D. Cal. Aug. 21, 2013) ("Plaintiffs allege that Countrywide mailed the false business partner letters to some of the Plaintiffs during the loan application process, but they do not allege that they or anyone else relied on the false letters in deciding to obtain a Countrywide loan."); *Evans Hotels, LLC v. Unite Here! Loc. 30*, No. 18-CV-2763 TWR (AHG), 2021 WL 10310815, at *23 (S.D. Cal. Aug. 26, 2021) (dismissing RICO claim premised on extortion of third party because, among other things, the immediate target of the alleged extortion had a greater "incentive to sue Defendants").

Id., ¶ 116 (quoting 45 C.F.R. § 149.510(c)(1)(v)). That notice includes only the initiating party's (*i.e.*, provider's) attestation of eligibility. *See id.*, ¶ 73. Defendants seek to dispute Anthem's well-pleaded allegations with an informal and non-binding technical guidance document issued by the Departments. For the reasons stated in Section II.D, Defendants cannot rely on this document to override the plain language of the controlling regulations and Anthem's allegations. Defendants also cannot dispute causation by contradicting the well-pleaded allegations of the AC.

C. Anthem Pleads a RICO Enterprise.

The AC pleads the three components of a RICO enterprise: "(A) a common purpose, (B) a structure or organization, and (C) longevity necessary to accomplish that purpose." *Ford Motor Co.*, 2025 WL 3306280, at *13. Defendants challenge only the common purpose and structure elements. The LaRoque Family Providers also argue that Anthem has failed to adequately plead their role in the enterprise. All these arguments fail.

1. Anthem Pleads a Common Purpose.

First, Anthem pleads a common purpose to commit fraud and not simply "routine commercial relationships." *Cf.* HaloMD Br. 22; Sound Br. 25. There is nothing ordinary about the relationships between HaloMD and the LaRoque Family Providers. These entities share employees, offices, and board members—and all are ultimately controlled by the LaRoques. AC, ¶¶ 130-64. And each of the Provider Defendants have fully joined their financial interests with those of HaloMD, which is responsible for submitting IDR disputes on behalf of each of the Provider Defendants and is paid on commission for every recovery. *Id.*, ¶¶ 157, 213.

To plead a common purpose, Anthem must allege that each Defendant was "aware of the 'essential nature and scope' of [the] enterprise and intended to participate in it." *United States v. Christensen*, 828 F.3d 763, 781 (9th Cir. 2015). And it need only allege "specific facts that move their allegations from the realm of

the possible to the plausible." *Shaw v. Nissan N. Am., Inc.*, 220 F. Supp. 3d 1046, 1057 (C.D. Cal. 2016) (reviewing filings in related case and finding "there were several instances where the parties demonstrated they lacked common purpose by reaching independent conclusions"). Here, the fact that the Defendants operate on a commission-based arrangement renders Anthem's allegations of a common purpose plausible because every Defendant has an immediate incentive to participate in the NSA Scheme. *See, e.g.*, *Blue Cross & Blue Shield Oklahoma*, 2025 WL 2004500, at *8 (finding adequate allegations of common purpose where alleged scheme would lead to "fraudulent billings to be split among Defendants"); *MSP Recovery Claims, Series LLC v. Amgen Inc.*, No. 2:23-CV-03130-MEMF-PD, 2024 WL 3464410, at *11 (C.D. Cal. July 15, 2024) (plaintiff plausibly "allege[d] facts as to why [defendants] would participate in the alleged scheme . . . executives at [each defendant] stand to make substantially more money as donations from pharmaceutical manufacturers increase.").[31]

Moreover, the AC pleads extensive facts supporting its assertion that Provider Defendants shared a common fraudulent purpose with HaloMD. *E.g.*, AC, ¶¶ 4-11. The AC alleges these Defendants submitted hundreds of fraudulent disputes after being *informed directly* by Anthem that these disputes were ineligible. *E.g.*, AC, ¶¶ 171, 176, 181, 187 (emphasis added). And it pleads concrete examples of fraudulent disputes establishing a clear pattern of deliberate misconduct by each of the Defendants. *E.g.*, AC, ¶¶ 171, 175, 180, 204, 227, 233, 240, 246.

This is not a case in which "alternative explanations for Defendants' actions abound." *Ford Motor*, 2025 WL 3306280, at *14. To initiate each of these fraudulent disputes through the IDR Portal, Provider Defendants had to authorize and submit

[31] This is also not a case in which the plaintiff makes conclusory allegations that independent actors with disparate economic interests agreed to engage in fraud. *Cf. Gardner v. Starkist Co.*, 418 F. Supp. 3d 443, 461 (N.D. Cal. 2019) (finding insufficient the allegations that "company 'stored, canned, and processed Defendants tuna products for sale' and 'knew' the products would be marketed as dolphin-safe").

detailed factual misrepresentations, including to multiple federal agencies. *See* AC, ¶¶ 54-67. It is not possible to explain these repeated actions as arising for "poor billing practices." *Ford Motor*, 2025 WL 3306280, at *14. Defendants' schemes of submitting an avalanche of disputes with hundreds of false certifications of eligibility resulting in millions of dollars in commercially unreasonable and exorbitant awards is not something that happens "by accident or as part of routine business dealings." *In re Chrysler-Dodge-Jeep Ecodiesel Mktg., Sales Pracs., & Prods. Liab. Litig.*, 295 F. Supp. 3d 927, 981 (N.D. Cal. 2018).

The AC's allegations are "more than adequate to establish, if true, that [Defendants] had a common purpose of increasing the number of [IDR disputes] through fraudulent means." *See Odom*, 486 F.3d at 552 (9th Cir. 2007); *see also Humana Inc. v. Mallinckrodt ARD LLC*, No. CV 19-06926 DSF (MRW), 2020 WL 3041309, at *7 (C.D. Cal. Mar. 9, 2020) ("Plaintiff has alleged a common purpose of increasing the number of people using Acthar, and doing so by fraudulent means[.]").

2. Anthem Pleads a Structure or Organization.

Second, and contrary to HaloMD's conclusory assertion, Anthem has alleged "an enterprise organization or structure as a vehicle for committing predicate crimes." HaloMD Br. 22. RICO's structural requirement requires only a "relationship among those associated with the enterprise." *Boyle*, 556 U.S. at 946. Neither a "hierarchy, role differentiation . . . [or] a chain of command" is required. *Id.* In this case, Anthem far exceeds the required allegations by alleging the specific roles played by each of the Defendants and the precise contractual arrangements binding them together. *E.g.*, AC, ¶¶ 4-11.

3. Anthem Pleads the LaRoque Family Providers' Role in the LaRoque Family Enterprise.[32]

Third, Anthem adequately pleads the LaRoque Family Providers' participation

[32] While Sound Physicians Providers have not raised the same challenge, these arguments apply with equal force to their role in the Sound Physicians Providers Enterprise.

in the LaRoque Family Enterprise. MPOWER Br. 18. "Like co-conspirators, knowing participants in the scheme are legally liable for their co-schemers' use of the mails or wires." *United States v. Stapleton*, 293 F.3d 1111, 1117 (9th Cir. 2002). Here, Anthem does not allege that LaRoque Family Providers were "[s]imply performing services for the enterprise." *Walter v. Drayson*, 538 F.3d 1244, 1249 (9th Cir. 2008). To the contrary, the LaRoque Family Providers were "indispensable to achievement of the enterprise's goal." *Id.* As detailed in Section III.B.1, the Enterprises can only achieve the NSA Schemes because the LaRoque Family Providers, despite being put on notice by Anthem that disputes are ineligible for IDR, authorize HaloMD to submit those disputes on their behalf through the IDR Portal. AC, ¶¶ 88-93, 275. The LaRoque Family Providers directly participated in and benefited from the predicate acts of wire fraud to obtain millions of dollars in awards based on the submission of disputes that they know are ineligible. AC, ¶¶ 96-104. These facts go far beyond raising a plausible inference that they are involved in directing and carrying out the NSA Scheme.

D. Anthem Pleads a Pattern of Racketeering Activity.

HaloMD contends that Anthem has failed to allege a pattern of racketeering activity because, other than HaloMD, it has not alleged that "any other Defendant committed at least two RICO predicate offenses." HaloMD Br. 22. But this argument relies on the false premise that Anthem failed to allege an act of wire fraud by each of the Defendants. As detailed in Section III.B,1, a "defendant need not personally have mailed the letter or made the telephone call" to commit wire fraud. *Johnson*, 297 F.3d at 870 It is sufficient that Provider Defendants are the source of all information and materials submitted for these disputes and authorize their submission after being expressly advised by Anthem that they are ineligible for IDR. *E.g.*, AC, ¶¶ 171, 175, 180, 204, 227, 233, 240, 246. As to the requirement that each defendant have committed two predicate acts, Anthem pleads two demonstrative disputes

involving predicate acts for MPOWERHealth & NANA (AC, ¶¶ 173-182), three involving MPOWERHealth & N. Express (id., ¶¶ 183-200), three involving SPEMC (id. ¶¶ 224-241), and additional disputes involving MPOWERHealth & Bruin (id., ¶¶ 168-172), MPOWERHealth & iNeurology (*id*., ¶¶ 201-205), and SPAC (id. ¶¶ 242-248). Moreover, even "'innocent' mailings—ones that contain no false information—may supply the mailing element." *In re WellPoint, Inc. Out-of-Network UCR Rates Litig.*, 903 F. Supp. 2d 880, 913 (C.D. Cal. 2012). For each of the demonstrative disputes listed in the complaint, the Provider Defendants were involved in at least two transmissions: (i) the submission of a claim to Anthem and/or (ii) the submission of a dispute through the IDR portal. Anthem has met its burden to plead two predicate offenses as to each Defendant. *See* AC, ¶¶ 168-205, 224-48. And the predicate acts identified in the AC are solely examples; Anthem alleges that all Defendants have engaged in hundreds of acts of wire fraud. *See* AC, ¶¶ 286, 291.[33]

E. Anthem Pleads a RICO Conspiracy.

Anthem easily clears the bar for pleading a RICO conspiracy under 18 U.S.C. § 1962(d). Initially, and as discussed in Sections III.A-D, Anthem adequately pleads a substantive RICO claim under 18 U.S.C. § 1962(c). And regardless of whether Anthem pleads a substantive RICO cause of action, "[i]t is the mere agreement to violate RICO that § 1962(d) forbids; it is not necessary to prove any substantive RICO violations ever occurred as a result of the conspiracy." *Oki Semiconductor Co. v. Wells Fargo Bank, Nat. Ass'n*, 298 F.3d 768, 774–75 (9th Cir. 2002). Moreover, "[t]he illegal agreement need not be express as long as its existence can be inferred from the words, actions, or interdependence of activities and persons involved." *Id.* at 775.

The requirement to plead an agreement "does not impose a probability

[33] To the extent the Court requires additional examples for pleading purposes, Anthem respectfully requests leave to amend and include those additional examples. *See infra* at Argument, Section VIII.

requirement at the pleading stage; it simply calls for enough fact to raise a reasonable expectation that discovery will reveal evidence of illegal agreement." *Twombly*, 550 U.S. at 556. Anthem has surpassed that requirement, both through explicit allegations of an agreement among the Defendants and the obvious inferences to be drawn from Anthem's allegations regarding Defendants' coordinated schemes to defraud Anthem and other victims.

IV. Anthem States a Claim Under ERISA (Count XII).

Contrary to Defendants' arguments, Anthem adequately alleges its fiduciary status to pursue Count XII. ERISA defines "fiduciary" as follows:

> Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan . . . .

29 U.S.C. § 1002(21)(A).

Anthem alleges that the employer sponsors of certain ERISA-governed health plans: (1) "delegate to Anthem discretionary authority to recover overpayments, including those resulting from fraud, waste, or abuse"; and (2) "delegate authority to Anthem to administer the IDR process on behalf of the plans." AC, ¶¶ 33, 361. Pursuant to this authority, Anthem now seeks to enjoin Defendants' fraudulent and abusive practices to protect and control the management and disposition of plan assets. *See id.* at ¶¶ 364-365, 367; *see also* 29 U.S.C. § 1132(a)(3) (authorizing a fiduciary of a health plan to bring a civil action to "enjoin any act or practice which violates any provision of this subchapter or the terms of the plan" or "to obtain other

appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan."); *see also FMC Med. Plan v. Owens*, 122 F.3d 1258, 1261 (9th Cir. 1997) (discussing right of fiduciary to seek injunctive and other appropriate equitable relief relating to the same).

Defendants' conclusory argument[34] that Anthem was required "to identify a[] specific health benefit plan" (HaloMD Br. 27) at the pleading stage is misplaced. Anthem is only required to allege the existence of ERISA plans and the terms thereof conferring fiduciary status. *See*, *e.g.*, *Nutrishare, Inc. v. Connecticut Gen. Life Ins. Co.*, No. 2:13-CV-02378-JAM-AC, 2014 WL 2624981, at *3 (E.D. Cal. June 12, 2014) ("Once the case is allowed to proceed to discovery, CIGNA would be required to specifically identify the plans at issue."); *UnitedHealthCare Servs. v. Team Health Holdings, Inc.*, 3:21-cv-00364, 2022 WL 1481171, at *8 (E.D. Tenn. May 10, 2022) ("The interests of judicial economy counsel that United be allowed to produce the relevant documents for its ERISA claim in the normal course of discovery."). Here, Anthem has specifically alleged self-funded plans at issue that are subject to ERISA. *See* AC, ¶¶ 33, 361, 365. Anthem has also alleged the terms of those ERISA plans that confer discretionary authority to Anthem. *See* AC, ¶ 361. This is all that is required.[35]

Anthem also does, in fact, "seek to enjoin an actual ERISA violation." HaloMD Br. 26. Under 29 U.S.C. § 1185e(c)(1)(B) and (2)(A), negotiations are a

[34] Sound Physicians Providers cite out-of-circuit authorities for the proposition "Blue Cross affiliates routinely" argue that "they are not ERISA fiduciaries." Sound Br. 27. These cases do not involve "affiliates" of Anthem. More importantly, a party may be a fiduciary for certain purposes but not for others; it is necessarily a fact-specific question. *Del Prete v. Magellan Behav. Health, Inc.*, 112 F. Supp. 3d 942, 946 (N.D. Cal. 2015).

[35] Moreover, "[t]he issue of fiduciary status [for ERISA] is a mixed question of law and fact and courts typically will have insufficient facts at the motion to dismiss stage[.]" *Bagley v. KB Home*, No. CV 07-1754 GPS(SSx), 2008 WL 11340342, at *4 (C.D. Cal. Feb. 22, 2008) (citation and quotation omitted). Consequently, while fiduciary status may be decided on a motion to dismiss, where, as here, that determination rests on factual determinations, this district has previously held that "the pleading stage is too early to determine fiduciary status." *Id.* at *10.

mandatory precursor to IDR. *See also* 29 C.F.R. § 2590.716-8(b)(2)(i). By pleading that Defendants have "fail[ed] to properly initiate or engage in open negotiations prior to initiating the IDR process" (AC, ¶ 365), Anthem pleads a statutory violation. In addition, 29 U.S.C. § 1185e(c)(1)(B) requires that an initiating party submit "to the other party and to the [DOL] Secretary a notification (containing such information as specified by the Secretary)," which includes, *inter alia*, the commencement date of open negotiations and the attestation that the items or services are qualified for IDR resolution. 29 C.F.R. § 2590.716-8(b)(2)(iii)(A)(1)-(9). By pleading that Defendants falsify this required information, Anthem pleads violations of 29 U.S.C. § 1185e(c)(1)(B) and 29 C.F.R § 2590.716-8(b)(2)(iii)(A).

Finally, there is no merit to Defendants' argument that, because Anthem alleges violations of ERISA provisions that were enacted through the NSA, the NSA's Judicial Review Provision somehow bars Anthem's ERISA claim. MPOWER Br. 20; HaloMD Br. 27. Under 29 U.S.C. § 1132(a)(3), Anthem is authorized to bring an action to address conduct that "violates any provision of this subchapter." There are no exceptions. And there is no rational basis to suggest that Congress intended to limit actionable ERISA claims, especially for prospective injunctive relief that is not available in IDR proceedings. *See* § II.A.

V. Anthem States Claims Under California Law.

The AC pleads viable causes of action under California Law including fraudulent misrepresentation (Counts V & VI), negligent misrepresentation (Counts VII & VIII), and violations of Cal. Bus. & Prof. Code §§ 17200 (Counts IX & X). Anthem responds to Defendants' arguments with respect to these claims in the accompanying Opposition to Defendants' Motions to Strike (ECF No. 92).

VI. Anthem States Claims Against the LaRoques.

Defendants Alla and Scott LaRoque incorrectly argue that the claims against them fail because they did not personally submit false certifications (LaRoque Br.

13-16) and there is no basis for piercing the corporate veil (*id.* at 16-17). But corporate officers and directors can be personally liable if they "specifically directed" others "to commit the tortious act." *Driscoll's Inc. v. Cal. Berry Cultivars, LLC*, No. 2:19-cv-00493-TLN-CKD, 2022 WL 956863, at *5 (E.D. Cal. Mar. 29, 2022) (citation and quotation omitted). They can also be personally liable for "the corporation's tort" based on their own "tacit consent and knowledge of unlawful purpose." *Planned Parenthood Fed'n of Am., Inc. v. Newman*, 51 F.4th 1125, 1136 (9th Cir. 2022) (citation and quotation omitted). Officers and directors can even be held personally liable for failing to stop tortious conduct that "they knew or had reason to know about." *Spence v. Clary*, No. CV 20-11166 DSF (JPRx), 2021 WL 304391, at *3 (C.D. Cal. Jan. 29, 2021) (citation and quotation omitted). And they can be liable for conspiring "to injure third parties through the corporation[.]" *Wyatt v. Union Mortg. Co.*, 598 P.2d 45, 52 (Cal. 1979).

The AC alleges detailed facts establishing each of these bases for personal liability. "Alla LaRoque and her husband, Defendant Scott LaRoque, are at the center of the LaRoque Family Enterprise[,]" which "operates via a web of interrelated corporate entities they directly or indirectly control, including Defendants HaloMD, MPOWERHealth, and the LaRoque Family Providers." AC, ¶ 133. Scott LaRoque is the founder, CEO, and sole owner of MPOWERHealth and exercises both managerial and operational control over MPOWERHealth and each of its subsidiaries, including the LaRoque Family Providers. *Id.,* ¶¶ 17, 135. Alla LaRoque sits on the board of MPOWERHealth and served as its COO. *Id.,* ¶ 148. While serving as COO of MPOWERHealth, she founded HaloMD (*id.,* ¶ 159), which is owned solely by the LaRoques. *Id.,* ¶ 15. Alla LaRoque is not only the public face of HaloMD, she directs its operations as a hands-on manager, overseeing its finances, operations, and practices, including the submission of fraudulent IDR disputes. *Id.,* ¶ 149-50.

The LaRoques created and run these interrelated entities that carry out the

fraudulent NSA Schemes. The LaRoque Family Providers (subsidiaries of MPOWERHealth) perform the underlying services, and then they funnel the claims to HaloMD (also owned and operated by the LaRoques). Contrary to Defendants' arguments (LaRoque Br. 14, 17), Anthem's allegations of the LaRoques' "operational control" of defendant companies on "information and belief" are proper because the belief is plausible based on these available facts and more detailed facts on operations are "peculiarly within the possession and control" of defendants. *See Park v. Thompson*, 851 F.3d 910, 928 (9th Cir. (2017) (recognizing *Twombly* allows factual allegations "upon information and belief" in such circumstances).

The LaRoques' arguments thus fail to show they can avoid personal liability here. First, the AC's allegations confirm that the LaRoques are "the 'guiding spirit' or 'central figure' behind wrongful conduct," which is sufficient to establish liability for corporate officers. *See McConkey v. Crawford*, No. CV 22-5834-MWF (AFM), 2022 WL 18278612, at *5 (C.D. Cal. Nov. 14, 2022) (citation omitted)). Second, through their managerial and operational control of HaloMD, MPOWERHealth and the LaRoque Family Providers outlined above, the LaRoques have knowledge of, tacitly consent to, and fail to stop the NSA Scheme. *See Planned Parenthood Fed'n of Am., Inc.*, 51 F.4th at 1136; *Spence*, 2021 WL 304391, at **3-4. And third, they failed to stop tortious conduct that—by virtue of their ownership and control over HaloMD and the LaRoque Family Providers—they "knew or had reason to know about." *Spence*, 2021 WL 304391, **3-4.

VII. Anthem Pleads a Claim For Declaratory and Injunctive Relief (Count XIII).

Defendants argue that Anthem's request for declaratory and injunctive relief (Count XIII) should be dismissed because each of the underlying claims fail and this claim "cannot stand on its own[.]" *See* HaloMD Br. 27–28. But, as discussed above, Anthem adequately pleads its underlying claims and thus this claim should survive.

See McCoy v. Alphabet, Inc., No. 20-CV-05427-SVK, 2021 WL 405816, at *13 (N.D. Cal. Feb. 2, 2021) (denying motion to dismiss independent claim for declaratory relief); *Wolf v. Wells Fargo Bank, N.A.*, No. C11-01337 WHA, 2011 WL 4831208, at *10 (N.D. Cal. Oct. 12, 2011) (same); *McMillin Mgmt. Serv., L.P. v. Am. Int'l Specialty Lines Ins. Co.*, No. 10-CV-1841 BEN NLS, 2011 WL 13239002, at *3 (S.D. Cal. July 5, 2011) (same).

VIII. In the Alternative, Anthem Should be Permitted to Cure Any Deficiencies Through Amendment.

Anthem has stated a plausible claim for relief with respect to each count alleged in the AC. In the event, however, that the Court finds any claim inadequately pleaded, Anthem should be afforded leave to remedy any deficiencies. "It is black-letter law that a district court must give plaintiffs at least one chance to amend a deficient complaint, absent a clear showing that amendment would be futile." *Nat'l Council of La Raza v. Cegavske*, 800 F.3d 1032, 1041 (9th Cir. 2015). Anthem's prior filing of an amended complaint pursuant to Rule 15(a) with consent of the defendants does not amount to "at least one chance to amend[.]" *See Bryant v. Dupree*, 252 F.3d 1161, 1163 (11th Cir. 2001).

CONCLUSION

For the foregoing reasons, Anthem respectfully requests that the Court deny Defendants' Motions in their entirety.

Dated: January 30, 2026

CROWELL & MORING LLP

By: /s/ *Amir Shlesinger*
Amir Shlesinger
Jennie W. VonCannon
Joshua M. Robbins
Jason T. Mayer (*admitted pro hac vice*)
Martin J. Bishop (*admitted pro hac vice*)
Alexandra M. Lucas (*admitted pro hac vice*)
Jed Wulfekotte (*admitted pro hac vice*)

Attorneys for Plaintiffs
Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California dba Anthem Blue Cross

L.R. 11-6.1 CERTIFICATE OF COMPLIANCE

Pursuant to Section 28 of the Procedures of the Honorable Karen E. Scott, the undersigned, counsel of record for ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY and BLUE CROSS OF CALIFORNIA D/B/A ANTHEM BLUE CROSS, certifies that this brief, excluding the caption, the signature block, tables of contents and authorities, and any supporting documents, contains 22,728 words, which:

___complies with the word limit of L.R. 11-6.1.

[X] complies with the word limit set by court order dated January 27, 2026, ECF No. 90.

Dated: January 30, 2026

CROWELL & MORING LLP

By: /s/ *Amir Shlesinger*_____
Amir Shlesinger

Counsel for Plaintiffs Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California d/b/a Anthem Blue Cross

EX. E

Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties
June 2025

Topic: Errors Identified After Dispute Closure

Purpose:
The Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) categorized three types of errors—clerical, jurisdictional, and procedural—that a certified Independent Dispute Resolution (IDR) entity may make, but is not identified until after a dispute is closed. These types of errors should be corrected by reopening a closed dispute to ensure the results of the Federal IDR process are aligned with the No Surprises Act (NSA) and that a certified IDR entity complies with the NSA and its implementing regulations. This Technical Assistance (TA) defines these types of errors and contains process guidelines to better ensure the efficient and logical correction of the certified IDR entity's errors, including when a closed dispute resulted in a payment determination.[1] It is intended only to provide clarity to the public regarding the Departments' process under their existing authority to establish an IDR process aligned with statutory and regulatory requirements. This TA is not intended to have the force of law or to impose substantive requirements on parties to the Federal IDR process or on certified IDR entities. It includes a general description of agency policy and sets forth operational guidance to the certified IDR entities.

Based on feedback from certified IDR entities and disputing parties, the Departments have determined that a process for reopening disputes to correct errors identified after dispute closure is needed to support disputing parties and certified IDR entities, and to ensure program integrity. This TA provides guidance to disputing parties and certified IDR entities on the error correction process and clarifies how certified IDR entities should treat three categories of errors identified after dispute closure. Specifically, this TA:

- Provides definitions and examples of the three categories of errors that may be corrected after dispute closure: (1) clerical, (2) jurisdictional, and (3) procedural;
- Includes instructions on correcting such errors;
- Clarifies the impact of a corrected error on the administrative and certified IDR entity fees; and
- Identifies types and examples of errors that may not be corrected after dispute closure.

To reduce errors, the Departments continue to strongly encourage certified IDR entities to have robust quality assurance (QA) programs to verify dispute eligibility and review payment determinations before transmitting determinations to disputing parties and/or closing disputes. A certified IDR entity that does not maintain an adequate QA process may be determined to not be

[1] Under section 9816(c)(5)(e) of the Internal Revenue Code (Code), section 716(c)(5)(E) of the Employee Retirement Income Security Act (ERISA), and section 2799A-1(c)(5)(E) of the Public Health Service Act (PHS Act), IDR payment determinations are generally binding, absent a claim of fraud or misrepresentation of facts, and are subject to judicial review only in limited circumstances described in 9 USC § 10(a).

fit or qualified to make determinations under the Federal IDR process.[2] The Departments will continue to monitor the volume of errors and emphasize that the certified IDR entities are responsible for ensuring that eligibility and payment determinations are accurate. This TA applies to requests to reopen closed disputes received by the Departments:

- On or after **June 6, 2025**; and
- Prior to **June 6, 2025**, but to which the Departments had not responded prior to **June 6, 2025**.

Eligible requests will be evaluated by the Departments in accordance with this TA document. Requests to reopen disputes that the Departments denied prior to **June 6, 2025** should not be resubmitted for reconsideration as they will not undergo additional review. This TA provides a streamlined approach to the requests to reopen closed disputes and ensures the process of correcting errors is uniform and consistent from publication of this TA onward.

Categories of Errors that Certified IDR Entities May Submit for Reopening and Correction After Dispute Closure:

Category 1: Clerical Error

The Departments define a clerical error as a typographical (typo), computational (user) error, or IT systems error impacting the operation or use of the Federal IDR portal made by the certified IDR entity while performing administrative tasks or functions that do not involve the certified IDR entity's discretion, judgment, or expertise.

Examples of clerical errors include, but are not limited to, the following:

1. Based on the documentation provided by the disputing parties, a certified IDR entity determines that the initiating party will be the prevailing party to a dispute. However, the certified IDR entity mistakenly selects the non-initiating party when identifying the prevailing party in the payment determination.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the original payment determination and issue a new one in favor of the initiating party, which will supersede the payment determination made in error.

2. When issuing a payment determination, the certified IDR entity mistakenly fails to upload the required documentation that one or both disputing parties submitted to the Federal IDR portal. The certified IDR entity appropriately considered the information included in this documentation when rendering the payment determination but did not upload the documentation to the Federal IDR portal.

[2] 26 CFR 54.9816–8T(e)(6)(ii)(G), 29 CFR 2590.716-8(e)(6)(ii)(G), 45 CFR 149.510(e)(6)(ii)(G).

If the Departments approve the request to reopen the dispute, the certified IDR entity should re-issue the payment determination that has been corrected to include the previously omitted documentation.

3. When issuing a payment determination, the certified IDR entity makes a typo in the summary section of the payment determination by misspelling a party's name.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should re-issue the payment determination reflecting the appropriate spelling.

4. When a disputing party receives a link from the Federal IDR portal to make an offer, the link is broken and cannot be accessed, and therefore an offer cannot be made in a timely manner.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should proceed with the Federal IDR process.

Category 2: Jurisdictional Error

The Departments define a jurisdictional error as a situation when the certified IDR entity incorrectly determines that an item or service either is or is not a qualified IDR item or service eligible for the Federal IDR process under the requirements of the NSA.

Examples of jurisdictional errors include, but are not limited to, situations where the eligibility of the item or service was incorrectly determined based on the following considerations:

1. Whether it relates to an item or service furnished during a plan year beginning prior to January 1, 2022;

2. Whether it is subject to an All-Payer Model Agreement under section 1115A of the Social Security Act or a specified State law;

3. Whether it relates to an item or service payable by Medicare, Medicaid, CHIP, or TRICARE, Indian Health Service, Veterans Affairs Health Care, short-term limited duration insurance, or excepted benefits;

4. Whether it is furnished by a participating provider, a participating facility, or a participating provider of air ambulance services; or

5. Whether it would not have been covered in-network by the health plan or issuer.

The Departments have determined that jurisdictional errors should be corrected by reopening a dispute to ensure compliance with the NSA's requirements. If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the payment determination, correct the eligibility determination (to reverse a determination of eligibility), communicate to the disputing parties the change to the eligibility determination, refund or invoice the certified

IDR entity fees as appropriate, and send the resulting eligibility determination to the disputing parties.

Category 3: Procedural Error

The Departments define a procedural error as a situation when the certified IDR entity incorrectly determines the eligibility of an item or service for the Federal IDR process or incorrectly makes a determination because a disputing party satisfied, or failed to satisfy, a required procedural step to engage in the Federal IDR process, such as submitting required documentation or timely completion of a step in the process.

Examples of procedural errors include, but are not limited to, the following:

1. The certified IDR entity renders a payment determination for a dispute in which the initiating party failed to timely furnish the notice of initiation to the non-initiating party.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the payment determination and update the eligibility determination to reflect that the dispute is ineligible for the Federal IDR process, close the dispute, and return the certified IDR entity fees, as applicable.

2. The certified IDR entity determines a dispute is ineligible for the Federal IDR process, believing the initiating party initiated the Federal IDR process before the open negotiation period expired when the party's initiation was, in fact, timely.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should update the eligibility determination to reflect that the dispute is eligible and proceed with the Federal IDR process.

3. The certified IDR entity renders a payment determination for a dispute but did not evaluate documentation received from a party that the dispute was subject to the 90-day cooling off period at the time of IDR initiation.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the payment determination and update the eligibility determination to reflect that the dispute is ineligible for the Federal IDR process, close the dispute, and return the certified IDR entity fees, as applicable. The initiating party may request an extension of time from the Departments to initiate the open negotiation period.

4. The certified IDR entity renders a payment determination on an item or service that has already received a payment determination through the Federal IDR process, either by the same or different certified IDR entity.

If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the second payment determination and update the eligibility determination to reflect that the dispute is ineligible for the Federal IDR process, close the dispute, and return the certified IDR entity fees for the second payment determination, as applicable.

5. Both parties requested to withdraw a dispute in a timely manner, but the certified IDR entity issued a payment determination before realizing the dispute was requested to be withdrawn.

   If the request to reopen the dispute is approved by the Departments, the certified IDR entity should complete the withdrawal of the dispute, retaining only half of the certified IDR entity fee from each party.[3]

6. The certified IDR entity does not realize it has received an offer and/or fees from one of the disputing parties in a timely manner and incorrectly issues a default judgment in favor of the other disputing party.

If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the default judgment and review the dispute, considering the offers and information submitted by both parties and issue a new, corrected payment determination, which will supersede the default judgment.

The Departments have determined that procedural errors should be corrected by reopening a dispute to ensure compliance with the NSA's requirements. If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the payment determination (if applicable), correct the eligibility determination (to reverse a determination of eligibility or ineligibility), communicate to the disputing parties the change to the eligibility determination, refund or invoice the certified IDR entity fees as appropriate, send the resulting eligibility determination to the disputing parties, and continue the Federal IDR process (if applicable).

Process of Reopening a Closed Dispute for Clerical, Jurisdictional, or Procedural Errors: A disputing party, the certified IDR entity, or the Departments may initiate the process for correcting a clerical, jurisdictional, or procedural error after dispute closure.

If a disputing party identifies an error after the certified IDR entity closes the dispute, one or both parties should report the error as soon as possible to the relevant certified IDR entity, which should validate the reported error by confirming its existence and that it falls into one of the three categories defined above. The certified IDR entity should then report the error to the Departments as soon as possible by submitting a request to reopen the closed dispute via the Federal IDR portal. If the Departments determine that the error is a clerical, jurisdictional, or procedural error, they will approve the reopening of the dispute in the Federal IDR portal, which will allow the certified IDR entity to make the appropriate adjustment to the dispute and/or

[3] 26 CFR 54.9816-8T(c)(2)(ii), 29 CFR 2590.716-8(c)(2)(ii), and 45 CFR 149.510(c)(2)(ii).

reissue the payment determination to both parties, as appropriate. Failure to promptly report errors to the Departments will result in processing delays. Disputing parties may lodge a complaint against the certified IDR entity if the certified IDR entity does not act on an error that falls into one of the three categories.[4]

If a certified IDR entity identifies an error after closing a dispute, it should submit a request to the Departments to reopen the closed dispute via the Federal IDR portal. If the Departments identify an error after a certified IDR entity closes a dispute, they will notify the certified IDR entity of the error, reopen the closed dispute, and instruct the certified IDR entity to correct the error.

The Departments recognize that the correction of an error could impact the amounts to be paid to the prevailing party or which party prevails in the dispute. Furthermore, the Departments recognize that the rescission of the original payment determination and issuance of a new payment determination impacts the deadline by which payments must be made under 26 CFR 54.9816–8T(c)(4)(ix), 29 CFR 2590.716-8(c)(4)(ix), and 45 CFR 149.510(c)(4)(ix), which is not later than 30-calendar days after a payment determination. If a payment determination is rescinded and reissued, the applicable party is no longer required to make a timely payment based on the withdrawn payment determination. Instead, a new 30-calendar-day period begins on the date the certified IDR entity issues a new binding payment determination following correction of a clerical, jurisdictional, or procedural error. The Departments will consider a party to be in compliance with 26 CFR 54.9816–8T(c)(4)(ix), 29 CFR 2590.716-8(c)(4)(ix), and 45 CFR 149.510(c)(4)(ix) if it makes the appropriate payment amount to the prevailing party within this time period.

Additionally, prior to the date on which the Departments reopen a closed dispute via the Federal IDR portal due to one of the categories of errors described in this TA, the applicable party remains subject to the requirement to pay the other party the applicable amount within 30 calendar days of the original payment determination, regardless of whether a request to reopen a closed dispute has been filed. If a payment determination is rescinded and is not replaced by a new payment determination, but rather, the dispute is closed as ineligible, the payment requirement associated with the rescinded determination is void.

The Departments expect that as soon as a dispute is closed following a correction, certified IDR entities will timely communicate any change to the dispute, such as a corrected payment or eligibility determination, and the appropriate next steps to both disputing parties and the Departments.

Administrative and Certified IDR Entity Fees:
The correction of an error does not change the requirement for both disputing parties to pay the administrative fee for all disputes for which a certified IDR entity is selected, including disputes where the certified IDR entity determines that the item(s) or service(s) under dispute are not

[4] Complaints against certified IDR entities may be submitted to the FederalIDRQuestions@cms.hhs.gov.

eligible for the Federal IDR process. With respect to the certified IDR entity fee, if the correction of an error reverses a determination that a dispute was or was not eligible for the Federal IDR process, the certified IDR entity must either refund or invoice the parties for the certified IDR entity fee as appropriate for the resulting eligibility determination.[5]

Denial of Request to Reopen a Closed Dispute:
The Departments will deny a request to reopen a dispute to correct an error identified after dispute closure if they determine that it is not a clerical, jurisdictional, or procedural error. In general, the Departments will deny a reopening request if the reopening would require the certified IDR entity to reconsider the factors described in 26 CFR 54.9816–8(c)(4)(iii), 29 CFR 2590.716-8(c)(4)(iii), and 45 CFR 149.510(c)(4)(iii). Additionally, the Departments will deny a request to reopen a dispute to correct a clerical, jurisdictional, or procedural error made by a disputing party, rather than the certified IDR entity.

Examples of a request to reopen a dispute that will be denied by the Departments include, but are not limited to, the following:

1. The certified IDR entity requests to reopen a closed dispute to reconsider its payment determination based on information it initially failed to consider, such as a document submitted by a disputing party containing information on the acuity of the participant receiving the qualified IDR item or service.

2. After a payment determination is issued, the certified IDR entity receives notification that the prevailing party made a typo in its offer, resulting in the party's actual offer amount differing from its intended offer amount. For example, the prevailing party submitted an offer of $1,000 but intended the offer amount to be $10,000.[6]

[5]As required by section 9816(c)(8)(A) of the Code, section 716(c)(8)(A) of ERISA, and section 2799A-1(c)(8)(A) of the PHS Act and 26 CFR 54.9816-8(d)(2), 29 CFR 2590.716-8(d)(2), and 45 CFR 149.510(d)(2), and as explained in the interim final rules titled, Requirements Related to Surprise Billing; Part II (published on October 7, 2021), each party to a determination for which a certified IDR entity is selected must, at the time the certified IDR entity is selected, pay to the certified IDR entity a non-refundable administrative fee due to the Secretary. Because the Departments expect that a large part of the expenditures in carrying out the Federal IDR process will come from the initiation of the Federal IDR process, the Departments will have incurred expenditures in instances in which the parties reach an agreement before the certified IDR entity makes a determination or in which the certified IDR entity determines that the dispute does not qualify for the Federal IDR process, and thus, it is appropriate that the parties should still be expected to pay the administrative fee for ineligible disputes. Therefore, if the correction of an error alters the eligibility determination of a dispute, both parties to a dispute must still pay an administrative fee.
[6] The Departments emphasize the importance of disputing parties ensuring accuracy in their Notice of Offer submissions to prevent such an error from occurring.

Jonah D. Retzinger (SBN 326131)
jretzinger@nixonpeabody.com
Christopher D. Grigg (SBN 220243)
cgrigg@nixonpeabody.com
Brock J. Seraphin (SBN 307041)
bseraphin@nixonpeabody.com
April C. Yang (SBN 330951)
ayang@nixonpeabody.com
NIXON PEABODY LLP
300 South Grand Avenue, Suite 4100
Los Angeles, California 90071-3151
Tel: 213-629-6000
Fax: 213-629-6001

Attorneys for Defendants
HALOMD, LLC, ALLA LAROQUE,
and SCOTT LAROQUE

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA - SOUTHERN DIVISION

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

Plaintiffs,

vs.

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

Defendants.

Case No. 25-cv-1467-KES

Before the Honorable Karen E. Scott, United States Magistrate Judge

DEFENDANT HALOMD'S REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF ITS MOTION TO DISMISS ANTHEM'S AMENDED COMPLAINT

Hearing Date: March 10, 2026
Time: 10:00 A.M.
Courtroom: 6D

Defendant HaloMD, LLC ("HaloMD") respectfully requests that the Court take judicial notice of the following documents cited in HaloMD's Memorandum in Support of its Motion to Dismiss Plaintiffs Anthem Blue Cross Life and Health Insurance Company's and Blue Cross of California d/b/a Anthem Blue Cross's (collectively, "Anthem") Amended Complaint, which are attached as exhibits to the accompanying Declaration of Jonah D. Retzinger (the "Retzinger Declaration"). Further, while the Court independently may take judicial notice of these documents, the documents are otherwise integral and incorporated by reference into Anthem's Amended Complaint.

- **Exhibit A:** Notice of IDR Initiation, OMB Control No. 1210-0169 (Expiration Date: 11/30/2025), available on the U.S. Department of Labor website at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/notice-of-idr-initiation.pdf;
- **Exhibit B:** IDR Guidance for Disputing Parties, (last revised December 2023), available on the Centers for Medicare & Medicaid Services ("CMS") website at https://www.cms.gov/files/document/federal-idr-guidance-disputing-parties-march-2023.pdf;
- **Exhibit C:** IDR Guidance for Certified IDR Entities, (last revised December 2023), available on the CMS website at https://www.cms.gov/files/document/federal-idr-guidance-idr-entities-march-2023.pdf;
- **Exhibit D:** Technical Assistance for Certified IDR Entities, (August 2022), available on the CMS website at https://www.cms.gov/files/document/ta-certified-independent-dispute-resolution-entities-august-2022.pdf; and
- **Exhibit E:** Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties, (June 2025), available on the CMS website at https://www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf.

I. Standard.

On a Fed. R. Civ. P. 12(b)(6) motion to dismiss, district courts are not required to accept as true allegations that contradict matters properly subject to judicial notice, documents incorporated by reference in the complaint, or allegations that are merely conclusory, unwarranted deductions of fact, or unreasonable inferences. *See Daniels-Hall v. Nat'l Educ. Ass'n*, 629 F.3d 992, 998 (9th Cir. 2010). The Court may

further consider matters of judicial notice or documents incorporated by reference in the complaint without converting the motion to dismiss into a motion for summary judgment. *See United States v. Ritchie*, 342 F.3d 903, 908 (9th Cir. 2003).

II. The Court May Take Judicial Notice of Guidance Documents Published by Federal Agencies Relating to the IDR Process.

The Court may judicially notice a fact that is not subject to reasonable dispute because it: (1) is generally known within the Court's territorial jurisdiction; or (2) can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned. Fed. R. Evid. 201(b). This includes matters of public record and government documents available from reliable sources on the Internet, such as websites run by governmental agencies. *See Daniels-Hall*, 629 F.3d at 999 (taking judicial notice of information on the website of two school districts because they were government entities). District courts routinely take judicial notice of federal agency documents, including guidance materials relating to agency procedures, when resolving motions to dismiss. *See, e.g., Eidmann v. Walgreen Co.*, 522 F.Supp.3d 634 (N.D. Cal. 2021) (taking judicial notice of Food and Drug Administration (FDA) webpages related to FDA regulatory processes).

Here, the guidance documents that HaloMD requests the Court judicially notice are not subject to reasonable dispute. CMS oversees the No Surprises Act's Independent Dispute Resolution ("IDR") process. The documents are published by federal agencies and appended to federal agency websites to help parties navigate the IDR process. The Notice of IDR Initiation Form is the form developed by federal agencies that parties must use to initiate the IDR process.[1] The IDR Guidance for Disputing Parties guidance document "provides information on how the disputing parties…initiate the Federal IDR Process…and meet the requirements of the Federal IDR Process."[2] The IDR Guidance for Certified IDR Entities guidance document

[1] Notice of IDR Initiation Form, **Exhibit A** to the Retzinger Declaration.

[2] IDR Guidance for Disputing Parties, Section 1.2, **Exhibit B** to the Retzinger Declaration.

"includes information on how the parties to a payment dispute may initiate the Federal IDR Process and describes the requirements of the Federal IDR Process, including the requirements that certified IDR entities must follow in making a payment determination."[3] The technical assistance guidance documents set forth further operational guidance on IDR processes.[4] Collectively, the documents describe the IDR process and are essential to the Court's evaluation of Anthem's Amended Complaint.

Because the guidance documents are published by federal agencies and are not subject to reasonable dispute, the Court may take judicial notice of them and consider them for purposes of HaloMD's Motion to Dismiss.

III. The Guidance Documents are Central to Anthem's Claims and Anthem's Amended Complaint Incorporates the Guidance Documents by Reference.

Although generally the scope of review on a motion to dismiss for failure to state a claim is limited to the complaint, a court may consider evidence on which the complaint necessarily relies if: (1) the complaint refers to the document; (2) the document is central to the plaintiff's claim; and (3) no party questions the authenticity of the copy attached to the motion to dismiss. *See Daniels-Hall,* 629 F.3d at 998 (citing *Marder v. Lopez*, 450 F.3d 445, 448 (9th Cir. 2006)) (internal quotations omitted). The Ninth Circuit has extended the incorporation by reference doctrine to situations in which the plaintiff's claim depends on the contents of the document, the defendant attaches the document to its motion to dismiss, and the parties do not dispute the authenticity of the document. *See Parrino v. FHP, Inc.*, 146 F.3d 699, 705–06 (9th Cir. 1998) (quotation omitted); *Knievel v. ESPN*, 393 F.3d 1068, 1076 (9th Cir. 2005). The court may treat such a document as part of the complaint and

[3] IDR Guidance for Certified IDR Entities, Section 1.3, **Exhibit C** to the Retzinger Declaration.

[4] Technical Assistance Guidance Documents for Certified IDR Entities and Disputing Parties, **Exhibits D** and **E** to the Retzinger Declaration.

thus may assume that its contents are true for purposes of a motion to dismiss. *Daniels-Hall*, 629 F.3d at 998 (quoting *Marder*, 450 F.3d at 448).

Here, the IDR process guidance documents are indisputably central to Anthem's allegations and claims, all of which relate to the IDR process. Indeed, Anthem's 89-page Amended Complaint includes 604 references to the term "IDR" and 183 references to the term "IDR process." Most of Anthem's substantive allegations describe IDR processes, along with representations regarding how CMS administers the IDR process, including among others:

- Anthem's general description of the IDR process (Amended Complaint ("AC"), ¶¶ 42-80);
- Anthem's specific reference to CMS resources and acknowledgement that, "[t]he Centers for Medicare & Medicaid Services ("CMS"), the federal agency within the Department of Health and Human Services ("HHS") that is primarily charged with implementing the IDR process, has issued several resources to aid interested parties…" (*id.*, ¶ 52) (footnoting other CMS guidance documents);
- Anthem's reference to the IDR initiation form published by federal agencies (*id.*, ¶¶ 53, 63, 96);
- Anthem's reference to "the online process for initiating IDR…." (*id.*, ¶ 55);
- Anthem's inclusion of images of the IDR online interface (*id.*, ¶¶ 56-58, 60, 64);
- Anthem's allegation that "HHS administers the IDR initiation process" (*id.*, ¶ 67);
- Anthem's references to "the layers of safeguards in the IDR initiation process" (*id.*, ¶ 73); and,
- Anthem's specific references to "CMS publications and resources" relating to IDR eligibility (*see, e.g.*, *id.*, ¶ 287).

Accordingly, the IDR guidance documents submitted by HaloMD with its Motion to Dismiss, which describe the IDR process, are central to Anthem's claims and incorporated into Anthem's Amended Complaint. For this reason, and because such documents are otherwise judicially noticeable, HaloMD requests that the Court consider them for purposes of HaloMD's Motion to Dismiss.

Dated: December 12, 2025

NIXON PEABODY LLP

By: */s/Jonah D. Retzinger*
Jonah D. Retzinger
Christopher D. Grigg
Brock J. Seraphin
April C. Yang

Attorneys for Defendants HALOMD, LLC., ALLA LAROQUE, AND SCOTT LAROQUE

L.R. 11-6.1 CERTIFICATE OF COMPLIANCE

Pursuant to Section 28 of the Procedures of the Honorable Karen E. Scott, the undersigned, counsel of record for Defendants HALOMD, LLC, ALLA LAROQUE, and SCOTT LAROQUE, certifies that this brief, excluding the caption, the signature block, and any supporting documents and exhibits, contains 1,213 words, which:

[X] complies with the word limit of L.R. 11-6.1.

___ complies with the word limit set by court order dated [*date*].

Dated: December 12, 2025

NIXON PEABODY LLP

By: */s/Jonah D. Retzinger*
Jonah D. Retzinger

Attorneys for Defendants HALOMD, LLC, ALLA LAROQUE, AND SCOTT LAROQUE

Jonah D. Retzinger (SBN 326131)
jretzinger@nixonpeabody.com
Christopher D. Grigg (SBN 220243)
cgrigg@nixonpeabody.com
Brock J. Seraphin (SBN 307041)
bseraphin@nixonpeabody.com
April C. Yang (SBN 330951)
ayang@nixonpeabody.com
NIXON PEABODY LLP
300 South Grand Avenue, Suite 4100
Los Angeles, California 90071-3151
Tel: 213-629-6000
Fax: 213-629-6001

Attorneys for Defendants
HALOMD, LLC, ALLA LAROQUE
and SCOTT LAROQUE

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Case No. 25-cv-1467-KES

Before the Honorable Karen E. Scott, United States Magistrate Judge

DEFENDANT HALOMD'S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF ITS MOTION TO DISMISS ANTHEM'S AMENDED COMPLAINT

Hearing Date: March 10, 2026
Time: 10:00 A.M.
Courtroom: 6D

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Federal Independent Dispute Resolution Operations Notice of Proposed Rulemaking, 88 Fed. Reg. 75744, 75759-63 (Nov. 3, 2023) 13

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MEMORANDUM OF POINTS AND AUTHORITIES

I. Introduction.

In time, Plaintiffs Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California d/b/a Anthem Blue Cross (collectively, "Anthem") will be held accountable for their abuse of process. For the moment, this Court should see this case for what it is: an attempt by Anthem, one of the wealthiest organizations in the world, to bury those that reveal its exploits, and in doing so, challenge its power. But Anthem cannot manufacture claims or liability where neither exist.

For the following reasons, this Court should dismiss the entirety of Anthem's Amended Complaint with prejudice pursuant to Fed. R. Civ. P. 12(b)(1), (2), and (6).[1]

II. The Genesis of the No Surprises Act.

This lawsuit is about the No Surprises Act's Independent Dispute Resolution ("IDR") process. But while the IDR process is at the center of this dispute, the genesis of the No Surprises Act ("NSA") is equally important to understanding this case.[2]

In America, healthcare insurance companies like Anthem have tremendous market power. They wield that power to force healthcare providers to accept unfair payments for healthcare services. With Anthem in particular, healthcare providers often have a dilemma—they can either: (i) accept Anthem's unfair contractual rates and join Anthem's provider network (*i.e.*, go "in-network"); or (ii) refuse to join Anthem's provider network (*i.e.*, go "out-of-network"), in which case Anthem and the healthcare provider have no agreement regarding how much Anthem must pay for services provided to patients with healthcare insurance through Anthem.

[1] In addition to the arguments set forth in this memorandum, HaloMD joins in all other arguments, as applicable to HaloMD, asserted by its co-Defendants in their respective motions to dismiss.

[2] The NSA is a component (Division BB, Title I) of the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182, 2758 (2020).

In the out-of-network context, the healthcare provider often is only in privity with the patient. Because of this, prior to the passage of the NSA, patients were often put in the middle of payment disputes between out-of-network healthcare providers and Anthem. If Anthem refused to pay fair rates, the healthcare provider could only seek recovery from the patient. It was an unfortunate reality for patients who believed—because of their Anthem insurance—that certain healthcare services were in-network and were surprised when they received a bill.

The NSA changed things. The NSA limits an insured patient's financial responsibility for certain out-of-network services that patients often incorrectly believe are in-network: (i) emergency services, (ii) services provided by out-of-network providers at in-network facilities, and (iii) air ambulance services. *See* 42 U.S.C. §§ 300gg-131; 300gg-132; 300gg-135. However, while this limitation resolved the issue of patients receiving surprise bills, Congress recognized that there needed to be an efficient way to resolve disputes regarding the ultimate payment for such services when there was no other controlling authority governing payment.[3] Congress's solution was the IDR process, whereby certified Independent Dispute Resolution Entities ("IDREs") would, according to strict, explicit parameters set by Congress, resolve out-of-network payment disputes. *See generally* 42 U.S.C. § 300gg-111(c). To ensure that the federal judiciary was not overburdened by parties' dissatisfaction with IDRE decisions, Congress explicitly barred judicial review of IDRE determinations, except in the limited cases where vacatur is permitted under the Federal Arbitration Act ("FAA"). *See* 42 U.S.C. § 300gg-111(c)(5)(E)(i).

While Congress recognized that the IDR process was necessary, it underestimated the prevalence—and significance—of the market power imbalance

[3] The NSA provides for resolution of out-of-network payment disputes through the IDR process when a state does not have a "specified State law" that provides for a method of determining the amount to be paid, or if the state does not have an All-Payer Model Agreement (*i.e.*, a healthcare payment system where all payers, including commercial insurers, agree to pay the same rate for a specific service). *See* 42 U.S.C. § 300gg-111(a)(3)(K) (defining "out-of-network rate"); 45 C.F.R. § 149.510(a)(2)(xi)(A) (Oct. 7, 2021) (defining "Qualified IDR item or service").

between commercial healthcare insurers and healthcare providers. The IDR process has been a revelation. Providers, often foreclosed from challenging commercial healthcare insurance payments due to the costs and burdens of litigation, now have the means through the IDR process to efficiently contest unfair payment rates for certain services and subject such rates to scrutiny. When IDREs scrutinize commercial healthcare insurance rates, they often determine that many such rates are indefensible.[4]

III. Anthem's Agenda.

Anthem is understandably threatened by the IDR process because it forces Anthem to pay fair rates for out-of-network services. If healthcare providers are better positioned to fight unfair rates, they also will be less willing to join Anthem's network, making it more difficult for Anthem to market and sell its insurance products. It is bad for Anthem's business.

Given this new reality, one might think that Anthem would offer more reasonable contracted rates to encourage healthcare providers to go in-network. Or that for those cases proceeding through the IDR process, Anthem would submit more reasonable offers to IDREs. Not so. Instead, Anthem has elected to file actions across the country against HaloMD, which contracts with healthcare providers to resolve payment disputes through the IDR process. All of Anthem's actions lead with alleged violations of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. § 1961 *et seq*. ("RICO"), a federal statute designed to dismantle organized crime syndicates.[5]

[4] As Anthem acknowledges, IDREs select the provider offer as the more reasonable offer in approximately 85% of disputes that proceed to a payment determination. Amended Complaint, Dkt. 50 ("AC"), ¶ 82.

[5] In addition to this action, Anthem's affiliates have filed similar actions against HaloMD and others in Georgia and Ohio. *See Blue Cross Blue Shield Healthcare Plan of Ga., Inc. v. HaloMD, LLC, et al.*, No. 1:25-cv-02919-TWT (N.D. Ga.); *Community Insurance Company v. HaloMD, LLC et al.*, No. 1:25-cv-00388-MWM (S.D. Ohio).

The intended effect of Anthem's actions is obvious: impose business-debilitating litigation costs on HaloMD, intimidate healthcare providers, and chill the use of the IDR process.

IV. Anthem Does Not Allege a Factual Basis for Liability.

Anthem's Amended Complaint largely amounts to an attack on the NSA itself. However, while Anthem's displeasure with the NSA is not a basis for liability generally, the contentions offered by Anthem are similarly illegitimate bases for all of Anthem's claims. Anthem's Amended Complaint thus fails to state a plausible claim and should be dismissed pursuant to Fed. R. Civ. P. 12(b)(6).

Anthem offers three factual predicates for its claims against HaloMD. In reverse order, Anthem alleges that HaloMD is liable because it submitted through the IDR process: (1) improperly inflated offers; (2) massive volumes of disputes; and (3) false and fraudulent attestations of eligibility. AC, ¶¶ 90-129. None of these contentions are sufficient to support any of Anthem's claims.

First, regarding Anthem's contention that HaloMD's offers are illegally inflated, there is no authority that limits what amount a party may offer in the IDR process. Rather, the IDR process is designed as a "baseball style" arbitration, whereby the IDRE selects (from the two offers submitted by the insurer and the provider) the offer that best represents the value of the service based on strict criteria set forth by Congress. *See* 42 U.S.C. § 300gg-111(c)(5)(C). As Anthem acknowledges, by law, an IDRE may not even consider a healthcare provider's billed charge (*i.e.*, the usual and customary charge) for the service at issue when making a payment determination. 42 U.S.C. § 300gg-111(c)(5)(D); AC, ¶¶ 76, 122. Presumably, if an IDRE selected HaloMD's offer in a dispute initiated by HaloMD against Anthem, it only selected such offer because it deemed HaloMD's offer more reasonable. That any such HaloMD offer may have been greater than the billed charge is irrelevant and fails to account for, among other things, the increased costs that a healthcare provider incurs because Anthem refused to pay a fair rate initially,

necessitating the initiation of the IDR process. Anthem's contention is thus an indictment of its own payment practices. Ironically, Anthem alleges the following in support of its legal contention that HaloMD's offers are unlawfully inflated:

> Indeed, upon information and belief, prior to the enactment of the NSA, [the healthcare provider Defendants] rarely, if ever, recovered their full billed charges from patients or health plans. AC, ¶ 125.

It is for this very reason that Congress felt compelled to create the IDR process.

Second, regarding the alleged volume of IDR proceedings initiated by HaloMD, no authority limits the number of IDR proceedings that a party may initiate. Indeed, any limitation would be illogical and serve as an arbitrary barrier to prevent healthcare providers from accessing the IDR process. Further, both the NSA and associated regulations set forth strict timing requirements for initiating IDR proceedings and provide for the batching of similar disputes in certain circumstances. *See* 42 U.S.C. § 300gg-111(c) (the statutory framework for the IDR process, including batching); 45 C.F.R. § 149.510 *et seq*. (Oct. 7, 2021) (IDR process implementing regulations). Thus, Anthem essentially alleges that HaloMD is liable for adhering to statutory and regulatory deadlines and requirements.

Anthem's contention is also self-defeating. Even assuming Anthem's allegations of volume to be true, the only reason that HaloMD would need to initiate a high volume of IDR proceedings is because Anthem refused to fairly pay healthcare providers for the same volume of services. In other words, Anthem seeks to hold HaloMD and the other defendants liable for a circumstance Anthem created.[6]

Finally, Anthem alleges that HaloMD is liable because it submitted false attestations of eligibility for the IDR process. But, in attempting to plead the

[6] Anthem describes HaloMD's initiation of "hundreds of disputes," including "***746 disputes against health plans per day***," as a "flood." AC, ¶¶ 110, 296 (emphasis in original). Anthem allegedly processes "tens of millions of health care claims annually." *Id.*, ¶ 30. While HaloMD is bound by statutory and regulatory deadlines, Anthem is as well-positioned as any entity to process and respond to IDR process filings (which, again, are only necessary if Anthem does not initially pay healthcare providers fairly).

materiality of the allegedly false attestations, Anthem misrepresents the attestation at issue, the IDR process, and specifically the process by which IDREs assess eligibility.

V. IDREs Evaluate and Resolve Eligibility Disputes.

By regulation, when notifying a party of its initiation of the IDR process, an initiating party must submit an attestation that it believes that the items and services under dispute qualify for resolution via the IDR process. 45 C.F.R. § 149.510(b)(2)(iii)(A)(6) (Oct. 7, 2021). This attestation provides:

> I, the undersigned initiating party (or representative of the initiating party), attests that to the best of my knowledge…the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) within the scope of the Federal IDR process.[7]

Despite being the crux of Anthem's case, Anthem glosses over the actual language of the attestation. Furthermore, there is no authority that directs the IDRE to rely upon an initiating party's attestation to determine eligibility when eligibility is disputed. Nor is the attestation a certification of eligibility in any respect. Rather, it is an attestation that an initiating party, "to the best of [its] knowledge," believes a dispute is eligible.

Given the information asymmetry between commercial healthcare insurers and healthcare providers, Anthem is often exclusively in possession of material information relating to NSA applicability and IDR process eligibility. Indeed, it is for this very reason that, in November 2023, federal agencies published comprehensive proposed rulemaking that would require healthcare insurers, like Anthem, to use specific codes when processing out-of-network claims to communicate material information relating to IDR process eligibility to healthcare

[7] HaloMD's Request for Judicial Notice ("RJN"), Ex. A (Notice of IDR Initiation Form). The Notice of IDR Initiation Form even permits a healthcare provider to check "Unknown" when selecting the "Type of Plan" involved in the dispute.

providers.[8] Federal agencies proposed such rules to enable healthcare providers to "understand not only when items and services are subject to the No Surprises Act, but also when they are not, to avoid submission of ineligible disputes…."[9]

While such rulemaking remains pending, by existing regulation, IDREs must determine eligibility in every single IDR proceeding. 45 C.F.R. § 149.510(c)(1)(v) (Oct. 7, 2021). And Anthem's mischaracterizations of the attestation aside, the Amended Complaint completely omits the process for resolving eligibility disputes. This process requires Anthem to submit eligibility challenges to the IDRE for consideration. 45 C.F.R. § 149.510(c)(1)(iii) (Oct. 7, 2021) ("[I]f the non-initiating party believes that the Federal IDR process is not applicable, the non-initiating party must…provide information regarding the Federal IDR process's inapplicability through the Federal IDR portal…"). The federal government's authoritative guidance document intended to clarify IDR processes for disputing parties reiterates Anthem's regulatory obligation and the IDRE's duty to determine eligibility upon initiation of the IDR process. As set forth explicitly in the IDR Process Guidance for Disputing Parties:

> **5.5 Instances When the Non-Initiating Party Believes the Federal IDR Process Does Not Apply**
>
> 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. This information must be provided not later than 1-business-day after the end of the 3-business-day period for certified IDR entity selection, (the same date that the notice of selection or of failure to select a certified IDR entity must be

[8] *See* Federal Independent Dispute Resolution Operations Notice of Proposed Rulemaking, 88 Fed. Reg. 75744, 75759-63 (Nov. 3, 2023) (federal agencies explaining their proposal to require healthcare insurers to use codes when processing out-of-network claims to address gaps in communication between healthcare insurers and providers).

[9] *Id.*, at 75761.

> submitted). This notification must include information regarding the Federal IDR Process' inapplicability.
>
> The certified IDR entity must determine whether the Federal IDR Process is applicable. The certified IDR entity must review the information submitted in the Notice of IDR Initiation and the notification from the non-initiating party claiming the Federal IDR Process is inapplicable, if one has been submitted, to determine whether the Federal IDR Process applies. If the Federal IDR Process does not apply, the certified IDR entity must notify the Departments and the parties within 3 business days of making that determination. While the matter is under review by the certified IDR entity, the timelines of the Federal IDR Process continue to apply, so the parties should continue to meet deadlines to the extent possible, as described in Section 9. Further, the Departments will maintain oversight of the applicability of the Federal IDR Process through their audit authority.[10]

The companion IDR Process Guidance for Certified IDR Entities contains identical guidance.[11] Federal agencies have also published technical assistance that addresses the specific steps IDREs must undertake to confirm eligibility if a commercial healthcare insurer, like Anthem, disputes eligibility.[12] None of these steps direct the IDRE to rely (exclusively or otherwise) upon the initiating party's attestation when determining eligibility. Instead, IDREs are directed to request and evaluate further documentation and explanations from disputing parties and proceed only if such documentation demonstrates the eligibility of the dispute. Further, when submitting offers, all parties to the IDR proceeding have an opportunity to again challenge eligibility and submit additional information relating to eligibility for the IDRE's consideration.

[10] HaloMD's RJN, Ex. B (IDR Guidance for Disputing Parties (last revised Dec. 2023)).

[11] HaloMD's RJN, Ex. C, (IDR Guidance for Certified IDR Entities (last revised Dec. 2023)) §§ 4.4, 4.6.2.

[12] HaloMD's RJN, Ex. D (Technical Assistance for Certified Independent Dispute Resolution Entities (Aug. 2022)).

Per IDR process regulations, if the IDRE finds a dispute ineligible, it "must notify…the parties within 3 business days of making that determination." 45 C.F.R. § 149.510(c)(1)(v) (Oct. 7, 2021). Regulatory agencies facilitate potential reconsideration of eligibility even after an IDRE payment determination. CMS, which oversees the IDR process, announced that parties may re-open closed IDR proceedings for "jurisdictional error[s]," such as where the IDRE "incorrectly determines" eligibility.[13] The Amended Complaint, which was filed well after CMS's announcement, conveniently pretends this eligibility reconsideration process does not exist.

Yet, the process to contest eligibility is robust. Anthem has multiple opportunities to challenge eligibility but often is overruled. *See, e.g.*, AC, ¶¶ 115, 118, 171, 176, 181, 187, 193, 199, 234, 240, 247, 287, 316, 341 (referencing Anthem's objections). While Anthem alleges that its objections were overruled "due to Defendants' knowingly false attestation," it cannot fabricate theories of liability that directly conflict with existing statutory and regulatory processes.

And this is the heart of the matter. Anthem disagrees with IDRE determinations. But that disagreement does not justify burdening this Court with what is fundamentally an illegitimate and impermissible appeal.

VI. Anthem Cannot Artfully Plead around the No Surprises Act's Judicial Review Prohibition and the Federal Arbitration Act.

In the NSA, Congress was unequivocal: "[an IDRE] determination…shall be binding upon the parties involved in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the [IDRE]; and shall not be subject to judicial review, except in a case [that would allow a court to vacate the award under the Federal Arbitration Act]." 42 U.S.C. § 300gg-111(c)(5)(E)(i).

[13] HaloMD's RJN, Ex. E (CMS, Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties at 1 (June 2025)).

Given this prohibition against judicial review, many other federal courts have already concluded that the only right of action in the NSA derives from the incorporated vacatur sections of the Federal Arbitration Act ("FAA"). *See*, *e.g.*, *Guardian Flight, L.L.C. v. Health Care Serv. Corp.* ("*Guardian Flight I*"), 140 F.4th 271, 275 (5th Cir. 2025) ("The only right of action provided [in the NSA] derives from the incorporated vacatur sections of…the FAA"); *Modern Orthopaedics of NJ v. Premera Blue Cross*, No. 2:25-CV-01087 (BRM) (JSA), 2025 WL 3063648, at *8 (D.N.J. Nov. 3, 2025) ("[T]he only role contemplated for the federal courts in the NSA is the ability to vacate an award granted due to misconduct.").

Pursuant to the FAA, district courts are prohibited from reconsidering the merits of an arbitration under the guise of post-award litigation; parties may not proceed with collateral attacks that repackage alleged arbitral wrongdoing into independent claims for damages. *See Nickoloff v. Wolpoff & Abramson, L.L.P.*, 511 F. Supp. 2d 1043, 1044 (C.D. Cal. 2007) ("[s]eeking damages in federal court for alleged wrongdoing that compromised an arbitration award is an impermissible collateral attack on the award itself"). If a claim seeks to redress harm caused by an allegedly tainted award or that would require the court to assess the validity of the arbitration process or result, it is an impermissible collateral challenge and must be dismissed. *See id*. (citing *Decker v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 205 F.3d 906, 908 (6th Cir. 2000) (affirming dismissal because the plaintiff's claims collaterally attacked the arbitration award)).

The reasons such collateral actions are barred are easy to understand: arbitration processes are designed to deliver a prompt and final resolution with minimal judicial involvement so as not to overburden the judiciary. Collateral actions, if permitted, would upend that balance by inviting expansive discovery and strategic re-litigation by well-funded, disappointed parties, like Anthem. This would ultimately chill reliance on the IDR process as a reliable dispute resolution mechanism.

Accordingly, with the exception of Anthem's vacatur claim, all of Anthem's other claims are impermissible collateral attacks on IDR awards.

VII. Anthem's Claims Are Barred by the *Noerr-Pennington* Doctrine.

On its face, the Amended Complaint also must be dismissed in its entirety because the conduct alleged by Anthem constitutes core petitioning activity protected by the *Noerr-Pennington* doctrine. The *Noerr-Pennington* doctrine is grounded in the First Amendment's Petition Clause, which provides that "Congress shall make no law…abridging…the right of the people…to petition the Government for a redress of grievances." U.S Const. amend. I. The *Noerr-Pennington* doctrine immunizes private actors from litigation in connection with petitioning for redress, unless the petitioning amounts to a sham. *See Sosa v. DIRECTV, Inc.*, 437 F.3d 923, 929 (9th Cir. 2006) (providing background on the *Noerr-Pennington* doctrine).

Although the *Noerr-Pennington* doctrine initially arose in the antitrust context, the Supreme Court has since expanded the doctrine to other contexts. *See id*. at 930. It shields any effort to elicit action from government decision-makers, courts, administrative agencies, and in other quasi-judicial proceedings. *See Cal. Motor Transp. Co. v. Trucking Unlimited*, 404 U.S. 508, 510–11 (1972) (holding that *Noerr-Pennington* applies when petitioning state and federal agencies); *Viriyapanthu v. California*, No. SACV172266JVSDFMX, 2018 WL 6136150, at *7 (C.D. Cal. Sept. 24, 2018) (providing that the *Noerr-Pennington* doctrine has been applied to quasi-judicial proceedings and citing its application to an arbitration proceeding). Immunity under the *Noerr-Pennington* doctrine extends to both: (i) communications made during the course of a lawsuit, and (ii) conduct incidental to a lawsuit, including pre-suit communications. *Theme Promotions, Inc. v. News Am. Mktg. FSI*, 546 F.3d 991, 1007 (9th Cir. 2008); *Sosa*, 437 F.3d at 936-38.

Courts apply a three-part analysis to determine if the *Noerr-Pennington* doctrine immunizes a defendant's allegedly illegal conduct: (i) whether the lawsuit imposes a burden on petition rights; (ii) whether the alleged activities constitute

protected petitioning activity; and (iii) whether the statute at issue must be construed to avoid that burden. *See B&G Foods N. Am., Inc. v. Embry*, 29 F.4th 527, 535 (9th Cir. 2022). If the answer to each step is "yes," then a defendant's conduct is immunized under *Noerr-Pennington*, unless the petitioning activity at issue amounts to a sham. *Id*.

Here, Anthem's theory of liability is that HaloMD abused the IDR process—by filing thousands of disputes, by inflating offers, and by submitting false attestations—yet the substance of Anthem's theory is indistinguishable from the conduct *Noerr-Pennington* squarely protects. Anthem's claims plainly burden petitioning rights. Anthem seeks to impose RICO liability on HaloMD and its co-Defendants for initiating IDR proceedings, which is the statutorily prescribed means for healthcare providers to resolve certain out-of-network payment disputes with commercial healthcare insurers. *See Ford Motor Co. v. Knight L. Grp. et al.*, No. 2:25-CV-04550-MWC-PVC, 2025 WL 3306280, at *8-9 (C.D. Cal. Nov. 24, 2025) (quotation omitted) (finding that protected petitioning activity includes the submission of documents in which a party makes representations to support its request for relief). Further, none of the statutory authorities relied upon by Anthem—including the allegedly implicated mail and wire fraud statutes—reach the initiation of IDR proceedings. *See cf. Sosa*, 437 F.3d at 939–42 (finding that mail and wire fraud statutes do not reach settlement demands)*; Ford Motor Co.*, 2025 WL 3306280 at *12. (finding that mail and wire fraud statutes do not reach the submission of inflated fee petitions).

The *Noerr-Pennington* doctrine's narrow "sham" exception does not save Anthem's claims. Anthem's Amended Complaint does not plausibly allege that HaloMD's petitioning was objectively baseless, that HaloMD's positions were meritless, that HaloMD's motive was unlawful, or that HaloMD knowingly made any false attestations. IDREs are, by regulation, required to determine eligibility prior to making a payment determination. The Amended Complaint acknowledges

that HaloMD prevailed in a significant percentage of disputes, confirming that HaloMD's positions with respect to eligibility were objectively reasonable. Indeed, a "winning lawsuit is by definition a reasonable effort at petitioning for redress and therefore not a sham." *Ford Motor Co.*, 2025 WL 3306280 at *9 (quoting *White v. Lee*, 227 F.3d 1214, 1232 (9th Cir. 2000)).

Put simply, since HaloMD's initiation of the IDR process itself is immunized, all of Anthem's claims based on those initiations collapse.

VIII. The Court Lacks Personal Jurisdiction over HaloMD.

While Anthem's claims are barred by both the NSA's judicial review prohibition and the *Noerr-Pennington* doctrine, Anthem also fails to establish personal jurisdiction over HaloMD, a nonresident Defendant. Anthem's claims against HaloMD thus should be dismissed pursuant to Fed. R. Civ. P. 12(b)(2).

Here, Anthem alleges that HaloMD is a Delaware limited liability company and it is a citizen of Texas because its two members and their sub-members are citizens of Texas. AC, ¶¶ 14-15. None of the operative factual allegations underlying Anthem's claims arise from HaloMD's alleged contacts with California, nor does Anthem's Amended Complaint connect HaloMD to California whatsoever, except for a vague allegation that "HaloMD solicits and represents physician practices…in California." *Id*. Rather, each of Anthem's claims relates to IDR proceedings overseen by federal agencies.

Accordingly, Anthem does not establish that this Court has personal jurisdiction (either general or specific) over HaloMD.[14]

IX. Anthem's Amended Complaint Fails to State a Claim (with or without Particularity).

While dismissal with prejudice is warranted for the many reasons set forth above, Anthem's claims individually fail.

[14] While Anthem's RICO and ERISA claims are barred and fail, Anthem also cannot show the "ends of justice" would require bringing HaloMD before this Court to satisfy RICO's nationwide service of process provision, 18 U.S.C. § 1965(b).

1. Anthem's Substantive RICO Claims Fail.

RICO prohibits conducting or participating in the conduct of a RICO enterprise's affairs through a pattern of racketeering activity, as well as conspiring to do so. 18 U.S.C. §§ 1964(c), 1962(c)-(d). To state a RICO claim, a plaintiff must allege the defendant: (1) engaged in conduct (2) of an enterprise (3) through a pattern (4) of racketeering activity and (5) caused injury to the plaintiff. *Casablanca Design Ctr, Inc. v. Closets by Design, Inc.*, No. 2:23-cv-02155-ODW, 2024 WL 4729461, at *3 (C.D. Cal. Nov. 8, 2024) (citing *Black v. Corvel Enter. Comp Inc.*, 756 F. App'x 706, 708 (9th Cir. 2018)). Regarding injury, Anthem must allege that Defendants' conduct was not only a "but for" cause of Anthem's injury but also the proximate cause of the injury. *Id.* (citing *Harmoni Int'l Spice, Inc. v. Hume*, 914 F.3d 648, 651 (9th Cir. 2019)). Proximate cause requires "some direct relation between the injury asserted and the injurious conduct alleged." *Id.*

A. Anthem Does Not Allege that HaloMD Proximately Caused Damage to Anthem.

Anthem does not sufficiently establish HaloMD's actions proximately caused damage to Anthem. Anthem's gripe is with IDRE determinations, but IDR process outcomes are hardly foreseeable. If Anthem thinks a dispute is ineligible for the IDR process, Anthem is required to challenge eligibility, which IDREs necessarily decide before making payment determinations. AC, ¶ 33; 45 C.F.R. § 149.510(c)(1)(v) (Oct. 7, 2021). Since IDREs exercise independent, congressionally mandated arbitral authority, in every case, the IDREs' actions broke any direct causal link to HaloMD's alleged conduct.[15] *See Galen v. Cnty. of Los Angeles*, 477 F.3d 652, 663 (9th Cir. 2007) (holding third-party acts requiring independent judgment in the course of official duties break the causal chain); *De Los Angeles Aurora Gomez v. Bank of Am., N.A.*, No. CV 12-8704-GHK (SHX), 2013 WL 12165673, at *6 (C.D. Cal. Aug. 21,

[15] By the same logic, Anthem does not allege a concrete and particularized injury traceable to HaloMD's allegedly wrongful conduct that would confer standing.

2013) (dismissing RICO claim for failure to allege reliance on misrepresentation and breaks in the causal chain).

B. Defendants' Routine Business Arrangements Do Not Qualify as a Pattern of Racketeering Activity.

Even if Anthem's Amended Complaint sufficiently alleged proximate cause, Anthem separately fails to allege the conduct of a RICO enterprise through a pattern of racketeering activity.

i. Litigation Activities are Not Predicate Racketeering Acts.

Courts have overwhelmingly barred civil RICO claims based on allegedly fraudulent litigation activities, like IDR proceedings. *See Kim v. Kimm*, 884 F.3d 98, 104–05 (2d Cir. 2018) (collecting federal court cases holding that litigation activity cannot act a predicate offense for a civil RICO claim). Otherwise, "every unsuccessful lawsuit could spawn a retaliatory action." *Id.* Here, while Anthem misrepresents both the initiating party's attestation and the process to resolve eligibility disputes generally, even if Anthem could plausibly plead the falsity of such attestation, HaloMD's attestations are no more federal wire fraud or mail fraud than Anthem's and its lawyers' own multiple factual misrepresentations in their initial complaint in this case.[16]

ii. Anthem Fails to Allege a Racketeering Pattern.

A "pattern of racketeering activity" requires at least two alleged acts of racketeering activity against each defendant. 18 U.S.C. § 1961(5). To assert a RICO claim against multiple defendants, the plaintiff must allege at least two predicate acts by each defendant and, at a minimum, differentiate defendants' conduct in the alleged fraud. *See Makarem v. Get Buzzed LLC*, No. 2:25-cv-02357-MWC-ASX, 2025 WL

[16] Anthem's initial complaint contained multiple, demonstrably false factual misrepresentations, to which co-Defendants objected in a Rule 11 letter, prompting Anthem to amend its pleading. Presumably, Anthem does not concede that its actions expose it and its counsel to RICO liability.

3030580, at *4-5 (C.D. Cal. Sep. 23, 2025) (quoting *In re WellPoint, Inc. Out-of-Network "UCR" Rates Litig.*, 903 F. Supp. 2d 880, 914 (C.D. Cal. 2012)).

Anthem fails on both counts. At best, the Amended Complaint establishes routine business relationships between parties in the health care ecosystem. The provider Defendants treat patients covered by Anthem. When Anthem refuses to make fair payments, the providers engage HaloMD to initiate IDR proceedings. But the initiation of IDR proceedings is not a pattern of racketeering. Further, Anthem offers no non-conclusory allegations that any other Defendant committed at least two RICO predicate offenses.

iii. Anthem Fails to Allege a Distinct RICO Enterprise.

Anthem also fails to sufficiently allege a racketeering enterprise within the meaning of 18 U.S.C. § 1964(1). Establishing a racketeering enterprise requires pleading the enterprise has: (A) a common purpose, (B) a structure or organization, and (C) longevity necessary to accomplish that purpose. *Ford Motor Co.*, 2025 WL 3306280 at *13.

The common purpose requirement demands more than pleading that parties engaged in ordinary business conduct. Courts have overwhelmingly rejected attempts to characterize routine commercial relationships as RICO enterprises. *See, e.g.*, *id*. at *14 (holding that conclusory allegations that the defendants' purpose was fraudulent were insufficient to infer that the defendants came together to engage in fraudulent conduct). Fundamentally, Anthem's allegations lack any indication that the parties came together for the purpose of fraud. Rather, Anthem "relies on the syllogism" that because it alleges false attestations and the Defendants have contractual relationships, the Defendants must have acted with the purpose of committing fraud. *Id*. at *15. But "[w]ithout more, this Court [should] not turn an ordinary business relationship into a RICO enterprise." *Id.* at *13-15 (citations and quotations omitted). Nor does Anthem allege an enterprise organization or structure as a vehicle for committing predicate crimes. At most, Anthem alleges that the

provider Defendants hired HaloMD to initiate IDR proceedings. That is insufficient to plead that Defendants' relationships are vehicles for fraud. *Id.* at *15-16.

iv. Anthem's Wire Fraud Allegations Lack Particularity.

Finally, Anthem fails to allege wire fraud predicates with the requisite Fed. R. Civ. P. 9(b) particularity. Wire fraud requires: "(A) the formation of a scheme to defraud; (B) use of the . . . wires in furtherance of that scheme; and (C) the specific intent to defraud." *Core Health & Fitness, LLC v. Transmedik Specialized Inc.*, No. 8:24-cv-02481-AB-JDE, 2025 WL 2958866, at *8 (C.D. Cal. Aug. 13, 2025) (quotations omitted). When alleged as RICO predicates, wire fraud allegations must meet Fed. R. Civ. P. 9(b)'s pleading standard. Because this case involves multiple defendants, Anthem must set forth more than neutral facts necessary to identify the transaction: it must identify each Defendant's role in the fraud scheme.[17] *Id.*

Stripped of conclusory statements and threadbare recitals, none of Anthem's allegations amount to wire fraud, as there are no particularized factual allegations showing any Defendant acted with an intent to defraud. No authorities arbitrarily limit either the number of IDR proceedings a party may initiate or the amount a party may offer in the IDR process. Nor is the attestation a certification of eligibility.

Fundamentally, Anthem alleges that, starting in 2024, HaloMD initiated IDR proceedings and attested that it believed such disputes were eligible for the IDR process. Anthem's mischaracterizations of the attestation aside, in the specific proceedings that Anthem identifies, Anthem at best alleges that it believed the disputes were ineligible. AC, ¶¶ 168-205. But, by law, that issue was for the IDREs to decide. Further, Anthem offers only conclusory allegations that multiple

[17] While Anthem fails to state a claim generally, the Amended Complaint also is an improper shotgun pleading that lumps Defendants together in ways that make it impossible to determine the specific allegations asserted against each Defendant. *See Prostitis v. Riverside Superior Fam. L. Ct.*, No. 520CV00026SVWKES, 2020 WL 3843727, at *2 (C.D. Cal. Apr. 15, 2020), report and recommendation adopted, No. 520CV00026SVWKES, 2020 WL 6450288 (C.D. Cal. Nov. 3, 2020) (discussing shotgun pleadings and noting that they "consume an inordinate amount of a court's time" and cause discovery and case management issues).

Defendants generally knew the attestations were false, which fail to satisfy Fed. R. Civ. P. 9(b)'s requirement that Anthem plead a scheme to defraud with particularity.

2. Anthem's RICO Conspiracy Claims Fail.

To plausibly state a RICO conspiracy claim, Anthem must successfully allege each element of a RICO violation and the "existence of an illicit agreement to violate the substantive RICO provision." *See Howard v. Am. Online Inc.*, 208 F.3d 741, 751 (9th Cir. 2000) (determining that the failure to adequately plead a substantive RICO violation precludes a claim for conspiracy). Because Anthem's substantive RICO claims fail, its derivative RICO conspiracy claims fail too. *See Ford Motor Co.*, 2025 WL 3306280 at *17 (dismissing the plaintiff's RICO conspiracy claim because the plaintiff did not adequately plead a substantive RICO violation). Moreover, Anthem offers no non-conclusory, fact-supported allegations that the Defendants agreed to commit a RICO violation.

3. Anthem's Vacatur Claim Fails.

Anthem's Amended Complaint asks this Court, "in the alternative," to vacate binding IDRE awards. This Court should not permit Anthem's vacatur claim to proceed. Anthem only identifies a handful of specific IDR proceedings in its Amended Complaint, but it asks this Court to set aside "each individual IDR determination at issue" based on inconsistent reasons. AC, ¶¶ 355-59. Anthem cannot plead a claim for vacatur across an indeterminate universe of IDR awards and otherwise satisfy Fed. R. Civ. P. 8 and 9(b). Indeed, apart from the few IDR proceedings specifically identified, HaloMD has no idea what other IDR awards allegedly are within the scope of Anthem's vacatur claim.

But more importantly, Anthem fails to state a plausible claim for vacatur at all. The NSA expressly limits judicial review of IDR awards to those circumstances warranting vacatur under the FAA. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II) (cross-referencing 9 U.S.C. § 10(a)(1)-(4)). Here, Anthem alleges that vacatur is permitted because: (i) the IDR awards at issue were procured by fraud and undue means; and

(ii) the IDREs otherwise exceeded their powers in making such awards. But Anthem does not sufficiently allege any of these bases to support a vacatur claim.

To set aside an IDR award for fraud, Anthem must show that the fraud was: (1) not discoverable upon the exercise of due diligence prior to the arbitration, (2) materially related to an issue in the arbitration, and (3) established by clear and convincing evidence. *See Lafarge Conseils Et Etudes, S.A. v. Kaiser Cement & Gypsum Corp.*, 791 F.2d 1334, 1339 (9th Cir. 1986). By its own pleading, Anthem cannot satisfy this standard, as Anthem acknowledges that it objects to IDR process eligibility and otherwise communicates its positions regarding eligibility to healthcare providers and IDREs. Nor has Anthem alleged any concrete facts that suggest that HaloMD engaged in any "immoral if not illegal" behavior to show undue means. *See Uddin v. TD Ameritrade, Inc.*, 740 F. Supp. 3d 975, 982 (N.D. Cal. 2024) (analyzing the FAA's undue-means prong).

As for the allegation that the IDREs exceeded their powers, eligibility determinations are expressly within the scope of the IDREs' authority, and IDREs must always determine eligibility prior to making payment determinations. *See* 45 C.F.R. § 149.510(c)(1)(v) (Oct. 7, 2021); IDR Process Guidance for Certified IDR Entities §§ 4.4, 4.6.2, Ex. C to HaloMD's RJN. Anthem cannot sufficiently plead vacatur simply by alleging an IDRE was wrong. *See HayDay Farms, Inc. v. FeeDx Holdings, Inc.*, 55 F.4th 1232, 1240 (9th Cir. 2022) (showing that an arbitrator committed even a serious error is "not enough" to satisfy the "high standard" for vacatur under 9 U.S.C. § 10(a)(4)); *Schoenduve Corp. v. Lucent Techs., Inc.*, 442 F.3d 727, 733 (9th Cir. 2006) (internal citation omitted) ("[i]n determining whether the arbitrator exceeded his jurisdiction, we resolve all doubts in favor of arbitration.").

The Eleventh Circuit recently addressed pleading requirements in connection with a claim for vacatur of an IDR award in *Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc.* ("*Reach Air*"), No. 24-10135, ___ F.4th ___, 2025 WL

3222820 (11th Cir. Nov. 19, 2025) (publication pending). In *Reach Air*, the plaintiff sought to vacate an IDR award on the same grounds that Anthem relies on here. Specifically, the plaintiff alleged that, during the IDR process, the defendant healthcare insurer misrepresented its median contracted rate (otherwise known as the "qualifying payment amount" or "QPA") for the service at issue and that the IDRE impermissibly applied an illegal presumption in favor of the allegedly misrepresented QPA when it rendered its payment determination.

The district court granted the defendant insurer's motion to dismiss. The plaintiff appealed, and the Eleventh Circuit affirmed, rejecting the plaintiff's "conclusory argument" that the IDRE exceeded its authority or that the plaintiff had not sufficiently alleged fraud as a basis for vacatur. *Id*. at *6-8 (noting that the complaint failed to allege numerous key details including: the "time and place of each statement and the person responsible for making" the statement, "the manner in which the [fraudulent statements] misled" the plaintiff, what the insurer "obtained as a result of the alleged fraud," and how the alleged misrepresentation was connected to the IDRE's determination).

Here, Anthem's claim for vacatur is even weaker. Not only does Anthem allege no facts with respect to the unspecified IDR awards that it seeks to vacate, Anthem also fails to allege any concrete facts that would establish that HaloMD engaged in fraudulent conduct (let alone any conduct that was not discoverable during the course of any IDR proceeding).

4. Anthem's ERISA Claim Fails.

Anthem's ERISA claim for equitable relief fails for multiple reasons. First, Anthem does not seek to enjoin an actual ERISA violation. Anthem predicates its ERISA claim on 29 U.S.C. § 1185(e), a codified provision of the NSA. 29 U.S.C. § 1132(a)(3) provides that that a civil action may be brought by a fiduciary: (A) to enjoin any act or practice which violates any ERISA provision, or (B) to obtain other appropriate equitable relief to redress such violations. But nothing that Anthem seeks

to enjoin is a violation of 29 U.S.C. § 1185(e), including initiating IDR proceedings: (a) without first properly initiating and engaging in open negotiations; (b) for services subject to California's specified State law; (c) for services that Anthem denied and thus are ineligible for the IDR process; and (d) for services when HaloMD failed to comply with other unspecified "NSA requirements." In fact, 29 U.S.C. § 1185(e) does not provide, anywhere, that it is an ERISA violation to initiate an IDR proceeding for any reason. Rather, 29 U.S.C. § 1185(e) just establishes the parameters of the IDR process.

Further, the Amended Complaint's failure to identify any specific health benefit plan (on behalf of which Anthem claims to be acting with discretionary authority) is independently fatal. Fiduciary status under ERISA does not exist in gross but only "with respect to a plan" and only to the extent the person exercises the requisite discretion or control required by the statute. *See* 29 U.S.C. § 1002(21)(A). A purported fiduciary must therefore plausibly allege facts showing that it is a fiduciary with respect to each particular ERISA plan for which it is seeking (a)(3) relief. Here, Anthem alleges no such facts with respect to any particular plan at all, let alone sufficient facts to satisfy Fed. R. Civ. P. 9(b)'s particularity requirement.

Anthem's ERISA claim is thus a veiled attempt to try to circumvent the NSA's judicial review prohibition to limit HaloMD's ability to seek relief when Anthem refuses to pay fair rates for services provided by healthcare providers. Accordingly, Anthem's ERISA claim under 29 U.S.C. § 1132(a)(3) fails.

5. Anthem's Claim for Declaratory and Injunctive Relief is Improper.

Declaratory and injunctive relief are remedies, not independent causes of action. *Wheeler v. Cnty. of Orange*, No. 820CV01264MCSDFM, 2022 WL 16951680, at *6 (C.D. Cal. June 22, 2022). Moreover, a claim for declaratory and injunctive relief cannot stand on its own; it must be linked to an underlying substantive claim. *Id.* While the federal Declaratory Judgment Act, 28 U.S.C. § 2201, may provide an avenue for district courts to declare the rights and other legal

relations of interested parties, federal courts have no obligation to do so. *Gov't Emps. Ins. Co. v. Dizol*, 133 F.3d 1220, 1223 (9th Cir. 1998) (citations and quotations omitted) (providing that the Declaratory Judgment Act gives federal courts competence to make a declaration of rights without imposing a duty to do so).

Here, for the reasons set forth above, Anthem has not stated a plausible claim in its Amended Complaint, so its request for declaratory and injunctive relief fails for that reason alone. But even if Anthem did state a claim, this Court should not entertain Anthem's efforts to bait it into issuing a declaration of rights of parties to access the IDR process, which was only recently created by Congress and which continues to evolve and is the subject of ongoing rulemaking.

X. Conclusion.

For these reasons: (i) this Court lacks subject-matter jurisdiction over Anthem's claims, which are barred by the NSA's judicial review prohibition; (ii) this Court lacks personal jurisdiction over HaloMD; and (iii) Anthem fails to state a claim upon which relief can be granted.

Anthem's dissatisfaction with NSA and the IDR process—and its discomfort with the IDR process's revelations—is not the basis for a legal claim. Pursuant to Fed. R. Civ. P. 12(b)(1), (2), and (6), the Court should dismiss the entirety of Anthem's Amended Complaint with prejudice.

Dated: December 12, 2025

NIXON PEABODY LLP

By: */s/Jonah D. Retzinger*
Jonah D. Retzinger
Christopher D. Grigg
Brock J. Seraphin
April C. Yang

Attorneys for Defendants HALOMD, LLC, ALLA LAROQUE and SCOTT LAROQUE

L.R. 11-6.1 CERTIFICATE OF COMPLIANCE

Pursuant to Section 28 of the Procedures of the Honorable Karen E. Scott, the undersigned, counsel of record for Defendants HALOMD, LLC, ALLA LAROQUE, and SCOTT LAROQUE, certifies that, excluding the caption, the table of contents, the table of authorities, the signature block, and any indices and exhibits, this brief contains 6,998 words, which:

[X] complies with the word limit of L.R. 11-6.1.

___ complies with the word limit set by court order dated [*date*].

Dated: December 12, 2025

NIXON PEABODY LLP

By: */s/Jonah D. Retzinger*
Jonah D. Retzinger

Attorneys for Defendants HALOMD, LLC, ALLA LAROQUE, AND SCOTT LAROQUE

L.R. 7-3 MEET AND CONFER DECLARATION

I, Jonah D. Retzinger, counsel of record for Defendants HaloMD, LLC, Alla LaRoque, and Scott LaRoque, declare that on December 3, 2025, I participated in a meet-and-confer videoconference with Anthem's counsel of record (as well as counsel of record for all other Defendants) regarding HaloMD's and the LaRoques' intent to file motions to dismiss Anthem's Amended Complaint and a request for judicial notice, along with a special motion to strike Anthem's Amended Complaint pursuant to Cal. Code Civ. Proc. § 425.

During this videoconference, I referenced the arguments in the motions to dismiss filed by HaloMD and the LaRoques in the other actions brought by Anthem's affiliates pending in Ohio and Georgia against HaloMD and the LaRoques based on similar allegations (in which Anthem's counsel of record also represents Anthem's affiliates). During our conference, Anthem's counsel did not agree that Anthem's claims should be dismissed against HaloMD or the LaRoques in this action for any reason. Accordingly, the parties were unable to reach a resolution that eliminates the necessity of this motion.

I, Jonah D. Retzinger, declare under penalty of perjury that the foregoing statements are true and correct.

Executed on December 12, 2025.

/s/Jonah D. Retzinger
Jonah D. Retzinger

No. 26-2355

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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

Plaintiffs-Appellants,

v.

HALOMD, LLC, *et al.*,

Defendants-Appellees.

On Appeal from the United States District Court for the
Central District of California,
No. 8:25-cv-01467-KES
The Honorable Karen E. Scott, Magistrate Judge

APPELLANTS' EXCERPTS OF RECORD VOLUME 3 OF 3

Martin J. Bishop
Jason T. Mayer
Alexandra M. Lucas
CROWELL & MORING LLP
300 N. LaSalle Drive. Suite
2500 Chicago, IL 60654
Telephone: 312-321-4200

Jared Levine
CROWELL & MORING LLP
Two Manhattan West
375 Ninth Ave.
New York, NY, 10001
Telephone: 212-223-4000

Emily T. Kuwahara (SB# 252411)
CROWELL & MORING LLP
EKuwahara@crowell.com
515 S. Flower St., 41st Floor
Los Angeles, CA 90071
Telephone: 213-622-4750
Facsimile: 213-622-2690

Attorneys for Plaintiffs and Appellants Anthem Blue Cross Life and Health Insurance Company, and Blue Cross of California d/b/a Anthem Blue Cross

James L. Poth (State Bar No. 185042)
jlpoth@jonesday.com
JONES DAY
3161 Michelson Dr, #800
Irvine, California 92612
Telephone: (949) 851.3939
Facsimile: (959) 553.2539

B. Kurt Copper (*pro hac vice*)
bkcopper@JonesDay.com
JONES DAY
2727 North Harwood Street, Suite 500
Dallas, Texas 75201-1515
Telephone: (214) 220.3939
Facsimile: (214) 969.5100

Attorneys for Defendants
MPOWERHEALTH PRACTICE MANAGEMENT, LLC; NORTH AMERICAN NEUROLOGICAL ASSOCIATES, PC; N EXPRESS PC; iNEUROLOGY, PC and BRUIN NEUROPHYSIOLOGY, PC

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

SOUTHERN DIVISION

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

Plaintiff,

v.

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

Defendants.

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

DEFENDANTS MPOWERHEALTH PRACTICE MANAGEMENT, LLC; BRUIN NEUROPHYSIOLOGY, P.C.; iNEUROLOGY, PC; N EXPRESS, PC; AND NORTH AMERICAN NEUROLOGICAL ASSOCIATES, PC'S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION TO DISMISS FOR FAILURE TO STATE A CLAIM UNDER FED. R. CIV. PRO. 12(B)(6)

Hearing Date: March 10, 2026
Hearing Time: 10:00 a.m.
Courtroom: 6D

Honorable Karen E. Scott
Magistrate Judge

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I. INTRODUCTION

Plaintiff Anthem Blue Cross and Blue Shield litigated in a congressionally-mandated dispute resolution process and denied that it underpaid medical providers who cared for the company's insureds. Dissatisfied with the fact that it lost the majority of those proceedings, Anthem attempts a collateral attack in this Court. Anthem asserts eight theories of relief—all predicated on statements made by the defendants during arbitrations and awards issued by arbitrators. Anthem seeks to convert the fact that the defendants and arbitrators disagreed with its assertions (regarding whether disputes qualified for the arbitration process and the value of the underlying services) into violations of RICO, Fraud, Misrepresentation, Unlawful Business Practices, Grounds for Vacatur, and Equitable Relief under ERISA. But disputes adjudicated in litigation and decided against an aggrieved party do not provide basis for these theories of relief. Moreover, Anthem repeatedly challenges the entire process which Congress established as including flaws that the defendants "exploit." (First Amended Complaint ("FAC") ¶ 10, ¶ 116, ¶ 123, and ¶ 125). The FAC reads far more like a press release or a petition to Congress to change the arbitration process. It comes nowhere close to stating any claim for relief.

Given the fatal deficiencies apparent in the FAC, MPOWERHealth Practice Management, LLC**;** Bruin Neurophysiology, P.C.; iNeurology, PC; N Express, PC; and North American Neurological Associates, PC (collectively "Providers") seek to dismiss the matter. As a dispositive matter, the Court lacks subject-matter jurisdiction over most of Anthem's claims. The No Surprises Act expressly limits judicial review to only viable claims seeking to *vacate* awards under the Federal Arbitration Act. As such, Anthem cannot seek monetary or prospective injunctive relief in this Court under any circumstances.

Anthem's unambiguous attempt to re-litigate issues decided in the arbitration necessarily implicates issue preclusion. Anthem's theories rely on allegedly false eligibility attestations. Yet for every dispute now in contention, that

issue was presented to and resolved by an Independent Dispute Resolution Entity (IDRE). Anthem cannot get a second bite at the apple in court.

Further, Anthem has not alleged any of its claims with particularity under Rule 9(b). Anthem has not particularly alleged the Providers' role in the fraud, that the Providers proximately caused Anthem's injuries, or that Anthem actually suffered an injury traceable to each Provider's supposedly illegal actions.

On top of this, the Noerr-Pennington doctrine shields the Providers from liability for accessing the federally created dispute procedures. The Noerr-Pennington doctrine prevents plaintiffs from predicating liability on protected speech. Here, the Providers' statements and submissions to IDRE arbitrators qualify as protected speech, so Anthem's claims for monetary and prospective injunctive relief must be dismissed.

Finally, Anthem's claims suffer individual defects. The reasons are many, but the outcome is straightforward. This Court should dismiss Anthem's Amended Complaint.

II. FACTUAL BACKGROUND

A. Congress Enacts The No Surprises Act To End Surprise Billing And Resolve Payment Disputes.

Effective January 1, 2022, Congress enacted the No Surprises Act. The statute protects patients from bills for certain out-of-network services when the patient's insurance company refuses to pay. 42 U.S.C. § 300gg-111. If the insurer and provider disagree on the proper amount to be paid, the NSA requires them to negotiate rather than bill the patient. If negotiations fail, either side can invoke binding arbitration (known as the Independent Dispute Resolution Process ("IDR")) where an arbitrator will determine a reasonable payment amount. *Id.* § 300gg-111(c)(2). During pre-IDR negotiations, the parties have their *first* chance to raise

eligibility issues.[1] If negotiations fail, either side can initiate IDR arbitration. *Id.* § 300gg-111(c)(1)(B). The initiating party attests the dispute is eligible for the proceedings. 45 C.F.R. § 149.510(b)(2)(iii)(A)(6) (2024). Importantly, the IDR initiation form requires the party to attest only "to the best of [its] knowledge." FAC ¶ 64. The parties then jointly participate in the selection of an arbitrator called an Independent Dispute Resolution Entity ("IDRE"). 42 U.S.C. § 300gg-111(c)(1)(B), (c)(4). After an IDRE's selection, each party pays a fee to compensate the IDRE. 26 C.F.R. § 54.9816-8T(d)(1) (2024).

At the start of each proceeding, the IDRE must find that the dispute is eligible for IDR.[2] 45 C.F.R. § 149.510(c)(1)(v) (2024). IDREs receive their fee partially for "the costs incurred in determining" eligibility. Federal Independent Dispute Resolution (IDR) Process Administrative Fee and Certified IDR Entity Fee Ranges, 88 Fed.Reg. 88494, 88505 (Dec. 21, 2023). The non-initiating party then gets its *second* chance to raise eligibility concerns. "[I]f the non-initiating party believes that the Federal IDR process is not applicable, the non-initiating party *must* . . . provide information regarding the Federal IDR process's inapplicability *through the Federal IDR portal*[.]" 45 C.F.R. § 149.510(c)(1)(iii) (2024) (emphases added). Agency guidance echoes the same.[3] And from this information, "[t]he certified IDR entity must determine whether the Federal IDR Process is applicable." HHS et al., *Federal IDR Process Guidance for Disputing Parties* 17 (updated Dec. 2023), https://www.cms.gov/files/document/federal-idr-guidance-

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[1] *See* HHS et al., *Federal IDR Process Guidance for Disputing Parties* 13 (updated Dec. 2023), https://www.cms.gov/files/document/federal-idr-guidance-disputing-parties-march-2023.pdf.

[2] "[T]he certified IDR entities are responsible for ensuring that eligibility and payment determinations are accurate." CMS, *Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties* 2 (June 2025), https://www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf.

[3] *Federal IDR Process Guidance for Disputing Parties*, *supra* n.2 at 17 (non-initiating party "must notify" the agency of non-eligibility).

disputing-parties-march-2023.pdf.

This disclosure requirement exists due to the asymmetries of information between insurers and providers. Regulations try to balance these asymmetries by requiring insurers to submit applicable insurance plan coverage information to the IDRE. 29 C.F.R. § 2590.716-8(c)(4)(i)(A)(3)(iii) (2024); *see also* FHAS, *Important Updates to CMS IDR Portal Web Forms: What You Need to Know* (Sept. 12, 2025)[4] (IDR portal requires insurers to "attest to whether the health plan type selected by the initiating party is correct" and fix accordingly). Given the FAC's extensive focus on the eligibility issue, one would expect Anthem to address its mandatory requirement to dispute eligibility through the portal. The FAC is tellingly silent on that point. If the IDRE finds a dispute ineligible, it "must notify . . . the parties." 45 C.F.R. § 149.510(c)(1)(v) (2024). To remain certified, IDREs must properly perform their duties. 42 U.S.C. § 300gg-111(c)(4)(A).

The parties then each submit one payment offer to the IDRE, along with supporting information. *Id.* § 300gg-111(c)(5)(B), (C). Participants now have a *third* chance to challenge jurisdiction and award—the parties can submit "any information relating to such offer submitted by either party," including objections to the underlying dispute. *Id.* § 300gg-111(c)(5)(B)(ii); *see* 29 C.F.R. § 2590.716-8(c)(4)(i)(B) (2024). In baseball-style arbitration, the IDRE considers the information submitted and then picks the offer that is most reasonable. 42 U.S.C. § 300gg-111(c)(5)(A); FAC ¶ 75. By law, in choosing the most reasonable offer, IDREs cannot consider the provider's billed charges—or the rate that would have been paid by Medicare or Medicaid—for the procedure. *Id.* § 300gg-111(c)(5)(D); FAC ¶ 76. Arbitration awards are "binding." *Id.* § 300gg-111(c)(5)(E)(i)(I).

The Centers for Medicare & Medicaid Services ("CMS"), which oversees the program, has introduced multiple ways for the losing party to seek relief. Here, an

[4] Archived at https://perma.cc/D93L-AMYB.

aggrieved party gets its *fourth* chance to dispute eligibility.[5] CMS provided that for "errors identified after dispute closure," parties may re-open closed arbitration proceedings for "jurisdictional error[s]" such as where the IDRE "incorrectly determines" eligibility.[6] Parties can even "petition to revoke" an IDRE's certification.[7]

Congress has strictly limited judicial review. "A determination of a certified IDR entity . . . *shall not be subject to judicial review*, except in a case" that would allow a court to vacate an award under section 10(a) of the Federal Arbitration Act. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II) (emphasis added); *see* 9 U.S.C. § 10(a)(1)–(4).

B. HaloMD And The Providers Bring IDR Arbitrations, And IDREs Often Select Their Offers Over Anthem's.

Bruin Neurophysiology, P.C.; iNeurology, PC; N Express, PC; and North American Neurological Associates, PC provided intraoperative neuromonitoring and other critical services for Anthem-insured patients. FAC ¶ 7. Those providers then asserted that Anthem underpaid them. The FAC leaves no doubt that is it predicated on providers initiating those disputes by asserting they "flooded the IDR system" with underpayment assertions. FAC ¶ 92.

Although Anthem bemoans the results, it alleges it has more success than most. Anthem alleges "providers prevailed in 85 percent of IDR payment determinations." FAC ¶ 82. But when Anthem alleges examples of claims it places at issue, it concedes it has secured far better results. FAC ¶ 112: alleging Anthem

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[5] *Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties supra* n.3 at 1.

[6] *Id.* at 1, 3.

[7] CMS, *Submit a Petition to Revoke the Certification of a Current IDR Entity Providing Dispute Services*, (Sept. 10, 2024, 6:18 p.m. EST), https://www.cms.gov/nosurprises/help-resolve-payment-disputes/submit-feedback-on-certified-organizations.

was ordered to pay additional costs in 65 [51%] out of 126 proceedings.[8] Despite its relative success (and fairly even outcomes) Anthem nevertheless blames Defendants. On its face, the FAC establishes that Anthem will only be willing to concede the IDR process was valid if it wins every one of them (the only IDRs excluded from this action are those where Anthem prevailed).

Anthem alleges that HaloMD and the Providers have concocted a scheme through which they (1) initiated ineligible IDR proceedings, (2) flooded the system with claims, and (3) submitted inflated payment offers. *Id.* ¶ 93. But the FAC undoes these assertions. Moreover, Anthem is silent with respect to a fourth, and necessarily dispositive step: jointly selected IDREs reviewed the eligibility information, concluded the dispute is eligible, reviewed both offers and supporting evidence, and *then selected HaloMD and the Providers' offer*. This omission is telling.

First, Anthem alleges that HaloMD falsely attested that claims are eligible for the IDR process. *Id.* ¶¶ 96–104.[9] But Anthem *admits* it was aware of these alleged issues. *See e.g., id.* ¶¶ 171, 176. Even now, Anthem knows the number of supposedly ineligible IDR awards it has lost and the reasons for purported ineligibility. *Id.* ¶¶ 9, 90. Anthem does not allege, however, that any IDRE failed to perform an eligibility determination. *See* 45 C.F.R. § 149.510(c)(1)(v) (2024).

Anthem next alleges that HaloMD "flooded" the IDR system with disputes. FAC ¶¶ 105–118. But Anthem fails to identify any limit on the number of disputes a Provider may bring when it is repeatedly underpaid. Thus, Anthem's "flood" is more of a mirage. Indeed, Anthem's complaints about timing merely attack the

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[8] Anthem fails to allege it paid these awards. That omission obscures that Anthem cannot point to actual damages.

[9] Anthem briefly suggests HaloMD submitted untimely claims. *See* FAC ¶¶ 168–72. But submitting an untimely claim would not constitute a fraudulent misrepresentation and this allegation suffers the same defects as Anthem's other alleged misrepresentations.

system Congress established. Anthem contradictorily alleges that it "processes tens of millions of health care claims annually"[10] while also asserting the submission of "hundreds" of claims rendered it "unable to investigate" them. *Cf.,* FAC ¶ 30 & ¶ 323.

Anthem also alleges HaloMD fraudulently submitted "inflated" offers "above the Providers[']billed charges." *Id.* ¶ 119. But Anthem concedes that IDREs by law "cannot consider the provider's charges" at all. *Id.* ¶ 122; *see* 42 U.S.C. § 300gg-111(c)(5)(D). The FAC, thus, concedes there is no basis that any payment offer was inflated. Beyond this concession, Anthem does not explain how these "inflated" offers violate the NSA's text or regulations. Nor does it acknowledge the key point: If the Providers' offers were "inflated" when compared to Anthem's offers, then Anthem would have won, not lost, the IDRs it puts at issue.

Finally, HaloMD and the Providers purportedly round out their "scheme" when certified, neutral IDREs—whom Anthem had a role in selecting—look at the evidence and select HaloMD and the Providers' offer. FAC ¶¶ 120, 124. But, Anthem's omissions are telling. Anthem does not allege bribery or corruption. Anthem does not allege the IDREs considered impermissible factors. And Anthem does not allege why neutral IDREs rejected Anthem's offers.

How has Anthem responded? Anthem has *not* sought to re-open the supposedly ineligible and inflated IDR awards. Anthem has *not* challenged the credentials of any IDRE. Instead, Anthem brought this and other lawsuits in an attempt to punish providers for their success and to chill them from pursuing future IDR arbitrations. Anthem pleaded a shotgun assortment of claims and asks to vacate thousands of IDR awards without describing the alleged errors in each individual award.

After Anthem filed suit, certain Defendants sent Anthem a letter addressing

[10] Equating to a minimum of 27,000 claims at day.

that the Complaint contained false allegations in violation of its Rule 11 obligations. Anthem filed an amended complaint removing certain allegations.

III. LEGAL STANDARD

Rule 12(b)(1) allows motions to dismiss based on lack of subject-matter jurisdiction. FED. R. CIV. P. 12(b)(1). Rule 12(b)(6) permits dismissal where the allegations, "taken as true, fail to plausibly show a legal violation." *Election Integrity Project California, Inc. v. Weber*, 113 F.4th 1072, 1081 (9th Cir. 2024). A court accepts the complaint's well-pleaded allegations as true, but not "[c]onclusory statements, unreasonable inferences, and legal conclusions couched as factual allegations." *Id.* (citation omitted).

Moreover, because Anthem's claims all sound in fraud, it must plead its allegations with particularity under Rule 9(b). *In re Finjan Holdings, Inc.*, 58 F.4th 1048, 1057 (9th Cir. 2023). Rule 9(b) plays a vital role in vetting RICO claims. "[T]he mere invocation of the [RICO] statute has such an in terrorem effect that it would be unconscionable to allow it to linger in a suit and generate suspicion and unfavorable opinion of the putative defendant unless there is some articulable factual basis which, if true, would warrant recovery under the statute." *Polzin v. Barna & Co.*, No. 3:07-cv-127, 2007 WL 2710705, at *4 (E.D. Tenn. Sept. 14, 2007).

IV. ARGUMENT

A. This Court Lacks Subject-Matter Jurisdiction (Counts I, III, V, VII, IX, XII, XIII).

Congress was emphatic in the NSA: "A determination of a certified IDR entity . . . *shall be binding* upon the parties involved . . . and . . . *shall not be subject to judicial review*, except in a case" that would allow a court to *vacate* the award under the Federal Arbitration Act. 42 U.S.C. § 300gg-111(c)(5)(E)(i) (emphases added); *see* 9 U.S.C. § 10(a)(1)–(4). Given this express incorporation, the *exclusive means* to challenge an IDR award is to seek vacatur under the FAA. *Guardian*

Flight, L.L.C. v. Med. Evaluators of Tex. ASO, L.L.C., 140 F.4th 613, 620 (5th Cir. 2025) ("*Guardian Flight II*"); *Worldwide Aircraft Servs. v. Worldwide Ins. Servs.*, No. 8:24-cv-840, 2024 WL 4226799, at *1–2 (M.D. Fla. Sept. 18, 2024). Indeed, the "NSA expressly *bars* judicial review of IDR awards *except* as to the specific provisions borrowed from the" Federal Arbitration Act that allow vacatur. *Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 275 (5th Cir. 2025) ("*Guardian Flight I*").

The FAA, in turn, prohibits direct actions that seek "damages…for alleged wrongdoing that compromised an arbitration award," which amounts to "an impermissible collateral attack on the award itself." *Nickoloff v. Wolpoff & Abramson, L.L.P.*, 511 F.Supp.2d 1043, 1044 (C.D. Cal. 2007). A party cannot bring a non-FAA claim seeking "to reverse the outcome [of an arbitration] in the subsequent proceeding or alleg[e] that the party was harmed by a wrongful act's impact on the award." *Wachovia Securities, LLC v. Wiegand*, No. 07CV243, 2007 WL 9776732, at *4 (S.D. Cal. Apr. 16, 2007) (citation omitted); *see Sander v. Weyerhaeuser Co.*, 966 F.2d 501, 502–03 (9th Cir. 1992). This principle applies to claims of fraud committed by the parties to the arbitration. *See Sander*, 966 F.2d at 503. In short, FAA vacatur is the "*exclusive remedy*" against improper IDR proceedings.[11] *Nickoloff*, 511 F.Supp.2d at 1044 (emphasis added).

Congress can limit courts' ability to hear cases. *Santos-Zacaria v. Garland*, 598 U.S. 411, 416 (2023). Some limits are jurisdictional, which "set[] the bounds of the court's adjudicatory authority." *Id.* While Congress must "clearly state[]" when a rule is jurisdictional, no "magic words" are needed. *Id.*; *Riley v. Bondi*, 606

[11] Anthem has administrative avenues to relief still open to it. Anthem can seek to re-open the awards if it truly believes the underlying claims were ineligible. *Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties*, *supra* n.3 at 1.

U.S. 259, 261 (2025). For example, a jurisdictional rule uses "language demarcating a court's power." *Riley*, 606 U.S. at 261.

Here, the NSA's limit on judicial review speaks to the court's power, not litigants' duties—in other words, it uses "language demarcating [the] court's power." *See id.* And the Act's carveout for judicial review to vacate implies that none other is permitted. *See, e.g.*, *Pakootas v. Teck Cominco Metals, Ltd.*, 646 F.3d 1214, 1224 (9th Cir. 2011). Given this jurisdictional limitation imposed by Congress, Anthem cannot pursue claims for money damages or prospective injunctive relief. *See Sander*, 966 F.2d at 502–03.

The Ninth Circuit has held similar collateral attacks improper. *Sander,* 966 F.2d at 503 (holding that it would not "upset the streamlined nature of arbitration by permitting the launching of collateral attacks."). Fraud is a ground for vacatur under the FAA, so the FAA's requirements would be "meaningless" if a party could circumvent them via a "an independent direct action." *Id.* (quotation omitted); *see also Gulf Petro Trading Co. v. Nigerian Nat'l Petroleum Corp.*, 512 F.3d 742, 750 (5th Cir. 2008) (affirming dismissal of RICO claims and holding that federal law bars most claims "alleging that wrongdoing had tainted the arbitration proceedings and caused unfair awards.").

Congress's choice to insulate the judiciary from these types of collateral challenges makes sense. Congress created the IDR process to help efficiently resolve out-of-network disputes. These cases are complex. *Cf. Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, No. CV-14-03053-MWF-AFM, 2016 WL 10651033, at *1 (C.D. Cal. May 16, 2016). Allowing losing parties to litigate—and re-litigate—the merits of these disputes would sap judicial resources. Congress accordingly preferred "an administrative enforcement mechanism" to "handle most award disputes instead of throwing open the floodgates of litigation." *Guardian Flight I*, 140 F.4th at 277.

B. Issue Preclusion Estops Anthem From Re-Litigating The Idres' Determinations (Counts I, III, V, VII, IX, XII, And XIII).

Issue preclusion also requires dismissal of claims seeking monetary or prospective injunctive relief. Anthem had a full opportunity to dispute eligibility and lost, so issue preclusion bars Anthem from re-litigating the eligibility of those same disputes in this Court. Issue preclusion "prevents the relitigation of a claim previously tried and decided." *Clark v Bear Stearns & Co*. 966 F.2d 1318, 1320 (9th Cir. 1992). Issue preclusion includes administrative determinations and arbitration awards. *B & B Hardware, Inc. v. Hargis Indus.*, 575 U.S. 138, 148 (2015). Where Congress authorizes administrative adjudicators to resolve disputes, Congress is presumed to have "legislated with the expectation that the principle [of issue preclusion] will apply" to those adjudicators' decisions except those limited circumstances "when a statutory purpose to the contrary is evident." *Id.* (citation omitted). The Ninth Circuit has made clear that issue preclusion can attach to arbitration decisions. *See Hansen v. Musk*, 122 F.4th 1162, 1172–73 (9th Cir. 2024).

Federal common law determines the preclusive effect of a federal tribunal's decision, like an IDRE's determinations. *See Taylor v. Sturgell*, 553 U.S. 880, 891 (2008). Issue preclusion attaches if four elements are met: "(1) the issue at stake was identical in both proceedings; (2) the issue was actually litigated and decided in the prior proceedings; (3) there was a full and fair opportunity to litigate the issue; and (4) the issue was necessary to decide the merits." *Hansen*, 122 F.4th at 1173.

In this case, issue preclusion prohibits Anthem from re-litigating the previous IDRE eligibility determinations. Congress did not disturb the presumption of preclusion. *See B & B Hardware*, 575 U.S. at 148. And all four issue preclusion elements are satisfied. *First*, for each contested award, the IDRE ruled against Anthem on eligibility—the cornerstone of Anthem's fraud-scheme theory. *E.g.*, FAC ¶¶ 82, 93. *Second*, every IDR award necessarily relies on an eligibility

finding; ineligible disputes did not result in awards. 45 C.F.R. § 149.510(c)(1)(v) (2024). *Third*, each IDR award represents a final judgment on the merits. *Fourth*, Anthem had a full and fair opportunity to contest eligibility in each IDR proceeding. *Id.* § 149.510(c)(1)(iii) (2024); *see Hansen*, 122 F.4th at 1174–75 (holding that arbitration procedures provided full and fair opportunity to litigate). *See e.g.*, FAC ¶¶ 171, 176, 181 (Anthem admitting it argued disputes were ineligible); *supra* 3–6 (discussing many times where an insurer can—and must—contest eligibility during the IDR process). Both under the NSA's text and issue preclusion law, this Court cannot entertain Anthem's claims for monetary and prospective relief.

A. Anthem Has Not Alleged Fraud With Particularity Under Rule 9(b) (Counts I, III, V, VII, IX, XI, XII and XIII).

All of Anthem's claims, including its vacatur claim, also fail to allege fraud with particularity under Rule 9(b). Anthem asserts that thousands of individual proceedings were subject to fraud without providing details to sustain such wide-ranging claims. The Federal Rules do not permit such tactics.

1. <u>Anthem has not particularly alleged the Providers' roles.</u>

First, Anthem fails to sufficiently distinguish its fraud allegations for the Providers from its fraud allegations for the other defendants. Rule 9(b) "does not allow a complaint to merely lump multiple defendants together, but 'require[s] plaintiffs to differentiate their allegations" "and inform each defendant separately of the allegations surrounding his alleged participation in the fraud.'" *Swartz v. KPMG LLP*, 476 F.3d 756, 764–75 (9th Cir. 2007). "In the context of a fraud suit involving multiple defendants, a plaintiff must, at a minimum, 'identif[y] the role of [each] defendant[] in the alleged fraudulent scheme.'" *Id*. at 765

Here, despite suing ten defendants, Anthem repeatedly alleges that "Defendants" engaged in a racketeering scheme, without specifying each defendant's specific role in causing the *thousands* of supposedly fraudulent IDR

awards. *E.g.*, FAC ¶¶ 86, 90, 93, 96–102. Even where Anthem breaks out a handful of supposedly improper IDR proceedings, it does not even bother to allege that the Providers *themselves* made the allegedly false attestations. *See e.g., id.* ¶¶ 169, 171, 175. Instead, Anthem attempts to bootstrap the Providers into this case by alleging—without further specificity—that false statements were submitted by HaloMD "on behalf of and in coordination with" the Providers. *Id.* These vague allegations fall short of Rule 9(b)'s requirements. *See Swartz*, 476 F.3d at 765 (holding mere allegations that defendants "were acting in concert with" other defendants were insufficient under Rule 9(b)).

Anthem alleges the Providers *received* awards in excess of billed amounts for their medical services (although, as discussed below, Anthem does not allege it actually *paid* those awards). *E.g.*, FAC ¶¶ 172, 177, 182. But, Anthem never specifies what the Providers actually *did*—beyond caring for Anthem's insureds. As one court put it, these allegations are "little more than a bare assertion that [each of the providers] somehow share blame for [another defendant's] conduct." "Rule 9(b) requires more—much more." *In re Pac One, Inc.*, Nos. 01-85207MGP; 1:06-cv-118-WSD, 2007 WL 2083817, at *8 (N.D. Ga. July 17, 2007).

Anthem also alleges the Providers knew that HaloMD submitted illegible disputes on their behalf. FAC ¶¶ 103–104. But this allegation at most goes to knowledge; it does nothing to prove any one provider or MPOWERHealth acted to further a fraud scheme. *See Nuñag-Tanedo v. E. Baton Rouge Par. Sch. Bd.*, 790 F.Supp.2d 1134, 1148–49 (C.D. Cal. 2011) (describing scienter as a separate element for RICO wire fraud); *see also Swartz*, 476 F.3d at 765 (holding allegation that defendants "knew that" other defendants were making false statements insufficient under Rule 9(b)).

2. <u>Anthem has not particularly alleged proximate causation.</u>

Anthem has likewise failed to plead with particularity that the alleged misrepresentations proximately caused Anthem's damages. Proximate causation

requires "some direct relation between the injury asserted and the injurious conduct alleged." *Holmes v. Sec. Inv. Prot. Corp.*, 503 U.S. 258, 268 (1992). At the outset, the supposed "misrepresentations" did not even *purport* to be conclusive on the question of IDR eligibility, as the IDR initiation form requires attestation of eligibility only "to the best of [the initiating party's] knowledge." FAC ¶ 64. And for every award being challenged, a neutral IDRE performed an independent investigation, found eligibility satisfied, and then "caused" the supposed injury by selecting the higher offer (and indeed was required to perform this investigation rather than relying upon the mere attestation of the party). *See* FAC ¶¶ 3–4. In doing so, the IDREs broke the causal chain between the supposed eligibility misrepresentations and the awards. *See Evans Hotels, LLC v. Unite Here! Loc. 30,* No. 18-cv-2763, 2021 WL 10310815 at *23 (S.D. Cal. Aug. 26, 2021).

In *Evans*, for example, another California federal court dismissed a RICO claim because the Plaintiff's alleged injuries resulted from a third party's actions rather than the Defendant's alleged actions. *Id.* at *14. Anthem faces the same problem here, because the alleged conduct "giving rise to the harm"—the IDRE awards in the Providers' favor—are "distinct from the [alleged] predicate offense"—supposedly false IDRE eligibility statements. IDREs assessed eligibility in every arbitration. So even assuming someone misrepresented eligibility, IDREs had the obligation to examine that question (after Anthem was required to submit materials contesting eligibility), and that IDRE determination is the proximate cause of any of Anthem's harms. Relatedly, Anthem theorizes that the Providers submitted "inflat[ed]" offers. FAC ¶ 164. Anthem fails to allege how inflated bids proximately caused injury when, in every case, the IDRE remained free to select Anthem's lower proposal. In fact, Anthem alleges that neutral IDREs sometimes did *not* select the Providers' proposals after reviewing all the evidence. FAC ¶ 120. Here as well, IDREs that *did* select the Providers' proposals broke any causal chain.

3. Anthem has not particularly alleged injury.

Anthem also has not particularly alleged any injury traceable individually to each Provider. Anthem likes to brandish the sum total of IDR *awards* it has lost.[12] *See* FAC ¶ 118. But Anthem notably does not allege that it actually *paid* this total. Nor does it allege any particular number of awards it paid, if any. "[W]hen a complaint omits facts that, if they existed, would clearly dominate the case, it seems fair to assume that those facts do not exist." *Scheid v. Fanny Farmer Candy Shops, Inc.*, 859 F.2d 434, 437 (6th Cir. 1988). Anthem's omissions speak loudly.

C. The Noerr-Pennington Doctrine Bars Anthem's Claims (Counts I, III, V, VII, IX, XII, And XIII).

Anthem's claims for monetary and prospective injunctive relief, also fail for another reason: they are barred by the Noerr-Pennington doctrine. This longstanding First Amendment doctrine safeguards the right to petition, including to agencies. *See United Mine Workers of Am. v. Pennington*, 381 U.S. 657, 669–70 (1965); *Kaiser Foundation Health Plan, Inc. v. Abbott Laboratories, Inc.,* 552 F.3d 1033, 1044 (9th Cir. 2009). The doctrine also protects against any claim based on that petitioning, including civil RICO claims and state tort claims. *See, e.g.*, *Sosa v. DIRECTV, Inc.* 437 F.3d 923, 932 (9th Cir. 2006); *KBS Holdco, LLC v. City of West Hollywood,* No. 2:22cv05750, 2024 WL 4800072, at *3 (C.D. Cal. July 8, 2024).

Here, the Noerr-Pennington doctrine shields the Providers' petitioning through the IDR process. To start, the IDR process is a government-established adjudication before a neutral decisionmaker. 42 U.S.C. § 300gg-111(c). So the

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[12] Anthem alleges it paid fees. *See, e.g.*, FAC ¶ 118. For civil RICO claims, the alleged predicate offense itself—here, wire fraud—must proximately cause the injury. *Hemi Grp., LLC v. City of New York*, 559 U.S. 1, 9 (2010). But fees are due in every dispute regardless of outcome. 26 C.F.R. § 54.9816-8T(d)(2) (2024). And Anthem only pays IDRE fees if the IDRE rules against Anthem, breaking any causal chain to fees as a form of damages. *Id.* § 54.9816-8T(d)(1) (prevailing party is refunded its IDRE fee). Therefore, IDRE fees cannot satisfy the injury element of Anthem's claims.

IDR procedure has the character of an agency adjudication. *See Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 506–07 (1988). Next, the same core allegations regarding IDR misrepresentations animate each of Anthem's claims. Thus, Noerr-Pennington gives the Providers presumptive immunity against Anthem's claims. *See Sosa*, 437 F.3d at 942 (explaining the Ninth Circuit "construe[s] federal statutes so as to avoid burdens on activity arguably falling within the scope of the Petition Clause of the First Amendment.").

Anthem has the burden of establishing some exception applies. *Evans*, 2021 WL 10310815 at *6. None does. While courts have recognized a narrow exception for "sham litigation," that does not save Anthem's claims. *Sosa,* 437 F.3d at 934. Critically, a "winning lawsuit is by definition a reasonable effort at petitioning for redress and therefore not a sham." *Pro. Real Estate Inv., Inc. v. Columbia Pictures, Indus.*, 508 U.S. 49, 60 n.5 (1993) ("PRE") And given the exceedingly high standard required to invoke the exception, it is unsurprising that the Ninth Circuit has routinely dismissed claims under the Noerr-Pennington doctrine for failure to adequately plead the sham litigation exception. *See, e.g., B&G Foods N. Am., Inc. v. Embry*, 29 F.4th 527, 539 (9th Cir. 2022); *Manistee Town Ctr. v. City of Glendale,* 227 F.3d 1090, 1095 (9th Cir. 2000).

Noerr-Pennington mandates dismissal. Anthem has not met its burden to plausibly allege that the "extraordinarily narrow" sham exception applies. *U.S. Futures Exch., L.LC. v. Bd. of Trade of the City of Chic., Inc.*, 953 F.3d 955, 963 (7th Cir. 2020). It does not plausibly allege that the IDR proceedings were "not genuinely aimed at procuring favorable government action[.]" *City of Columbia v. Omni Outdoor Advert., Inc.*, 499 U.S. 365, 380 (1991). Nor has Anthem plausibly alleged that "no reasonable litigant could realistically expect success" in the IDR proceedings. *PRE*, 508 U.S. at 60. Just the opposite. Anthem openly admits that Defendants *consistently prevailed*. FAC ¶ 82. And to the extent Anthem contests whether some of the claims were *eligible*, Anthem had the relevant information for

contesting eligibility—and the obligation to contest it. Yet the IDREs' awards necessarily meant that they found eligibility on the information provided to them. Anthem's supposed "wire fraud" examples only further prove why this Court should dismiss Anthem's claims. *See* FAC ¶¶ 168–205. In each, Anthem supposedly had an objection to eligibility. Yet in each, IDREs found eligibility satisfied and ruled for HaloMD and the Providers. So "[t]he fact that [the Providers] succeeded" on their IDRE actions "strongly suggests" these actions "[were] not baseless." *Boulware v. State of Nev., Dep't of Hum. Res.*, 960 F.2d 793, 798 (9th Cir. 1992).

D. Anthem Has Not Plausibly Alleged Civil RICO Claims (Counts I And III).

Anthem has also failed to plausibly allege either civil RICO claim on additional grounds. To plead a civil RICO claim, the plaintiff must allege the defendants participated in "(1) the conduct of (2) an enterprise that affects interstate commerce (3) through a pattern (4) of racketeering activity or collection of unlawful debt. In addition, the conduct must be (5) the proximate cause of harm to the victim." *Eclectic Props. E., LLC v. Marcus & Millichap Co*., 751 F.3d 990, 997 (9th Cir. 2014). The fourth element of "[r]acketeering activity," "requires predicate acts." *Id.* Anthem predicates its claim on wire fraud. FAC ¶¶ 251, 266.

Anthem's civil RICO claim falls short. First, Anthem's RICO wire fraud allegations suffer the Rule 9(b) pleading defects described above. *Supra* Part C.

Second, litigation activities, like IDR proceedings, cannot give rise to a civil RICO claim absent corruption. *Acres Bonusing, Inc. v. Ramsey*, No. 19-cv-05418-WHO, 2022 WL 17170856 at *10–11 (N.D. Cal. Nov. 22, 2022) (collecting cases). Otherwise, "every unsuccessful lawsuit could spawn a retaliatory action," which "would inundate the federal courts with procedurally complex RICO pleadings." *Id.* at *11. Here, the FAC says the Providers' fraud scheme entailed false IDR submissions. FAC ¶¶ 96–104. IDR arbitrations are government-sponsored

adjudications before neutral decisionmakers, meaning Anthem effectively bases its civil RICO claim on supposedly fraudulent litigation activities. But "the overwhelming weight of authority" rejects this approach. *Pompy v. Moore*, No. 19-10334, 2024 WL 845859, at *15–16 (E.D. Mich. Feb. 28, 2024); *see Acres*, 2022 WL 17170856 at *10-12 (citing Ninth Circuit case law). Anthem makes no allegation that IDREs have succumbed to corruption.

The point is further emphasized by considering how Anthem's position would apply had its repeated losses occurred in state court, rather than arbitration. If the Providers had brought multiple lawsuits in court against Anthem over underpayments for which Anthem suspected the court lacked jurisdiction, and Anthem either failed to raise jurisdictional arguments in those state proceedings or did raise them and repeatedly lost, could Anthem thereafter skip over to federal court to re-litigate the state courts' determinations regarding their own jurisdiction? Surely not.

Third, Anthem has not plausibly alleged that the Providers sufficiently directed the enterprise to create liability. For civil RICO claims, "[s]imply performing services for the enterprise" is insufficient. *Walter v. Drayson*, 538 F.3d 1244, 1249 (9th Cir. 2008). Anthem nowhere alleges the Providers took steps to "control the enterprise." Its claims fail.

E. Anthem Has Not Alleged A Claim To Vacate Awards En Masse (Count XI).

Anthem likewise fails to plausibly allege a claim for vacatur. Anthem's vacatur request must satisfy 9 U.S.C. § 10(a)'s rigorous requirements—the exclusive basis for vacating an IDR award. *Reach Air Medical Services v. Kaiser Foundation Health Plan*, No. 24-10135, 2025 WL 322820 at *6 (11th Cir. Nov. 20, 2025) (affirming dismissal of attempt to vacate NSA IDR awards because plaintiff knew the alleged truth such that defendant's statements to the IDRE did not mislead plaintiff). Anthem's two attempts to satisfy this standard fail.

Anthem first contends the awards should be vacated for fraud or undue means. FAC ¶ 357; 9 U.S.C. § 10(a)(1). That standard requires plaintiffs to demonstrate (1) "clear and convincing evidence" of fraud, (2) the fraud "not be discoverable by due diligence before or during the proceeding," and (3) the fraud "be materially related to the submitted issue." *Pac & Arctic Ry. & Nav. Co. v. United Transp. Union,* 952 F.2d 1144, 1148 (9th Cir. 1991).

Anthem's allegations fall short. IDR initiation forms required attestations of IDR eligibility only to "the best of [the initiating party's] knowledge," FAC ¶ 64, and Anthem does not allege any facts establishing that HaloMD or the Providers subjectively believed the attestations were false. For another, Anthem concedes the supposed fraudulent facts were discoverable as it alleges it knew the supposed facts "during" the IDR proceedings. *Pac & Arctic Ry. & Nav. Co.*, 952 F.2d at 1148; *see Agrasanchez v. Argranchez*, No. 23-55110, 2024 WL 3384199 at *1 (9th Cir. July 12, 2024); FAC *e.g.* ¶¶ 171, 176, 181. In fact, Anthem claims that it "often directly notifies Defendants that the items or services at issue in their IDR initiation violate the NSA's eligibility requirements." *Id.* ¶ 101.

Anthem also suggests the IDREs exceeded their authority under 9 U.S.C. § 10(a)(4); FAC ¶ 358. "This is a very high standard for vacatur," and it is "not enough for petitioners to show that the panel committed an error—or even a serious error." *Sanchez v. Elizondo*, 878 F.3d 1216, 1221 (9th Cir. 2018) (citations omitted). An arbitral panel exceeds its authority only where an award is "completely irrational" or exhibits a "manifest disregard of law." *Id.* at 1221–22. Anthem comes nowhere close, contending only that the IDREs erred by "issuing payment determinations" "that are not qualified IDR items and services within the scope of the NSA's IDR process." FAC ¶ 358. But IDREs unquestionably have authority to make those eligibility and payment determinations. *See* 45 C.F.R. § 149.510(c)(1)(v) (2024). Anthem can disagree with those determinations, but that disagreement does not suffice for vacatur.

But there is more. Anthem must particularly allege the error infecting *each* challenged award under Rule 9(b). *See Semegen v. Weidner,* 780 F.2d 727, 731 (9th Cir. 1985). Instead, Anthem seeks a blanket vacatur of "hundreds" of individual IDR awards since January 2024. FAC ¶ 86. Anthem does not even bother to set a number to the challenged awards, let alone identify each award and the supposed error that affected each proceeding. Anthem cannot plead vacatur en masse through generalized allegations—particularly where Anthem contends the specific acts of fraud varied across IDR awards.

F. Anthem Cannot Invoke ERISA (Counts XII And XIII).

Nor can Anthem use ERISA to evade the NSA's limits on judicial review. The ERISA provisions Anthem invokes are the provisions added by the NSA. *See Tex. Med. Ass'n v. HHS*, 110 F.4th 762, 768 n.6 (5th Cir. 2024); 29 U.S.C. § 1185e. But the Act limits judicial review of IDR determinations solely to vacatur under the FAA. *Supra* Part A. And it is common "statutory construction that the specific governs the general[.]" *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 384 (1992).

G. Anthem's State Claims Fail (Counts V, VI, VII, IX, And XIII).

First, Anthem's Unfair Competition Law ("UCL") claim (Count IX) has the same defects as the civil RICO claim. *Supra* Part E. In addition, state claims are barred by the litigation privilege under California Civil Code § 47. That privilege applies to "any communication (1) made in judicial or quasi-judicial proceedings; (2) by litigants or other participants authorized by law; (3) to achieve the objects of the litigation; and (4) that have some connection or logical relation to the action." *Komarova v. Natl. Credit Acceptance, Inc.*, 175 Cal.App.4th 324, 336 (Cal. App. 1st Dist. 2009) (quoting *Silberg v. Anderson*, 50 Cal.3d 205, 212 (2009)). The privilege also applies to arbitration. *Id.*; *see Moore v. Conliffe*, 7 Cal.4th 634, 642, 648–49 (1994). The privilege is absolute and applies "regardless of malice." *Komarova*, 175 Cal.App.4th at 336.

Here, the alleged communications forming the basis of all of Anthem's state law based misrepresentation and UCL claims—"false attestations of eligibility"—were all made in IDR arbitration by participants to achieve the objects of the arbitration. FAC ¶ 316; *see id.* ¶¶ 284, 340. And by definition, the eligibility of the disputes for IDR arbitration "have some connection or logical relation" to those arbitrations. *Home Ins. Co. v. Zurich Ins. Co*., 96 Cal.App.4th 17, 19 (Cal. Ct. App. 2002). The privilege forecloses Anthem's misrepresentation and UCL claims. *See id. at* 23 (noting privilege applies to fraud and misrepresentation claims); *Rubin v. Green*, 4 Cal.4th 1187, 1204 (1993) (same for UCL claims seeking injunctive relief).

Moreover, an essential element of fraudulent misrepresentation (Counts V, VI) and negligent misrepresentation (Count VII) is reliance. *See Vess v. Ciba-Geigy Corp*., 317 F.3d 1097, 1105 (9th Cir. 2003) (noting justifiable reliance is an "indispensable element[]" of fraud claims under California law) (citations omitted). But the FAC alleges that far from relying on Provider's eligibility statements, Anthem objected to them. (FAC ¶¶ 115, 118, 171, 187, 199, 234, 240, 247, 316). That necessarily destroys any basis for "reliance" rendering these claims meritless.[13]

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[13] Anthem seeks to obscure the absence of reliance by alleging it was "compelled to rely" on the putatively false statements. (FAC ¶ 288, 304, 319, 342). While the law does not recognize the concept of "compelled" reliance, what Anthem is referencing here is that its objections were overruled and it then had to proceed with the IDR.

V. CONCLUSION

This Court should dismiss all claims against the Providers with prejudice.[14]

Dated: December 12, 2025

Respectfully submitted,

JONES DAY

By: _____

James L. Poth (State Bar No. 185042)
jlpoth@jonesday.com
JONES DAY
3161 Michelson Dr, #800
Irvine, California 92612
Telephone: (949) 851.3939
Facsimile: (959) 553.2539

B. Kurt Cooper (*pro hac vice*)
bkcopper@jonesday.com
2727 North Harwood Street, Suite 500
Dallas, Texas 75201-1515
Telephone: (214) 220.3939
Facsimile: (214) 969.5100

Attorneys for Defendants MPOWERHEALTH PRACTICE MANAGEMENT, LLC; NORTH AMERICAN NEUROLOGICAL ASSOCIATES, PC; N EXPRESS PC; iNEUROLOGY, PC and BRUIN NEUROPHYSIOLOGY, PC

[14] The Providers expressly incorporate arguments made by their co-defendants' motions to dismiss.

CERTIFICATE OF COMPLIANCE

The undersigned, counsel of record for the Providers certifies that this brief contains 6,598 words, which complies with the word limit of L.R. 11-6.1.

Dated: December 12, 2025

JONES DAY

By: 

James L. Poth (State Bar No. 185042)
jlpoth@jonesday.com
JONES DAY
3161 Michelson Dr, #800
Irvine, California 92612
Telephone: (949) 851.3939
Facsimile: (959) 553.2539

B. Kurt Cooper (*pro hac vice*)
bkcopper@jonesday.com
2727 North Harwood Street, Suite 500
Dallas, Texas 75201-1515
Telephone: (214) 220.3939
Facsimile: (214) 969.5100

Attorneys for Defendants MPOWERHEALTH PRACTICE MANAGEMENT, LLC; NORTH AMERICAN NEUROLOGICAL ASSOCIATES, PC; N EXPRESS PC; iNEUROLOGY, PC and BRUIN NEUROPHYSIOLOGY, PC

MCDERMOTT WILL & SCHULTE LLP
TALA JAYADEVAN (SBN 288121)
tjayadevan@mwe.com
2049 Century Park East, Suite 3200
Los Angeles, CA 90067-3206
Telephone: (310) 277-4110
Facsimile: (310) 277-4730

LAURA MCLANE (appearing *pro hac vice*)
lmclane@mwe.com
MATTHEW L. KNOWLES (appearing *pro hac vice*)
mknowles@mwe.com
CONNOR S. ROMM (appearing *pro hac vice*)
cromm@mwe.com
200 Clarendon Street
Boston, MA 02116
Telephone: (617) 535-3885

Attorneys for Defendants
Sound Physicians Emergency Medicine of Southern California, P.C.; and Sound Physicians Anesthesiology of California, P.C.

McDermott Will & Schulte LLP
Attorneys at Law

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Anthem Blue Cross Life and Health Insurance Company, a California corporation; Blue Cross of California dba Anthem Blue Cross, a California corporation

Plaintiffs,

v.

HaloMD, LLC; Alla LaRoque; Scott LaRoque; MPOWERHealth Practice Management, LLC; Bruin Neurophysiology, P.C.; iNeurology, P.C.; N Express, P.C.; North American Neurological Associates, P.C.; Sound Physicians Emergency Medicine of Southern California, P.C.; and Sound Physicians Anesthesiology of California, P.C.,

Defendants.

CASE NO. 8:25-cv-01467-KES

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF SOUND PHYSICIANS' MOTION TO DISMISS

Filed concurrently with Notice of Motion and Motion; Declaration of Matthew L. Knowles Regarding Meet and Confer Efforts; [*Proposed*] Order

DATE: March 10, 2026
TIME: 10:00 a.m.
COURTROOM: 6D
JUDGE: Karen E. Scott

AMENDED COMPLAINT FILED: 10/17/2025

McDERMOTT WILL & SCHULTE LLP
ATTORNEYS AT LAW

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ATTORNEYS AT LAW

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McDERMOTT WILL & SCHULTE LLP
ATTORNEYS AT LAW

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McDERMOTT WILL & SCHULTE LLP
ATTORNEYS AT LAW

McDermott Will & Schulte LLP
Attorneys at Law

I. INTRODUCTION

Congress passed the No Surprises Act, 42 U.S.C. § 300gg-111 ("NSA") to protect patients from large out-of-network medical bills. The NSA requires insurance companies (like plaintiff Anthem[1]) to negotiate with medical providers (like defendant Sound Physicians) about how much they will pay for a patient's medical care. If negotiations fail, either side can invoke binding arbitration (known as Independent Dispute Resolution or "IDR") where an arbitrator will determine a reasonable payment.

Anthem's lawsuit attempts an end-run around the NSA. It asks the Court to vacate hundreds of (mostly unidentified) arbitrations where Anthem disagrees with the arbitrators' rulings, and to find Sound Physicians liable for damages as to arbitrations where Sound Physicians was the prevailing party.

The relief Anthem seeks is prohibited by law, and two circuit courts of appeal have already rejected similar challenges. Congress expressly barred judicial review of IDR awards except under the Federal Arbitration Act's ("FAA") narrow vacatur

[1] This brief refers to defendants Sound Physicians Emergency Medicine of Southern California, P.C. and Sound Physicians Anesthesiology of California, P.C. together as "Sound Physicians." It refers to plaintiff Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California d/b/a Blue Cross together as "Anthem." "AC" citations refer to Anthem's amended complaint, Docket No. 50. "OC" citations refer to Anthem's original complaint, Docket No. 1.

provisions, and Anthem's allegations fail these standards. Thus, the Court lacks subject-matter jurisdiction to conduct the merits review that Anthem seeks.

Nor can Anthem evade this bar on judicial review by invoking RICO, ERISA, or state-law claims. Its overheated rhetoric accuses Sound Physicians of wire fraud and operating a "criminal enterprise" based on disputes whether certain claims and healthcare plans are eligible for arbitration. AC ¶¶ 11, 207. But ironically, as discussed below on pages 23-24, it was Anthem's initial complaint in this case that made exactly the sort of error that it claims is wire fraud. Changes in the amended complaint show that it was *Anthem* that was wrong on the facts in several instances. If Anthem's broader theory was right—that a purported error of fact in a submission to a tribunal was actionable as wire fraud—then Anthem itself would be liable for wire fraud. Of course, this is not the law. Beyond that, Anthem's factual errors illustrate Sound Physicians' point: this Court should not be an appellate forum to second-guess arbitrators' rulings on fact disputes. Congress prohibited that, and thus the Court should dismiss this case.

II. BACKGROUND AND PROCEDURAL HISTORY

A. The parties

Anthem Blue Cross is a health care service plan and Anthem Blue Cross Life and Health Insurance Company is a large healthcare insurance carrier. *Id.* ¶¶ 12, 13. Anthem has sued defendants Sound Physicians, HaloMD, LLC ("HaloMD"),

McDermott Will & Schulte LLP
Attorneys at Law

MPOWERHealth Practice Management LLC ("MPOWERHealth"), and Alla and Scott LaRoque in this case ("LaRoque Family Providers"). *Id.* ¶¶ 14-27.

Sound Physicians is comprised of "over 4,000 physicians, advanced practice providers, CRNAs, and nurses." *Id.* ¶ 25.

HaloMD administers the IDR process on behalf of healthcare organizations, including Sound Physicians. *Id.* ¶ 153. Anthem alleges that HaloMD submitted and administered some, but not all, of the IDR claims at issue here. *Id.* ¶ 215.

The complaint does not allege any connection between Sound Physicians and the other provider defendants (*i.e.*, MPOWERHealth and the LaRoque Family Providers).

B. The NSA and the IDR process

Congress enacted the NSA to address the practice of "surprise billing" to patients for out-of-network items and services. *Id.* ¶ 42. The NSA created a process for resolving disputes about payment for medical services with the goal of taking the consumer out of billing disputes between insurers and providers. *Id.* ¶ 43. This process involves three steps: open negotiations, IDR submissions, and then a binding payment determination by arbitrators known as Independent Dispute Resolution Entities ("IDREs"). *Id.*; *see* 42 U.S.C. § 300gg-111(c).

When a dispute arises over the payment amount for an out-of-network service covered by the NSA, either side can initiate negotiations with the other. *See* 42 U.S.C. § 300gg-111(c)(1)(B); AC ¶ 43. If they are unable to agree on a payment amount

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within thirty days, either party can then initiate the IDR arbitration process. *See* 42 U.S.C. § 300gg-111(c)(1)(A)-(B); 45 C.F.R. § 149.510(b)(2)(i).

As the complaint acknowledges, the first step of the IDR process is for the arbitrator to determine whether a claim is eligible for IDR. AC ¶ 73. The arbitrators are expressly authorized and indeed required to make this determination. *Id.*; *see also* 45 C.F.R. § 149.510(c)(1)(v). A dispute only moves forward—and there can only be an award—if the IDRE determines that it is eligible. *See* 45 C.F.R. § 149.510(c)(1)(v). Thus, for each IDR in which Anthem alleges it suffered "damages," *see* AC ¶ 11, the IDRE must have determined that the claim was eligible for IDR.

If the IDRE determines the dispute is eligible for arbitration, each party proposes a payment amount for the medical care at issue. The IDRE then applies criteria specified in the NSA, and using these mandatory government criteria, selects the offer it determines to be most reasonable, which is thus the amount the insurer must pay the provider. *See* 42 U.S.C. § 300gg-111(c)(5). This is a "baseball" style arbitration, where the IDRE must select between the two sides' offers and pick the one that is most reasonable under specified statutory factors. AC ¶¶ 75-76.

C. The original and amended complaints

Anthem filed its original complaint on July 7, 2025, and amended it on October 17, 2025 (Dkt. Nos. 1, 50). The amended complaint asserts RICO, ERISA, and state-law claims, along with a request to vacate hundreds of IDR awards (which it does not identify, apart from the four referenced by docket number).

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In addition to this motion to dismiss, Sound Physicians has moved to strike the state-law claims under California's anti-SLAPP law. Docket No. 68.

III. LEGAL STANDARD

Sound Physicians moves to dismiss the amended complaint under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6).

Under Rule 12(b)(1), a court must dismiss a case where it lacks subject-matter jurisdiction. "[F]ederal courts are courts of limited jurisdiction. They possess only that power authorized by Constitution and statute, which is not to be expanded by judicial decree." *Gila River Indian Cmty. v. Schoubroek*, 145 F.4th 1058, 1070 (9th Cir. 2025). The presumption is that a case lies outside this jurisdiction, and the burden to establish otherwise rests squarely on the plaintiff. *Id.*

Under Rule 12(b)(6), a complaint must "state a claim to relief that is plausible on its face." *Soo Park v. Thompson*, 851 F.3d 910, 918 (9th Cir. 2017)*; see also Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). A claim is plausible only when it contains sufficient factual allegations "to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 678. "Where a complaint pleads facts that are 'merely consistent with' a defendant's liability, it 'stops short of the line between possibility and plausibility….'" *Id.* (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 557 (2007)).

Fraud claims require a higher pleading standard. *Bodenburg v. Apple Inc.*, 146 F.4th 761, 770-71 (9th Cir. 2025). Rule 9(b) requires that when alleging fraud or

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mistake, a party must "state with particularity the circumstances constituting fraud or mistake." *Id.* They must allege "the who, what, when, where, and how of the misconduct charged." *Id.* (cleaned up). Moreover, a plaintiff must also allege facts with respect to each defendant's participation in the fraud, and cannot simply make generic allegations against the defendants together. *In re Cloudera, Inc.*, 121 F.4th 1180, 1187 (9th Cir. 2024).

As to a request for vacatur (Count 11), the rules of notice pleading do not apply. *See Pac. & Arctic Ry. & Navigation Co. v. United Transp. Union*, 952 F.2d 1144, 1148 (9th Cir. 1991). Instead, for the reasons set out in § IV.B.2, below, the party seeking vacatur must make an application or motion supported by clear and convincing evidence. *Id.*

IV. ARGUMENT

A. Congress prohibited judicial review of IDR rulings, unless the requirements for vacatur under the FAA are met.

Congress has expressly prohibited judicial review of IDR rulings—unless certain narrow exceptions are met—and this bar is jurisdictional. Specifically, the NSA 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 the FAA. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). Paragraphs (1) through (4) of § 10(a) of the FAA set out the grounds for vacatur. 9 U.S.C. § 10(a)(1)-(4). And "subparagraph (A)" refers to the previous section of the

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NSA authorizing the IDRE's work, including selecting the prevailing offer or bid. 42 U.S.C. § 300gg-111(c)(5)(A), (E)(i)(II).

Where Congress makes a clear statement restricting judicial review, it is limiting the subject-matter jurisdiction of the courts. *See Arbaugh v. Y&H Corp.*, 546 U.S. 500, 515-16 (2006); *see also Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 153-54 (2013). This occurs when Congress enacts a statute that provides "clear and convincing evidence that Congress intended to deny" access to judicial review. *Bd. of Governors of Fed. Reserve Sys. v. MCorp Fin., Inc.*, 502 U.S. 32, 44 (1991).

For example, where—as here—Congress states that a determination is not subject to judicial review, the bar is jurisdictional. *Ctr. For Biological Diversity v. Bernhardt*, 946 F.3d 553, 557, 563 (9th Cir. 2019) (analyzing statute providing no determination under a certain law "shall be subject to judicial review"); *see also Montanans For Multiple Use v. Barbouletos*, 568 F.3d 225, 229 (D.C. Cir. 2009) (same as to statute providing that "no determination" under a certain process "shall be subject to judicial review"); *Acker v. Tarr*, 486 F.2d 654, 656 (7th Cir. 1973) (finding no jurisdiction to review deferment classification, where statute provided for "[n]o judicial review" except in limited circumstances).

B. Anthem has not met the requirements for vacatur under the FAA.

The exclusive means to challenge an IDR award is to seek vacatur under the FAA. *See Guardian Flight, L.L.C. v. Med. Evaluators of Tex. ASO, L.L.C.*, 140 F.4th 613, 620 (5th Cir. 2025) ("[I]f Providers wish to seek vacatur of the awards, they must

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do so through the FAA paragraphs explicitly incorporated for that purpose."); *Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc.*, 2025 WL 3222820, at *4 (11th Cir. Nov. 19, 2025) ("*RAMS*") ("The NSA explicitly incorporates the FAA's provisions allowing for the vacatur of arbitration awards…."). There is no path for judicial review in the NSA itself, nor another path elsewhere in federal law. Thus, Anthem's complaint (including its request for "vacatur" in Count 11) must be analyzed as a request for vacatur under § 10(a)(1)-(4) of the FAA—there is no other source of jurisdiction, and that is all it could be.

But this requires Anthem to provide clear and convincing evidence to support its request for vacatur. For the reasons below, Anthem has failed to meet the standard for vacatur under the FAA, and this is not a close call.

1. The demanding standard for vacatur

Federal courts have "extremely limited review authority" under the FAA. *Kyocera Corp. v. Prudential-Bache Trade Servs., Inc.*, 341 F.3d 987, 998 (9th Cir. 2003). Arbitration awards should not be vacated by courts "even in the face of erroneous findings of fact or misinterpretations of law." *French v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 784 F.2d 902, 906 (9th Cir. 1986) (quotations omitted). Indeed, "the FAA provides no authorization for a merits review." *Biller v. Toyota Motor Corp.*, 668 F.3d 655, 664 (9th Cir. 2012). This review of arbitration decisions must be "both limited and highly deferential." *Coutee v. Barington Cap. Grp., L.P.*, 336 F.3d 1128, 1132 (9th Cir. 2003); *see also Dogherra v. Safeway Stores, Inc.*, 679

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F.2d 1293, 1297 (9th Cir. 1982) ("[I]n order to protect the finality of arbitration decisions, courts must be slow to vacate an arbitral award on the ground of fraud.").

Thus, the Ninth Circuit recognizes that courts must give a "nearly unparalleled degree of deference to the arbitrator's decision." *Sw. Reg'l Council of Carpenters v. Drywall Dynamics, Inc.*, 823 F.3d 524, 530 (9th Cir. 2016) (quotations omitted). Here, Congress created IDR arbitration as "a separate framework outside the judicial process," AC ¶ 43, and "the wisdom of Congress's policy choice is beyond [] judicial ken," *Guardian Flight L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 277 (5th Cir. 2025).

2. Vacatur requires a timely motion supported by clear and convincing evidence, not merely allegations in a complaint.

To challenge an arbitration ruling under the FAA, the required procedure is to file an application or motion to vacate in the district court, supported by clear and convincing evidence. *A.G. Edwards & Sons, Inc. v. McCollough*, 967 F.2d 1401, 1404 (9th Cir. 1992); *Arora v. TD Ameritrade, Inc.*, 2010 WL 2925178, at *6 (N.D. Cal. July 26, 2010) (citing *O.R. Sec., Inc. v. Pro. Plan. Assocs., Inc.*, 857 F.2d 742, 745 (11th Cir. 1988)). Under 9 U.S.C. § 12, a motion for vacatur must be filed within three months of the award, and such requirement is not displaced merely because a party has filed under "the guise of an independent suit." *Sander v. Weyerhaeuser Co.*, 966 F.2d 501, 503 (9th Cir. 1992). Indeed, "[t]he three month limitation 'is meaningless if a party to the arbitration proceedings may bring an independent direct action asserting

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such claims outside of the statutory time period.'" *Id.* (quoting *Corey v. N.Y. Stock Exch.*, 691 F.2d 1205, 1213 (6th Cir.1982)).

The rules of notice pleading do not apply. A party cannot rely on mere allegations; otherwise, "the burden … would be on the party defending the arbitration award," and, absent a successful motion to dismiss, the proceeding "would develop into full scale litigation." *O.R. Sec., Inc.*, 857 F.2d at 745 (11th Cir. 1988). If parties could take "full-bore legal and evidentiary appeals," arbitration would become "merely a prelude to a more cumbersome and time-consuming judicial review process." *Hall St. Assocs., L.L.C. v. Mattel, Inc.*, 552 U.S. 576, 588 (2008).

As Anthem's complaint emphasizes, there are hundreds of thousands of arbitrations each year under the NSA. AC ¶ 108. The United States District Court for the Central District of California should not be the forum to relitigate each IDR arbitration where the losing side merely pleads that the other side and the arbitrator got the facts wrong.

3. Anthem's unsupported complaint falls far short of the requirements for vacatur.

Anthem's complaint lacks exhibits, declarations, or evidence of any kind. It merely *alleges* that Sound Physicians initiated "nearly 400 ineligible disputes" and prevailed in more than 250 of them. AC ¶ 222. Of these, Anthem identifies only ***four*** by docket number and raises various substantive and factual issues it claims to have argued in these IDR proceedings. AC ¶¶ 224-48. Nor does it plead the date of the

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award as to *any* of the arbitrations discussed in the complaint, and thus has failed to show that any of its requests are timely (*i.e.*, filed within three months of the ruling). In short, what it has filed is not nearly enough for vacatur under the FAA.

And even if Anthem's unsupported allegations were enough from a procedural perspective (they are not), its allegations fall far short of showing a substantive basis for vacatur. Every court that has considered the NSA's incorporation of the FAA has agreed that the meaning and established understanding of paragraphs (1) through (4) of the FAA apply when analyzing a challenge to an NSA IDR ruling. *See e.g.*, *RAMS*, 2025 WL 3222820, at *4; *Guardian Flight*, 140 F.4th 271 at 275; *Guardian Flight*, 140 F.4th 613 at 620.

Anthem seeks vacatur of hundreds of arbitration awards (which it does not even list) on the grounds that they were "procured by undue means and fraud" (*i.e.*, § 10(a)(1)) and because the arbitrators "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" (*i.e.*, § 10(a)(4)). AC ¶¶ 357-58. In other words, it relies on only two of the four potential grounds for vacatur under the FAA. Its complaint does not satisfy either of them.

a) No grounds for vacatur under § 10(a)(1)

Anthem has failed to show that any arbitration award was procured by fraud, corruption, or undue means as required to prevail under § 10(a)(1). This provision of the FAA "requires a showing of bad faith during the arbitration proceedings, such as

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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.*, 2001 WL 637446, at *5 (N.D. Cal. June 1, 2001).

(1) No fraud

"Under the FAA [as incorporated by the NSA], '[f]raud requires a showing of bad faith during the arbitration proceedings, such as bribery, undisclosed bias of an arbitrator, or willfully destroying or withholding evidence.'" *Guardian Flight*, 140 F.4th 613 at 621 (citation omitted). In the Ninth Circuit, 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. & Nav. Co.*, 952 F.2d at 1148.

The first element requires the movant to establish fraud by clear and convincing evidence. Anthem fails at this step, as it merely alleges that Sound Physicians, in "nearly 400" IDR arbitrations, misrepresented that claims were eligible for IDR arbitration under the NSA, that Anthem contested this eligibility at the arbitrations, and the arbitrator ruled in Sound Physicians' favor in "more than 250 IDR determinations." AC ¶ 222; *see, e.g.*, *id.* ¶¶ 2, 90, 93, 115, 117-18, 124, 128.

This is not fraud under the FAA. For example, the Fifth Circuit recently upheld the dismissal of a complaint seeking to overturn IDR arbitrations on the grounds that

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one party misrepresented key information during the proceedings. *Guardian Flight*, 140 F.4th 613, at 621-22. Similarly, the Eleventh Circuit recently held that allegations of misrepresentations of fact in an IDR arbitration are not sufficient to sustain a claim without meeting the requirements of § 10(a). *RAMS*, 2025 WL 3222820, at *6-8.

Even if the alleged misrepresentations were somehow clear and convincing evidence of fraud (they are not), Anthem fails to meet the second requirement for vacatur under § 10(a)(1): that the fraud must not have been discoverable upon the exercise of due diligence prior to or during the arbitration. *See A.G. Edwards & Sons*, 967 F.2d 1404 (stating that if fraud is "discovered and brought to the attention of the arbitrators, a disappointed party will not be given a second bite at the apple.").

Here, Anthem pleads the opposite: that it was aware of the supposed misstatements and argued to the arbitrator that the statements were wrong. Anthem has pleaded itself out of court. It alleges that it knew about these "misrepresentations" during the IDR process and that it presented this information to the arbitrators. For example, as to each of the four awards that Anthem references in its complaint related to Sound Physicians, it alleges that it "responded to the IDR initiation to assert that IDR was not applicable to the dispute," or "submitted an objection to eligibility." *See, e.g.*, AC ¶¶ 228, 234, 240, 247. By establishing that it contested the eligibility of the claims at the time of the arbitration, Anthem defeats its own argument that "misrepresentation" occurred that was not discoverable by due diligence prior to or during the arbitration process.

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(2) No undue means

"Undue means" in the context of § 10(a) refers to conduct that "is immoral if not illegal." *A.G. Edwards & Sons*, 967 F.2d at 1403. "Sloppy or overzealous lawyering" does not constitute "undue means." *Id.* 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.*, 2001 WL 637446, at *5; *accord RAMS*, 2025 WL 3222820, at *9 (addressing challenge to IDR award and noting, "Courts of Appeals have limited undue means to those actions 'equivalent in gravity to corruption or fraud, such as a physical threat to an arbitrator or other improper influence.'" (quoting *Am. Postal Workers Union v. U.S. Postal Serv.*, 52 F.3d 359, 362 (D.C. Cir. 1995))).

No evidence (or even allegation) of intentional conduct like bribery, destruction of evidence, or undisclosed bias is present here, nor does Anthem allege anything remotely close to it. At most, Anthem argues that Sound Physicians submitted a large number of arbitrations, and that its settlement demands were larger than Anthem thinks they should have been. But there is no cap on the number of claims eligible for IDR. Anthem is a massive insurance company, and Sound Physicians has "over 4,000 physicians, advanced practice providers, CRNAs, and nurses." AC ¶ 25. A large volume of claims between them is the expected outcome, not a surprise.

The same is true of Anthem's theory that Sound Physicians' monetary demands were too high. As Anthem explains, the arbitrator's job is to select the most reasonable and appropriate option between the two that are submitted (one by each side). If Sound Physicians' offer is too high, why would the arbitrator select it—and what are the undue means? Anthem points to no statutory or other constraints limiting the amount that a provider can request in the IDR process. It objects that Sound Physicians' demands were sometimes higher than the billed charges but then notes that Congress expressly prohibited consideration of the billed charges in the IDR process. *Id.* ¶ 122. In any event, if the provider's offer is unreasonably high, then the arbitrator will select the insurance company's number instead, given the NSA employs "baseball-style arbitration," which "incentiviz[es] both parties to eschew extreme offers that the arbitrator would be more likely to reject." *RAMS*, 2025 WL 3222820, at *9. Anthem has shown no undue means.

b) No grounds for vacatur under § 10(a)(4)

Vacatur is permitted under 9 U.S.C. § 10(a)(4) only if 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. "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) (cleaned up). "It is not enough to show that the panel committed an error—or even a serious error." *Lagstein v. Certain Underwriters at Lloyd's, Lond.*, 607 F.3d 634, 641

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(9th Cir. 2010) (cleaned up). Rather, "it must be clear from the record that the arbitrator recognized the applicable law and then ignored it." *Bosack*, 586 F.3d at 1104 (cleaned up). The question is whether the arbitrators were authorized to decide, not whether they made the wrong decision. *See Schoenduve Corp. v. Lucent Techs., Inc.*, 442 F.3d 727, 733 (9th Cir. 2006) ("[T]he arbitrator's interpretation of the scope of his powers is entitled to the same level of deference as his determination on the merits").

Anthem's position here is a non-starter. The arbitrators are plainly authorized to decide eligibility and to decide between the parties' proposed awards for compensating the medical provider. *See* AC ¶ 73; 42 U.S.C. § 300gg-111(c)(5); *see also* 45 C.F.R. § 149.510(c)(1)(v). This precludes Anthem's § 10(a)(4) argument. While reviewing an arbitration award under this provision of the FAA, courts are empowered to decide only whether the arbitrator has engaged in an authorized determination, not to second guess "the rightness or wrongness of" such decision. *HayDay Farms, Inc. v. FeeDx Holdings, Inc.*, 55 F.4th 1232, 1241 (9th Cir. 2022).

Anthem merely alleges that the arbitrators sometimes made errors in some eligibility determinations, and that they sometimes picked the wrong offer (because Anthem would prefer that the arbitrator selected its offer instead). Anthem has failed to allege facts showing that the arbitrators exceeded their powers. To say otherwise would be to make this Court a court of appeals for *de novo* review of each IDR eligibility ruling. That is the opposite of the system that Congress designed.

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C. Anthem cannot use other claims and theories to circumvent the jurisdictional bar on judicial review or the requirements for vacatur.

The only plausible reading of § 300gg-111(c)(5)(E)(i)(II) of the NSA is that it bars judicial review of IDR rulings, no matter what cause of action a plaintiff might invoke to challenge them. That is what it says: these rulings "shall not be subject to judicial review, except" under the vacatur provision of the FAA. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). Any other reading would be atextual—and flatly contrary to the law.

Similarly, caselaw from other contexts makes clear that the losing side of an arbitration cannot invoke other claims—like RICO or state-law fraud—to challenge the arbitration ruling while ignoring the strict limits and procedures under the FAA. Where a plaintiff's "underlying complaint is that the arbitration award was procured by fraud," it must file a motion to vacate the arbitration award under the FAA. *Sander*, 966 F.2d at 503 (cleaned up); *accord id.* at 502 ("We would establish poor precedent if we allowed Sander to bring an action under securities laws because he is unhappy with the results of an adjudicative proceeding.").

Anthem's attempts to bring RICO, ERISA, and state-law claims despite the NSA's jurisdiction-stripping provision are nothing more than an "impermissible collateral attack" on the arbitration awards. *Nickoloff v. Wolpoff & Abramson, L.L.P.*, 511 F. Supp. 2d 1043, 1044 (C.D. Cal. 2007) ("Seeking damages in federal court for alleged wrongdoing that compromised an arbitration award is an impermissible

collateral attack on the award itself." (citing *Decker v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 205 F.3d 906 (6th Cir. 2000))). Therefore, the Court's inquiry should end here, and it should dismiss the case.

D. Anthem's claims are barred by the First Amendment under the *Noerr-Pennington* doctrine.

The right to petition the government for redress of grievances is within the protection of the First Amendment, and this extends to acts in and around litigation or arbitration—such acts generally cannot be the basis for civil liability. *See Sosa v. DIRECTV, Inc.*, 437 F.3d 923, 942 (9th Cir. 2006) (holding *Noerr-Pennington* doctrine barred plaintiff's RICO suit against television broadcaster for prelitigation demand letters); *see also Relevant Grp., LLC v. Nourmand*, 116 F.4th 917, 927-28 (9th Cir. 2024) (dismissing RICO suit barred by *Noerr-Pennington* doctrine). Thus, parties are generally immune from liability arising from litigation activity under the *Noerr-Pennington* doctrine. *Octane Fitness, LLC v. ICON Health & Fitness, Inc.*, 572 U.S. 545, 555-56 (2014). This rule extends to arbitration, at least where (as here) the arbitration involves a public or quasi-public arbitration forum or process. *See, e.g.*, *Viriyapanthu v. California*, 2018 WL 6136150, at *7 (C.D. Cal. Sept. 24, 2018); *Entrepreneur Media, Inc. v. Dermer*, 2019 WL 4187466, at *2 (C.D. Cal. July 22, 2019); *Eurotech, Inc. v. Cosmos Eur. Travels Aktiengesellschaft*, 189 F. Supp. 2d 385, 392-93 (E.D. Va. 2002) (applying doctrine to quasi-governmental arbitration process

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concerning internet domain names). The IDR process that Congress established by statute plainly qualifies as a public or quasi-public arbitration process.

To overcome this constitutional immunity, a plaintiff must allege facts sufficient to show that *Noerr-Pennington* immunity does not apply. *See, e.g.*, *NM LLC v. Keller*, 2024 WL 4336428, at *2 (W.D. Wash. Sept. 27, 2024) (dismissing RICO case where "the fundamental problem with Plaintiffs' complaint is that all the actions it challenges are protected speech or petitioning activity"). In cases implicating the First Amendment, the Ninth Circuit employs a heightened pleading standard. *Kottle v. Nw. Kidney Ctrs.*, 146 F.3d 1056, 1063 (9th Cir. 1998) (noting the standard "would have no force if in order to satisfy it, a party could simply recast disputed issues from the underlying litigation as 'misrepresentations' by the other party.").

Anthem has failed to allege sufficient facts to overcome *Noerr-Pennington* immunity here, as the complaint is based entirely on arbitration conduct and statements made as part of arbitrations. Thus, Anthem's claims should be dismissed because Sound Physicians' arbitration conduct is protected under the First Amendment.

E. The complaint does not comply with Rule 9(b).

Anthem also fails to satisfy Rule 9(b)'s heightened pleading standard for pleading fraud. *Schreiber Distrib. Co. v. Serv-Well Furniture Co.*, 806 F.2d 1393, 1400 (9th Cir. 1986). Under Rule 9(b), plaintiffs must allege: "the time, place, and specific content of the false representations as well as the identities of the parties to the misrepresentation." *Id.* at 1401; *accord Desoto v. Condon*, 371 F. App'x 822, 824 (9th

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Cir. 2010). Moreover, a plaintiff must also allege facts with respect to each defendant's participation in the fraud. *In re Wellpoint, Inc. Out-of-Network UCR Rates Litig.*, 903 F. Supp. 2d 880, 914 (C.D. Cal. 2012).

Anthem's complaint fails twice over. First, it lists four arbitrations by docket number, but does not provide the specifics (names, dates, speakers, etc.) as to them. Then it doubles down by asking the Court to assume fraud in hundreds more arbitrations that it does not even identify. For example, it alleges:

- "Since no later than January 2024, Defendants have initiated many hundreds of knowingly ineligible disputes against Anthem." AC ¶ 9.
- "Anthem often directly notifies Defendants that the items or services at issue in their IDR initiation violate the NSA's eligibility requirements." AC ¶ 101.
- "For more than 380 IDR disputes, Defendants' payment offers exceeded the charges that they initially billed Anthem by more than $1.5 million." AC ¶ 124.

These general statements—which do not identify actors, dates, or actions—fail under Rule 9(b). Nor does Anthem identify which defendants were involved, instead resorting to impermissible shotgun pleading that "merely lump[s] multiple defendants together." *Swartz v. KPMG LLP*, 476 F.3d 756, 764-65 (9th Cir. 2007). In the Ninth Circuit, plaintiffs are required "to differentiate their allegations when suing more than one defendant … and inform each defendant separately of the allegations surrounding his alleged participation in the fraud." *Id.*; *accord Moore v. Kayport Package Express, Inc.*, 885 F.2d 531, 541 (9th Cir.1989).

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The Eleventh Circuit recently confirmed that Rule 9(b) applies to challenges to IDR arbitration awards. *RAMS*, 2025 WL 3222820, at *6-8. Indeed, it applied Rule 9(b) strictly and made clear that the plaintiff failed to satisfy the rule. *Id.* Anthem offers no basis for watering down that standard, nor could it, particularly when it seeks to overturn hundreds of unidentified awards *en masse*.

F. The RICO claims fail as a matter of law.

For the reasons set out above, Congress has precluded the judicial review that Anthem seeks, no matter which legal theory it invokes—including RICO. Furthermore, Anthem's RICO theory also fails as a matter of law for several additional and independent reasons:

1. Arbitration submissions cannot be wire or mail fraud.

To survive a motion to dismiss, a RICO claim must set out two or more predicate acts. *Howard v. Am. Online Inc.*, 208 F.3d 741, 746 (9th Cir. 2000). Here, Anthem has failed to do so. It appears to rely on five supposed predicate acts constituting wire or mail fraud related to Sound Physicians:

(1) Submitting arbitration filings that include incorrect facts about eligibility;

(2) Collecting on judgments from favorable IDR determinations;

(3) Initiating large numbers of IDR disputes;

(4) Demanding "outrageous" payments far exceeding the actual charges; and

(5) Engaging in the IDR process "in bad faith."

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See AC ¶ 279.[2] These theories fail for two reasons: first, as a matter of law, none of them constitutes wire or mail fraud, and second, Anthem has not provided the details required under Rule 9(b).

a) Neither arbitration submissions nor collecting judgments from successful arbitrations constitute wire or mail fraud.

As courts have made clear, the "mailing of litigation documents, even perjurious ones, [does] not violate the mail-fraud statute." *United States v. Pendergraft*, 297 F.3d 1198, 1209 (11th Cir. 2002).[3] Likewise, courts have repeatedly held that litigation activity generally cannot give rise to racketeering liability. *Acres Bonusing, Inc. v. Ramsey*, 2022 WL 17170856, at *10 (N.D. Cal. Nov. 22, 2022); *Pendergraft*, 297 F.3d at 1208 (collecting cases); *Kim v. Kimm*, 884 F.3d 98, 104 (2d Cir. 2018) (collecting cases); *see also Snow Ingredients, Inc. v. SnoWizard, Inc*., 833 F.3d 512, 525 (5th Cir. 2016). This rule applies to actions taken in furtherance of litigation more broadly. *See Acres Bonusing*, 2022 WL 17170856, at *12.

These principles extend to arbitration proceedings as well, as courts have held that arbitration activities cannot form the basis for mail or wire fraud. *Republic of Kazakhstan v. Stati*, 380 F. Supp. 3d 55, 60-61 (D.D.C. 2019) (holding litigation

[2] For clarity, the allegations from Paragraph 279 have been reordered to align with the sequence in which they are addressed in this Brief.

[3] This applies equally to electronic transmissions, as mail and wire fraud are treated interchangeably for RICO purposes. *Tatung Co. v. Shu Tze Hsu*, 217 F. Supp. 3d 1138, 1161 (C.D. Cal. 2016).

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materials transmitted during prior arbitration could not constitute wire or mail fraud); *Diamond Resorts Int'l, Inc. v. Aaronson*, 2018 WL 735627, at *5 (M.D. Fla. Jan. 26, 2018) (holding false statements in arbitration demands were not grounds for mail or wire fraud). Anthem's theories fail under this rule. Indeed, all of the alleged misrepresentations it points to are in submissions made attendant to the IDR process. AC ¶¶ 278-79. Such arbitration conduct cannot support a wire fraud theory.

Likewise, the collection of judgments secured through successful IDR arbitrations is simply an extension of the same litigation-related conduct, and it cannot support a mail or wire fraud claim. *See Pendergraft*, 297 F.3d at 1208 ("Again, prosecuting litigation activities as federal crimes would undermine the policies of access and finality that animate our legal system.").

Anthem's errors in its own filings underscore the point. Its theory is that false statements in arbitration filings amount to wire fraud, so if a party submits incorrect facts and wins, the loser can sue in federal court. But Anthem's original complaint in this case (Docket No. 1) was riddled with factual errors. For example, Anthem pleaded that Sound Physicians failed to initiate open negotiations in DISP-1289721, DISP-803189, and DISP-2639953. OC ¶¶ 213, 221. After Sound Physicians explained that this is wrong, Anthem amended its complaint to withdraw the assertion. Anthem changed or withdrew the following allegations:

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Docket No.	Initial Complaint	Amended Complaint
DISP-1289721	"Neither SPEMSC, nor HaloMD acting on its behalf, initiated open negotiations for this service." ¶ 213	"On March 13, 2024 SPEMSC sent a notice of open negotiation to ABC at the Anthem IDR Email Address." ¶ 232
DISP-803189	"Neither SPAC nor HaloMD acting on its behalf initiated open negotiations for this service." ¶ 221	*Withdrawn* – Sound Physicians sent a request for open negotiations; Anthem failed to respond.
DISP-2639953	"DISP-2639953 (**No Open Negotiation**; Ineligible State Law Claim)." Header above ¶ 224 (emphasis added)	"DISP-2639953 (Ineligible State Law Claim)." Header above ¶ 242

Additionally, Anthem apparently overstated the number of allegedly ineligible arbitrations by an order of magnitude, later revising "thousands" to "hundreds." *Compare* OC ¶ 5, *with* AC ¶ 9.

Under its own theory, these misstatements would constitute wire fraud, allowing Sound Physicians to sue Anthem under RICO based on its initial complaint. Fortunately, this is not the law. Instead, Anthem's factual errors illustrate exactly why its theory fails: fact disputes are common in arbitration and litigation, and the proper remedy is to raise them with the tribunal, not to file a new RICO action.

b) Anthem's remaining theories fail to establish wire fraud.

Anthem's remaining theories of wire fraud consist of its claims that Sound Physicians (1) initiated many disputes at once, (2) demanded "outrageous" payments, and (3) engaged in IDR arbitration "in bad faith." AC ¶ 279. None comes close to wire

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or mail fraud because none alleges deception. There is no limit on the number of IDRs a party may pursue or the amount it may seek—and even if there were, filing multiple disputes or requesting high payments is not a predicate act under RICO, as nothing is concealed or misrepresented. *See generally* 18 U.S.C. § 1961(1) (listing the predicate acts capable of supporting RICO claims).

As for "bad faith," that theory fails outright: bad faith alone does not constitute mail or wire fraud. *See Miller v. Yokohama Tire*, 358 F.3d 616, 620 (9th Cir. 2004); *United States v. Miller*, 953 F.3d 1095, 1102-03 (9th Cir. 2020). RICO does not impose a 'good-faith overlay' on litigation and arbitration, allowing a party to sue for racketeering if it thinks the other side acted in bad faith.

2. Anthem's claims under 18 U.S.C. § 1962(c) should be dismissed because it has failed to identify an enterprise.

Anthem's RICO claims related to Sound Physicians rely on an "associated in fact" enterprise theory. *See* AC ¶ 256; 18 U.S.C. § 1961(4). The Supreme Court has held that an association-in-fact enterprise must possess three qualities: "a purpose, relationships among those associated with the enterprise, and longevity sufficient to permit these associates to pursue the enterprise's purpose." *Boyle v. United States*, 556 U.S. 938, 946 (2009). It must be "a continuing unit that functions with a common purpose." *Id.* at 948. "[C]ourts have overwhelmingly rejected attempts to characterize routine commercial relationships as RICO enterprises." *Shaw v. Nissan N. Am., Inc.*, 220 F. Supp. 3d 1046, 1054 (C.D. Cal. 2016). "[O]rdinary business conduct and an

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ordinary business purpose" do not show the existence of a RICO enterprise. *Id.*; *accord Gardner v. Starkist Co.*, 418 F. Supp. 3d 443, 460-62 (N.D. Cal. 2019).

Anthem has not alleged sufficient facts to plausibly support the inference that the defendants share a common purpose under RICO, as opposed to the obvious alternative explanation that the defendants simply interpret IDR eligibility differently—or even that they erred on some subset of the thousands of IDR claims in question (which Sound Physicians does not concede). At a minimum, Anthem has failed to plead facts to rule out this "obvious alternative explanation." *Twombly*, 550 U.S. at 567; *accord In re Century Aluminum Co. Secs. Litig.*, 729 F.3d 1104, 1108 (9th Cir. 2013) ("[P]laintiffs cannot offer allegations that are 'merely consistent with' their favored explanation but are also consistent with the alternative explanation." (citation omitted)). Under the strict pleading rules in Rule 9(b), this is not sufficient.

3. Anthem cannot show a § 1962(d) violation because there is no violation of § 1962(c), and no agreement to operate a RICO enterprise.

The failure to state a claim for a primary RICO violation under § 1962(c) defeats a civil RICO conspiracy claim. *Sanford v. MemberWorks, Inc.*, 625 F.3d 550, 559 (9th Cir. 2010); *see also Dennis v. JP Morgan Chase Bank*, 812 F. App'x 607, 607 (9th Cir. 2020). For the reasons above, Anthem failed to allege sufficient facts to support a finding that defendants engaged in a pattern of racketeering activity pursuant to § 1962(c), let alone that they knew about and agreed to facilitate the pattern of racketeering activity.

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Attorneys at Law

McDermott Will & Schulte LLP
Attorneys at Law

G. The ERISA claims fail as a matter of law.

The ERISA equitable relief provision that Anthem cites, 29 U.S.C. § 1132, does not apply because—as explained above—the NSA expressly prohibits judicial review in these circumstances. Further, Anthem's ERISA claim fails because it does not plead facts sufficient to show fiduciary status. ERISA permits equitable relief only for "a participant, beneficiary, or fiduciary." 29 U.S.C. § 1132(a)(3); *see also S. Coast Specialty Surgery Ctr., Inc. v. Blue Cross of Cal.*, 90 F.4th 953, 958 (9th Cir. 2024). Anthem is not, of course, a participant or a beneficiary. Nor is it a fiduciary. Anthem is aware of this requirement, and the complaint attempts a sleight-of-hand to avoid it. In paragraph 362, it acknowledges that "ERISA authorizes a fiduciary of a health plan to bring a civil action" but Anthem never even asserts that it is one, let alone plead facts to show that it is an ERISA fiduciary.

This omission is deliberate. In other cases, Anthem and its Blue Cross affiliates routinely attempt to avoid liability from plan members by arguing they are *not* ERISA fiduciaries. *See, e.g.*, *King v. Blue Cross & Blue Shield of Ill.*, 871 F.3d 730, 745 (9th Cir. 2017) ("Blue Cross argues that it is not a fiduciary…."); *Tiara Yachts, Inc. v. Blue Cross Blue Shield of Mich.*, 138 F.4th 457, 469 (6th Cir. 2025) (Blue Cross of Michigan argued that it was "insulate[d] … from ERISA fiduciary duties"); *Technibilt Grp. Ins. Plan v. Blue Cross & Blue Shield of N.C.*, 438 F. Supp. 3d 599, 604 (W.D.N.C. 2020) ("Blue Cross' primary substantive argument is that, as a matter of law, it is not an ERISA fiduciary….").

To determine ERISA fiduciary status, a court must evaluate whether the entity "exercises any discretionary authority or discretionary control respecting management of such plan or has any discretionary authority or discretionary responsibility in the administration of such plan." *King*, 871 F.3d at 745 (cleaned up). Anthem has not pleaded facts to meet this test.

H. The state-law claims fail for the reasons set out in Sound Physicians' special motion to strike.

For the reasons set out in § IV.A-C, above, the Court lacks jurisdiction to review the IDR arbitrations at issue—no matter what cause of action Anthem invokes, including state-law claims. Furthermore, the state-law claims that Anthem asserts to challenge arbitrations conducted under the federal NSA fail for the independent reasons set out in Sound Physicians' Motion to Strike, § IV.B.2-5, which we respectfully incorporate and re-assert here.

V. CONCLUSION

For the reasons above, the Court should dismiss Anthem's amended complaint.

McDermott Will & Schulte LLP
Attorneys at Law

Dated: December 12, 2025

MCDERMOTT WILL & SCHULTE LLP

By: */s/ Tala Jayadevan*
Tala Jayadevan

Laura McLane (appearing *pro hac vice*)
Matthew L. Knowles (appearing *pro hac vice*)
Connor S. Romm (appearing *pro hac vice*)

Attorneys for Defendants Sound Physicians Emergency Medicine of Southern California, P.C. and Sound Physicians Anesthesiology of California, P.C.

McDERMOTT WILL & SCHULTE LLP
ATTORNEYS AT LAW

CERTIFICATE OF COMPLIANCE

The undersigned, counsel of record for Defendants Sound Physicians Emergency Medicine of Southern California, P.C. and Sound Physicians Anesthesiology of California, P.C., certifies that this brief contains 6,997 words, which complies with the word limit of L.R. 11-6.1.

Dated: December 12, 2025

MCDERMOTT WILL & SCHULTE LLP

By: */s/ Tala Jayadevan*
Tala Jayadevan

Laura McLane (appearing *pro hac vice*)
Matthew L. Knowles (appearing *pro hac vice*)
Connor S. Romm (appearing *pro hac vice*)

Attorneys for Defendants Sound Physicians Emergency Medicine of Southern California, P.C. and Sound Physicians Anesthesiology of California, P.C.

McDermott Will & Schulte LLP
Attorneys at Law

Amir Shlesinger (SBN 20413)
ashlesinger@crowell.com
CROWELL & MORING LLP
515 South Flower Street, 41st Floor
Los Angeles, CA 90071-1514
Telephone: 213.443.5507

Martin J. Bishop (*pro hac vice*)
mbishop@crowell.com
Illinois Bar No. 6269425
Alexandra M. Lucas (*pro hac vice*)
alucas@crowell.com
Illinois Bar No. 6313385
Jason T. Mayer (*pro hac vice*)
jmayer@crowell.com
Illinois Bar No. 6309633
CROWELL & MORING LLP
455 North Cityfront Plaza Dr., Suite 3600
Chicago, IL 60611
Tel: 312.321.4200

Attorneys for Plaintiffs

CROWELL & MORING LLP
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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA, SOUTHERN DIVISION

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

Plaintiffs,

vs.

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

Defendants.

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

AMENDED COMPLAINT AND DEMAND FOR JURY TRIAL

VIOLATION OF RICO, 18 U.S.C. § 1962(c); VIOLATION OF RICO, 18 U.S.C. § 1962(d); FRAUDULENT MISREPRESENTATION; NEGLIGENT MISREPRESENTATION; BUSINESS ACTS OR PRACTICES IN VIOLATION OF CAL. BUS. & PROF. CODE §§ 17200 *ET SEQ.*; VACATUR OF NSA DISPUTE RESOLUTION AWARDS; ERISA CLAIM FOR EQUITABLE RELIEF; DECLARATORY AND INJUNCTIVE RELIEF

Plaintiffs Anthem Blue Cross Life and Health Insurance Company ("ABCLH") and Blue Cross of California d/b/a Anthem Blue Cross ("ABC") (collectively, "Anthem") hereby bring suit against HaloMD, LLC ("HaloMD") and Alla LaRoque, (collectively, the "HaloMD Defendants"); Scott LaRoque and MPOWERHealth Practice Management, LLC ("MPOWERHealth"; and, together with Scott LaRoque, the "MPOWERHealth Defendants"); Bruin Neurophysiology, P.C.; iNeurology, PC; N Express, PC; and North American Neurological Associates, PC (collectively, the "LaRoque Family Providers"; and, together with the HaloMD Defendants and the MPOWERHealth Defendants, the "LaRoque Family Enterprise"); and Sound Physicians Emergency Medicine of Southern California, P.C. and Sound Physicians Anesthesiology of California, P.C. (collectively, the "Sound Physicians Providers"; and, together with HaloMD, the "Sound Physicians Enterprise"). The LaRoque Family Providers and the Sound Physicians Providers are collectively referred to herein as the "Provider Defendants;" and, together with the HaloMD Defendants and the MPOWERHealth Defendants, the "Defendants."

INTRODUCTION

1. Congress enacted the No Suprises Act ("NSA") to protect Americans from abusive health care providers who engaged in the financially devasting practice of sending "surprise bills" for out-of-network services. For patients, the NSA provided significant protection against surprise bills where they are not otherwise protected by state laws. For the LaRoque Family Enterprise and the Sound Physicians Enterprise, however, the NSA provided the opportunity to defraud health plans like Anthem.

2. The NSA created an independent dispute resolution ("IDR") process to resolve certain types of surprise billing disputes between health plans and out-of-network providers. The NSA's IDR process is limited to "qualified IDR items or services" that meet strict eligibility criteria. But beginning no later than January 2024, Defendants have engaged in a scheme to defraud Anthem by flooding the IDR process with hundreds of knowingly ineligible disputes and reaping millions of dollars in

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wrongfully obtained awards.

3. In furtherance of their "NSA Scheme," Defendants: (1) use interstate wires to knowingly submit false and fraudulent attestations of eligibility for services and disputes that they know are ineligible for the IDR process, (2) strategically initiate massive volumes of IDR disputes simultaneously against Anthem, and (3) improperly inflate payment offers that far exceed what the LaRoque Family Providers and the Sound Physicians Providers could have received in a competitive market, more often than not exceeding the Provider Defendants' ***own billed charges*** (*i.e.*, the inflated, non-market-based rates, which already far exceed commercially reasonable rates).

4. Critically, Defendants knowingly made false statements, representations, and attestations at multiple stages throughout the IDR process. To access the IDR process in the first instance, Defendants falsify key elements as part of the initiation process, such as the type of health plan at issue, negotiation dates, and supporting documentation, to bypass mandatory regulatory safeguards intended to filter out such ineligible disputes. After they fraudulently obtain access to the IDR process, they falsely attest that the disputes "are qualified item(s) and/or service(s) within the scope of the Federal IDR process." Defendants do so despite Anthem's repeated communications that services and disputes are ineligible for the IDR process. These misrepresentations are necessary to initiate the IDR process in the first instance and to force payors like Anthem into costly dispute resolution proceedings that the system was designed to weed out.

5. This fraudulent course of conduct is the product of two coordinated enterprises, one among the HaloMD Defendants, the MPOWERHealth Defendants, and the LaRoque Family Providers (the "LaRoque Family Enterprise"), and the other between HaloMD and the Sound Physicians Providers (the "Sound Physicians Enterprise"). The participants in the LaRoque Family Enterprise and the Sound Physicians Enterprise knowingly conspired to exploit the IDR process and fraudulently obtain exorbitant payments for out-of-network services at the expense of Anthem and

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other health care payors. Each of the participants in each enterprise plays a crucial role in their fraudulent schemes.

6. Defendant Alla LaRoque is the president of Defendant HaloMD, a company that operates "[w]ith an exclusive focus on Independent Dispute Resolution (IDR)[.]"[1] HaloMD initiates and administers IDR proceedings on behalf of health care providers like the Provider Defendants. HaloMD supplies automation and artificial intelligence infrastructure to operate "at scale."[2] But HaloMD does not itself provide health care services or bill claims; it requires willing co-schemers like the Provider Defendants to effectuate the scheme to defraud health plans like Anthem.

7. For the LaRoque Family Enterprise, the HaloMD Defendants conspire with Defendant Scott LaRoque, Alla's husband and the Chief Executive Officer ("CEO") of Defendant MPOWERHealth, Defendant MPOWERHealth, and the LaRoque Family Providers to use claims and services provided by the LaRoque Family Providers to initiate fraudulent IDR proceedings. Defendants Scott LaRoque and MPOWERHealth operate a closely-managed network of subsidiaries and affiliated providers—including the LaRoque Family Providers—that provide out-of-network intraoperative neuromonitoring ("IONM") services at hospitals and ambulatory surgical centers. The LaRoque Family Providers do not function independently; rather, the MPOWERHealth Defendants direct material aspects of their operations.

8. For the Sound Physicians Enterprise, HaloMD conspires with the Sound Physician Providers to use claims and services provided by the Sound Physician Providers to initiate fraudulent IDR proceedings. The Sound Physician Providers provide emergency medicine and anesthesiology services to patients.

9. Through the LaRoque Family Enterprise and the Sound Physicians Enterprise, Defendants have unlawfully corrupted the IDR process for financial gain. Since no later than January 2024, Defendants have initiated many hundreds of

[1] https://halomd.com
[2] *Id.*

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knowingly ineligible disputes against Anthem. Knowing that these disputes on their face did not qualify for IDR, the HaloMD Defendants, on behalf of the MPOWERHealth Defendants and the LaRoque Family Providers, on the one hand, and HaloMD on behalf of the Sound Physicians Providers, on the other, made false statements, representations, and attestations to fraudulently bypass IDR safeguards to take advantage of the IDR process. Through these schemes, Defendants have caused Anthem to have to pay millions of dollars in ineligible IDR payment determinations and related fees.

10. Defendants also deliberately exploited the IDR system to seek payments that far exceed the charges the Provider Defendants had billed Anthem—far beyond the actual cost or market value of their services. In disputes where Defendants prevailed with such outrageous offers, Anthem was ordered to pay $1.5 million more than the Provider Defendants' own billed charges.

11. The fraudulent NSA Schemes of the LaRoque Family Enterprise and the Sound Physicians Enterprise violated the federal Racketeering Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. §§ 1961 *et seq.*, as well as other federal and state laws, as set forth herein. Anthem brings this action against Defendants—who, together with other co-conspirators, known and unknown, conspired to engage in the NSA Schemes, as set forth herein—to end Defendants' ongoing criminal enterprise and recover resulting damages.

THE PARTIES

I. Plaintiffs

12. Plaintiff ABC is a health care service plan licensed by the California Department of Managed Health Care and governed by the requirements of the Knox-Keene Health Care Service Plan Act of 1975, Cal. Health & Safety Code §§ 1340 *et seq.* Its principal place of business is in Woodland Hills, California.

13. Plaintiff ABCLH is an insurance company regulated by the California Department of Insurance. Its principal place of business is in Woodland Hills,

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California.

II. The HaloMD Defendants

14. Defendant HaloMD is a Delaware limited liability company with a business address at 5080 Spectrum Drive, Suite 1100E, in Addison, Texas (the "5080 Spectrum Address"). HaloMD solicits and represents physician practices throughout the United States, including in California.

15. HaloMD has two members: LFF Holdings Groups Ltd. Co. ("LFF") and Scalla Investments, LLC ("Scalla"). LFF is a Texas limited liability company whose sole member is Scott LaRoque. Scalla is a Texas limited liability company with both Scott LaRoque and Alla LaRoque as its only two members. For the purposes of diversity, HaloMD is a citizen of Texas.

16. Defendant Alla LaRoque is the founder and President of HaloMD. She is a resident of Texas.

III. The MPOWERHealth Defendants

17. Upon information and belief, Defendant MPOWERHealth is a Delaware limited liability company located at the 5080 Spectrum Address. MPOWERHealth's member is LFF, whose sole member is Scott LaRoque.

18. Defendant Scott LaRoque, the husband of Defendant Alla LaRoque, is the CEO and founder of MPOWERHealth. He is a resident of Texas.

IV. The LaRoque Family Provider Defendants

19. Defendant Bruin Neurophysiology, P.C. ("Bruin") is a California professional corporation that provides IONM services, including for California residents. Bruin's principal place of business is the 5080 Spectrum Address, with a mailing address 2915 W. Bitters Road, Suite 201, San Antonio, Texas 78248 (the "2915 W Bitters Address").

20. Defendant iNeurology, PC ("iNeurology") is a California professional corporation that provides IONM services, including for California residents. iNeurology's principal place of business is 218 Foothills Road, Beverly Hills,

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California 90210, and it has a mailing address of 1141 N. Loop 1604 E, #105-612, San Antonio, Texas 78232 (the "1141 N Loop Address").

21. Defendant N Express, PC ("N Express") is a California professional corporation that provides IONM services, including for California residents. N Express's principal place of business is 1213 Walnut Avenue, Manhattan Beach, California 90266, with a mailing address of the 2915 W Bitters Address.

22. Defendant North American Neurological Associates, PC ("NANA") is a California professional corporation that provides IONM services, including for California residents. NANA is located at 701 Palomar Airport Road, Suite 300, in Carlsbad, California, and has a mailing address of the 2915 W Bitters Address.

V. The Sound Physician Provider Defendants

23. Defendant Sound Physicians Anesthesiology of California, P.C. ("SPAC") is a California professional corporation with its principal place of business at 120 Brentwood Commons Way, Suite 510, in Brentwood, Tennessee (the "Brentwood Tennessee Address"). SPAC is located at 4002 Vista Way in Oceanside, California.

24. Defendant Sound Physicians Emergency Medicine of Southern California, P.C. ("SPEMSC") is a California professional corporation with its principal place of business also at the Brentwood Tennessee Address. SPEMSC is located at 2615 Chester Avenue in Bakersfield, California.

25. Upon information and belief, the Sound Physicians Providers are all subsidiaries and/or corporate affiliates of Sound Physicians, which holds itself out as a multi-specialty practice group with "over 4,000 physicians, advanced practice providers, CRNAs, and nurses" that partners with more than 400 hospitals across the United States and manages approximately 6% of all acute medical hospitalizations.[3]

26. The Sound Physicians Providers were all incorporated by persons located at 1498 Pacific Ave., Suite 400, in Tacoma, Washington 98402, which is also Sound

[3] *See* https://soundphysicians.com/about/why-sound/.

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Physicians' corporate headquarters.[4]

27. Lindsay Vaughan, Associate General Counsel of Sound Physicians, served as the incorporator for SPAC, and has signed annual Statements of Information forms filed with the California Secretary of State for the Sound Physician Providers.

JURISDICTION AND VENUE

28. This Court has subject matter jurisdiction pursuant to 18 U.S.C. § 1964, which gives federal district courts jurisdiction over civil RICO actions. This Court also has subject-matter jurisdiction pursuant to 28 U.S.C. § 1331, as this action arises under federal law, including the NSA, 42 U.S.C. § 300gg-111, and the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* The Court has supplemental jurisdiction over state law claims pursuant to 28 U.S.C. § 1367.

29. Venue is proper in this District under 28 U.S.C. § 1391 because: (i) a substantial part of the events or omissions giving rise to the claims set forth herein occurred in, and were directed toward, this District; (ii) Anthem is headquartered in this District and has suffered injury here; and (iii) one or more of the Defendants reside here.

BACKGROUND

I. Anthem Administers Health Care Claims and IDR Proceedings for Members, Plan Sponsors, Government Programs, and BlueCard Plans.

30. Anthem offers a broad range of health care and related plans, insurance contracts and services to its plan sponsor "members" and insureds who enroll in an Anthem plan, including fully insured and self-funded employee health benefit plans. Anthem processes tens of millions of health care claims annually and is responsible for ensuring that claims are paid accurately and in accordance with plan terms. As a critical part of that responsibility, Anthem is authorized to undertake efforts to safeguard and protect itself, its members and insureds, and the various employer group health plans it administers from fraud, waste, and abuse—like the fraud Defendants are perpetrating here.

[4] *See* https://www.soundphysicians.com/about/contact/.

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31. Anthem administers claims and benefits for several different types of health care plans relevant to this Amended Complaint.

32. First, Anthem issues and administers health plans and insurance contracts, whereby Anthem collects premiums and is financially responsible for any benefits paid out under the plan terms or pursuant to law. Anthem sells these products either directly to consumers or to small or large employer groups who offer coverage to their employees but do not themselves insure the loss under the plan. These products are typically subject to state regulation, including state laws prohibiting surprise billing and mandating payment for certain out-of-network claims.

33. Second, Anthem administers self-funded plans, typically offered by large employers to their employees. These employers self-insure the plan and are financially responsible for any payment of benefits or other losses. Because employers often lack infrastructure to provide health insurance to their employees, these plans contract with Anthem for administrative services, such as provider network development, customer service, and claims pricing and adjudication. These plans often delegate authority to Anthem to administer the IDR process on behalf of the plans and discretionary authority to perform other services incident or necessary to Anthem's administration of the IDR process. The plans typically (though not always) reimburse Anthem for any awards resulting from IDR. They may opt into following certain state insurance laws, such as state surprise billing laws; otherwise, they are subject to ERISA and federal law.

34. Third, pursuant to the BlueCard program, Anthem acts as a "Host Plan" to other independent Blue Cross and/or Blue Shield "Home Plans" whose members obtain treatment from providers in Anthem's service area in California. As a Host Plan, Anthem manages and participates in IDR proceedings that are initiated by providers in Anthem's California service area for non-Anthem plans whose members received treatment from the initiating California provider.

35. While Anthem administers different types of health plans and claims, providers generally know what type of health care coverage the patient has. Providers

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require proof of insurance at the point of service to submit claims to the health plan, and the member's health insurance card identifies the nature of the member's coverage. When Anthem issues payment on a claim, the payment is accompanied by an explanation of payment ("EOP"), which includes information about the member's coverage, among other information.

II. Before the NSA, Out-of-Network Physicians Exploited American Consumers with Surprise Medical Bills.

36. Health plans like Anthem contract with a network of health care providers, including hospitals and physicians, from whom their members may obtain "in-network" care. Such contracts govern the rate for the relevant services and prohibit the providers from billing patients above that amount. Generally, patients receive better and more affordable health care coverage when receiving treatment from in-network providers.

37. Patients can also choose to obtain treatment from out-of-network providers, which have no contract with their health plan. Because out-of-network providers are not bound by contractual billing limitations, patients typically pay more when they elect to receive care from out-of-network providers. The health plan will cover a portion of the cost of the services, and the out-of-network provider will "balance bill" the patient for the difference between their "inflated," "non-market-based rates"—known as "billed charges"—and the amounts paid by health plans. H.R. Rep. No. 116-615 (2020), at 53, 57. Patients who choose to seek treatment from an out-of-network provider understand that it will likely be more expense than in-network care; they will likely receive less coverage from their health plan, and in turn, higher bills from their out-of-network provider.

38. However, there are certain situations in which a patient has no ability to choose between in- and out-of-network care. One example is when a patient is suffering from a medical emergency and receives treatment at the nearest emergency room, where the on-call physician may not be in the patient's health plan's network. Another example is when a patient visits an in-network hospital but unknowingly receives

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treatment from an out-of-network physician, such as an anesthesiologist or IONM provider. Before state and federal governments acted, out-of-network emergency providers like the Sound Physician Providers, air ambulance providers, and IONM providers like the LaRoque Family Providers capitalized on patients' lack of meaningful choice in these circumstances.

39. These types of out-of-network providers widely engaged in the aggressive and financially devastating practice of "surprise billing." Specifically, the providers would exploit patients' inability to choose an in-network provider and bill the patient for the difference between their "inflated," "non-market-based" "billed charges" and the amounts paid by health plans. H.R. Rep. No. 116-615, at 53, 57. Surprise billing was particularly rampant among particular provider groups, including IONM providers, who refused to contract with health plans because being able to engage in surprise billing yielded higher profits at the expense of patients who were not in a position to choose from whom they received such care.

40. Before legislation banned their exploitative practices, surprise billing providers like the LaRoque Family Providers and the Sound Physicians Providers held "substantial market power." H.R. Rep. No. 116-615, at 53. They were able to "charge amounts for their services that … result[ed] in compensation far above what is needed to sustain their practice" because they "face[d] highly inelastic demands for their services because patients lack the ability to meaningfully choose or refuse care." *Id.* Surprise billing providers like the LaRoque Family Providers and the Sound Physicians Providers could reap massive profits by issuing surprise medical bills to patients and had little incentive to contract with health plans like Anthem to offer more affordable health care services to American consumers.

41. Congress called this framework a "market failure" that was having "devastating financial impacts on Americans and their ability to afford needed health care." *Id.* at 52. In response to such abuses by providers, Congress—as well as many state legislatures like California's—enacted laws to ban surprise medical bills.

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III. The No Surprises Act Created an IDR Process for Specific Qualified IDR Items and Services.

42. 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. To be subject to the NSA and IDR, health care services must fall into one of these three categories and meet other statutory and regulatory requirements described below.

43. When enacting the NSA, Congress also found "that any surprise billing solution must comprehensively protect consumers by 'taking the consumer out of the middle' of surprise billing disputes." H.R. Rep. No. 116-615, at 55. Thus, the 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").

44. When a health plan receives a claim for out-of-network services subject to the NSA (*i.e.*, emergency services, services provided at an in-network facility, or air ambulance services), the health plan will 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). The health plan's explanation of benefits ("EOB") includes, among other information, a phone number and email address for providers to seek further information or initiate open negotiations. *See* 45 C.F.R. § 149.140(d)(2).

45. 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). After initiating open negotiations, the

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provider must attempt in good faith to negotiate a resolution with the health plan over the 30-business-day open negotiations period. *See id.*

46. 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). The IDR process is only available to providers who first initiate and exhaust open negotiations with the health plan. *See id.* Providers must initiate the IDR process within four business days after the open negotiations period has been exhausted. *See id.*

47. The 30-day open negotiations period is a central requirement of the IDR process. Indeed, Congress explained that one of the primary purposes of the NSA was to ensure that health care providers, including hospitals and doctors, and payors, including insurance companies and self-funded plans, are incentivized to resolve their differences amongst themselves.[5]

48. The IDR process is only available for a "qualified IDR item or service" eligible for the process. 42 U.S.C. § 300gg-111(c)(1); 45 C.F.R. § 149.510(a)(2)(xi), (b)(1), (b)(2). To be eligible for the process and considered a qualified IDR item or service within the scope of the IDR process, 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 health care 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);

[5] *See* Brady Opening Statement at Full Committee Markup of Health Legislation (Feb. 12, 2020), available at https://waysandmeans.house.gov/2020/02/12/brady-opening-statement-at-full-committee-markup-of-health-legislation-3/.

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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.

42 U.S.C. § 300gg-111(c)(1)(B); 45 C.F.R. § 149.510(a)(2)(xi), (b)(2).

49. With the NSA, Congress did not intend to supplant specified state laws. Congress lauded the fact that at the time the NSA was enacted, more than half of states had already "taken significant steps to address surprise medical bills through consumer protection laws that shield patients from surprise billing in the individual, small group, and fully-insured group markets." H.R. Rep. No. 116-615, at 54. Congress enacted the NSA to supplement state laws, not replace them. *See id.* If the state law already protects the patient from the surprise medical bill and provides a method of determining the out-of-network rate for the services, then the state law applies, and the dispute is not eligible for the NSA. 42 U.S.C. § 300gg-111(a)(3)(H)-(K), (c)(1); 49 C.F.R. § 149.510(a)(2)(xi)(A).

50. California has two specified state laws (collectively referred to herein as the "California's Surprise Billing Laws"). First, the Knox-Keene Act (California Health and Safety Code § 1371.4 and its implementing regulations—California Code of Regulations Title 28, Sections 1300.71 and 1300.71.39), as applied through case law, is a specified state law that concerns emergency services. Case law and the Knox-Keene Act require reimbursement for out-of-network emergency services at the reasonable and customary value, based on statistically credible information taking into consideration (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are

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relevant; and (vi) any unusual circumstances in the case. This specified state law applies to Plaintiff ABC.

51. Second, AB 72, codified at California Health and Safety Code §§ 1371.30 and 1371.31, applies to non-emergency services by non-participating providers in participating facilities and (1) requires payment of the greater of the payor's average contracted rate or 125 percent of Medicare rates, and (2) provides for an independent dispute resolution process to resolve any payment disputes regarding such services.[6] This specified state law applies to both Plaintiffs.

52. The Centers for Medicare & Medicaid Services ("CMS"), the federal agency within the Department of Health and Human Services ("HHS") that is primarily charged with implementing the IDR process, has issued several resources to aid interested parties in determining whether a state surprise billing law exists.[7]

53. 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.[8] A copy of the IDR initiation form, including the attestation, is provided to the non-initiating party, the IDRE, and the Departments.[9]

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[6] *See also* California CAA Enforcement Letter (Dec. 22, 2021), available at https://www.cms.gov/files/document/cms-letter-ca-caa-enforcement-and-dispute-resolution.pdf.

[7] *See, e.g.*, CAA Enforcement Letters, available at https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/consolidated-appropriations-act-2021-caa; Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process (Jan. 13, 2023), available at https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf (last accessed May 19, 2025).

[8] *See* 45 C.F.R. § 149.510(b)(2)(iii)(A)(6); *see also* Notice of IDR Initiation Form, U.S. Dep't of Labor, available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/notice-of-idr-initiation.pdf.

[9] The "Departments" include HHS, the Department of Labor, and the Department of the Treasury.

IV. The IDR Initiation Process Notifies Parties of Ineligible Disputes.

54. Parties must initiate the IDR process online through a federal "IDR Portal." The website for submissions is https://nsa-idr.cms.gov/paymentdisputes/s/.

55. The online process for initiating IDR is designed to notify initiating parties of ineligible disputes and prevent initiating parties from inadvertently initiating the IDR process for ineligible items or services.

56. The first page of the website specifies that parties may "[u]se this form if you participated in an open negotiation period that has expired without agreement for an out-of-network total payment amount for the qualified IDR item or service."

> Use this form if you participated in an open negotiation period that has expired without an agreement for an out-of-network total payment amount for the qualified IDR item or service.
>
> You can start the Federal Independent Dispute Resolution (IDR) process within 4 business days after the end of the 30-business-day open negotiation period if a determination of the total payment for the qualified IDR item(s) or service(s), including cost-sharing, wasn't reached.
>
> You will need to **provide information for both parties involved** in the dispute.

57. The first page also provides a link to a list of states with specified state laws that render certain disputes ineligible for the IDR process:

> Review the IDR State list to determine which states will have processes that apply to payment determinations for the items, services, and parties involved. FEHB plans are subject to the Federal IDR process unless OPM contracts with FEHB carriers to include terms that adopt state law as governing for this purpose.

58. Before initiating the IDR process, parties must agree to certain terms and conditions. The terms and conditions include a notice that the initiating party must submit an "[a]ttestation that qualified IDR items or services are within the scope of the Federal IDR process."

> **Before starting:**
> You may need to provide information by uploading separate documents. The total file size limit for all uploaded documents is 500MB. Be sure your files meet this limitation.
>
> Along with the general information you'll need to start your Federal IDR dispute process, provide:
>
> - Information to identify the qualified IDR items or services (and whether they are designated as batched or bundled items or services)
> - Dates and location of qualified IDR items or services
> - Type of qualified IDR items or services such as emergency services and post-stabilization services
> - Codes for corresponding service and place-of-service
> - Attestation that qualified IDR items or services are within the scope of the Federal IDR process
> - Your preferred certified IDR entity

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59. 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.

60. For example, one of the key Qualification Questions on the federal IDR website asks when the party began the open negotiation process. That question as it appears on the website is below:



61. Parties must exhaust a 30-business-day open negotiation period before either party may initiate the federal IDR process. If the initiating party enters a date that is not at least 31 days before the date of website submission, the federal IDR website will not permit the initiating party to proceed and seek payment for the service.

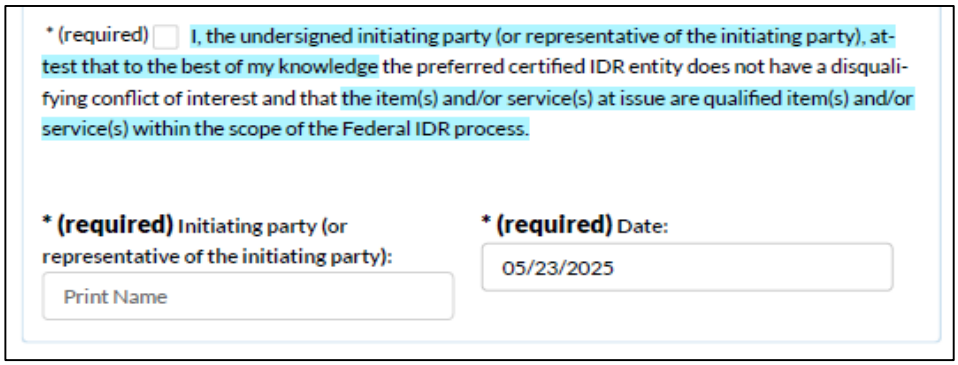
62. Further, if the IDR initiation is not within four business days of the end of

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the 30-day open negotiation period, the initiating party must provide a reason why they are eligible for an extension and provide supporting documentation.

63. After successfully completing the Qualification Questions, the initiating party is asked to complete the Notice of IDR Initiation Form. The initiating party must provide a variety of relevant information, including the name and contact information of the health care provider, the claim number, the date of the service, the qualifying payment amount ("QPA")—generally the plan's median in-network rate for the same service in the same geographic area—for the qualified IDR item or services at issue, and documentation supporting these facts.

64. At the end of this process, the submitting 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."



65. A copy of the Notice of IDR Initiation—including the initiating party's attestation that 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"—is provided to the non-initiating party (*i.e.*, the health plan), the IDRE, and the Departments.

66. As illustrated above, at every stage of this online process, the initiating party must make false statements to submit a dispute for services that are not eligible for IDR, or the initiation process cannot continue. As such, when a party initiates the IDR process, it has full knowledge of the requirements and limits of the IDR process.

67. HHS administers the IDR initiation process. Any submission made

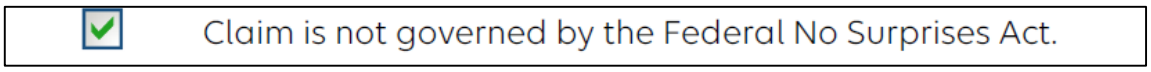
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through this system is a statement made to the federal government, and any attestation made as part of the submission process is also made to the federal government. False attestations to the federal government can violate 18 U.S.C. § 1001.

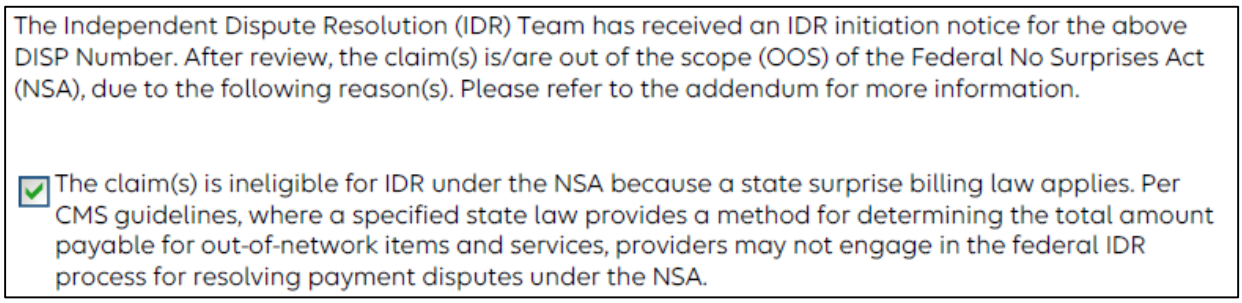
V. Anthem Also Informs Providers of Ineligible Disputes, including Those Subject to State Surprise Billing Laws.

68. In addition to the Qualification Questions and IDR initiation process, Anthem sends multiple communications informing providers when services are ineligible for the IDR process.

69. When providers initiate negotiations for items and services subject to California's Surprise Billing Laws, Anthem notifies the provider that the "***[c]laim is not governed by the Federal No Surprises Act.***"



70. And even when providers ignore Anthem's negotiations communications for items and services subject to California's Surprise Billing Laws, Anthem informs the provider or designee that the items or services are "***ineligible for IDR under the NSA because a state surprise billing law applies***."



71. Like the Qualification Questions and IDR initiation process, Anthem's communications of ineligibility in the EOP, during open negotiations, and after IDR initiation ensure that providers do not mistakenly pursue the IDR process for non-qualified items or services that are outside the scope of the process.

VI. If Applicable, IDREs Make Payment Determinations Subject to Judicial Review in Certain Specified Circumstances.

72. After the provider initiates the IDR process, the parties select, or HHS

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appoints, an IDRE. 42 U.S.C. § 300gg-111(c)(4)(F). The IDRE performs two tasks.

73. *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). In making this determination that the IDR process applies, the IDRE is directed to "review the information submitted in the notice of IDR initiation" with the provider's attestation of eligibility. 45 C.F.R. § 149.510(c)(1)(v). In practice, this is a cursory review by the IDRE based on incomplete, one-sided information. The layers of safeguards in the IDR initiation process—including the Qualification Questions and provider attestations—are intended to prevent parties from initiating the IDR process with ineligible disputes at the outset, before the dispute reaches the IDRE. Once a dispute reaches the IDRE, the initiating party has already bypassed those safeguards and affirmatively attested to the eligibility of the dispute, and the IDRE reviews the notice of IDR initiation with the affirmative attestation to determine eligibility. *See id.*

74. *Second*, if the IDRE determines the IDR process applies, then the IDRE proceeds to a payment determination. 42 U.S.C. § 300gg-111(c)(5)(A). The IDRE's payment determination must involve "a qualified IDR item or service." *Id.*

75. 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).

76. In making its determination, the IDRE must consider the QPA—which approximates the health plan's median in-network contracting rate for the services—and several "additional circumstances," such as training, experience, and quality of the provider, its market share, and the acuity of the patient, among others. 42 U.S.C. § 300gg-111(c)(5)(C). IDREs cannot consider, among other things, the provider's charges. 42 U.S.C. § 300gg-111(c)(5)(D) (IDREs "shall not consider … the amount that would have been billed by such provider or facility …"). Congress reasoned that permitting IDREs to "consider non-market-based rates such as the providers' billed charges … may drive up consumer costs." H.R. Rep. No. 116-615, at 57.

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77. The NSA states that 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).

78. The NSA also states that an IDR determination for a "qualified IDR item or service" "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. § 300gg-111(c)(5)(E)(II). Paragraphs (1) through (4) of section 10(a) of title 9 describe:

(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 behavior 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).

79. 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. The party whose offer is selected by the IDRE is refunded its IDRE fee, meaning it is only responsible for the $115 administrative fee. The non-prevailing party is responsible for both the

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administrative fee and the IDRE fee.

80. Notably, IDREs are only compensated when a dispute reaches a payment determination. *See* 42 U.S.C. § 300gg-111(c)(5)(F). They do not receive compensation when dismissing a dispute due to the ineligibility of the service. *See id.* And because IDREs are compensated on a per-dispute basis, they receive greater compensation when there are a greater total number of disputes.

VII. The NSA's IDR Process Skews Heavily in Favor of Providers.

81. Government data shows that the IDR process has not led to fair or balanced outcomes with objectively reasonable payment determinations. Instead, the IDR process heavily favors providers.

82. In the most recent reporting period, providers prevailed in 85 percent of IDR payment determinations.[10]

83. Moreover, providers are not prevailing with objectively reasonable payment offers. Congress directed IDR payment determinations to be made according to the QPA and several "additional circumstances," such as the training, experience, and quality of the provider, its market share, and the acuity of the patient, among others. 42 U.S.C. § 300gg-111(c)(5)(C). In practice, however, IDRE payment determinations far exceed the QPA.

84. During the most recent reporting period, prevailing offers exceeded the QPA 85 percent of the time. *See id.* For line items in which the provider prevailed, the median payment determination was 459 percent of the QPA.[11] "[T]he rationale behind payment determinations remains unclear due to limited transparency into how IDR

[10] *Supplemental Background on the Federal IDR Public Use Files, July 1, 2024—Dec. 31, 2024*, CMS, *supra*.

[11] *See Independent Dispute Resolution Reports, Federal IDR PUF for 2024 Q4 (as of May 28, 2025)*, CMS, available at https://www.cms.gov/nosurprises/policies-and-resources/reports.

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entities evaluate submissions."[12]

85. Recognizing these dynamics, Defendants launched their fraudulent NSA Schemes to enrich themselves at the expense of Anthem.

DEFENDANTS' FRAUDULENT NSA SCHEMES

86. Beginning no later than January 2024, Defendants launched their NSA Schemes to defraud Anthem by initiating hundreds of knowingly ineligible IDR proceedings against Anthem. To effectuate their schemes, Defendants made false statements, representations, and attestations regarding eligibility for IDR under the NSA.

87. The LaRoque Family Enterprise consists of the HaloMD Defendants, the MPOWERHealth Defendants, and the LaRoque Family Providers, who associated together with the common purpose of engaging in a course of conduct to conduct the LaRoque Family NSA Scheme.

88. The Sound Physicians Enterprise consists of HaloMD and the Sound Physicians Providers, who associated together with the common purpose of engaging in a course of conduct to conduct the Sound Physicians NSA Scheme.

89. The LaRoque Family Enterprise and the Sound Physicians Enterprise overlap in that both enterprises rely on HaloMD to pursue the same NSA Scheme to defraud Anthem.

90. The core of each enterprise's NSA Scheme relies on Defendants' calculated bet: that through repeated and knowing misrepresentations that the submitted disputes—over services performed by the LaRoque Family Providers and the Sound Physicians Providers—met the criteria for the federal IDR process, they could flood the IDR process and procure payments on knowingly ineligible disputes. And they did. Nearly half of the disputes submitted by Defendants that reached a payment

[12] *No Surprises Act Arbitrators Vary Significantly in Their Decision Making Patterns*, Health Affairs, available at https://www.healthaffairs.org/content/forefront/no-surprises-act-arbitrators-vary-significantly-their-decision-making-patterns.

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determination were categorically ineligible for the IDR process. As a result of these ineligible disputes, since January 2024, Anthem's records show that Defendants have fraudulently secured millions of dollars from improper IDR awards from Anthem, while costing Anthem hundreds of thousands of dollars in IDR fees.

91. As alleged herein, IDR is only available for specific categories of disputes, subject to strict statutory and regulatory criteria. However, Defendants submit false attestations through the IDR portal, claiming eligibility for disputes involving: (1) services and disputes governed by a specified state law (*i.e.*, California's Surprise Billing Laws); (2) services not covered by the patient's plan; (3) disputes for which Defendants failed to initiate or pursue open negotiations; and (4) disputes already resolved or barred by timing rules.

92. The NSA Schemes both operate by exploiting the scale and automation of artificial intelligence ("AI"). Promoting their use of AI in IDR submissions, the HaloMD Defendants, on behalf of and in coordination with the MPOWERHealth Defendants and the LaRoque Family Providers, on the one hand, and HaloMD on behalf of and in coordination with the Sound Physicians Providers, on the other, have flooded the IDR system with fraudulent disputes at an industrial scale, deliberately overwhelming IDR safeguards and enabling payment on their fraudulent disputes.

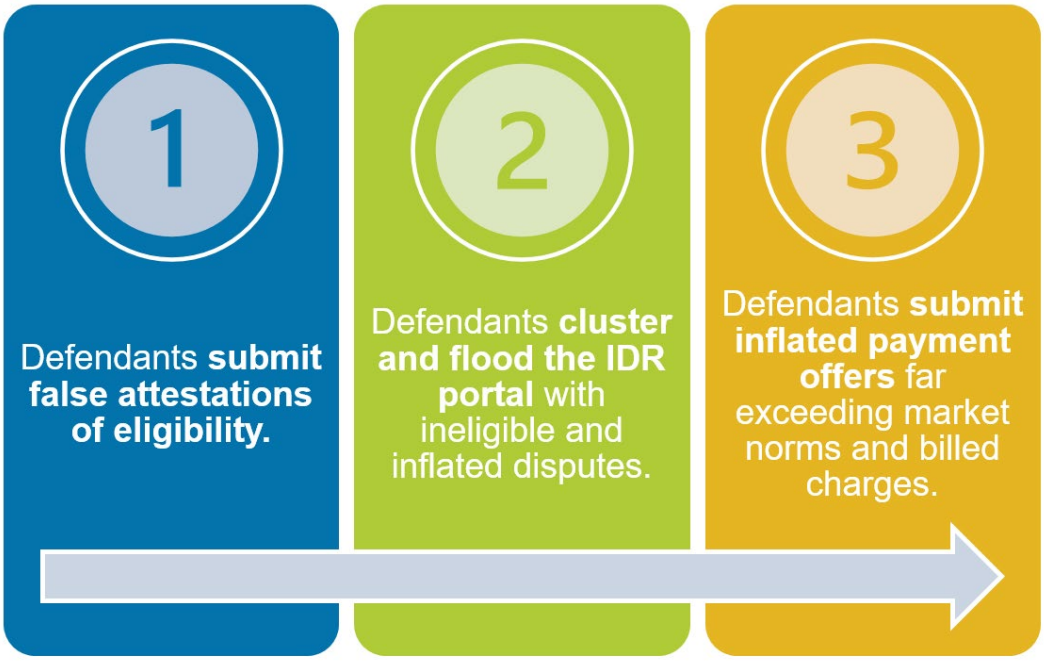
93. Both NSA Schemes involve three related tactics. ***First***, using interstate wires, Defendants make repeated false statements, representations, and attestations of eligibility to Anthem, the IDREs, and the Departments. ***Second***, Defendants manipulate the IDR process by strategically submitting 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. ***Third***, 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' own billed charges. *See* H.R. Rep. No. 116-615 (2020), at 53, 57 (noting

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that billed charges should not be considered in the IDR process because they are "inflated," arbitrary, and "non-market-based" figures).

94. Through their respective NSA Schemes, the LaRoque Family Enterprise and the Sound Physicians Enterprise have intentionally turned the NSA's IDR process into a vehicle for fraud.

95. This multi-step process is depicted visually in the diagram below:



I. Defendants Knowingly Make False Statements, Representations, and Attestations of Eligibility to Initiate the IDR Process.

96. When flooding the IDR process with ineligible disputes against Anthem, Defendants make repeated false attestations and representations that the items or services in dispute are "qualified item(s) and/or service(s) within the scope of the Federal IDR process" when, in fact, they known they are not. 45 C.F.R. § 149.510(b)(2)(iii)(A)(6); *see also* Notice of IDR Initiation Form, U.S. Dep't of Labor, available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/notice-of-idr-initiation.pdf. Defendants make these false attestations and representations to Anthem, the IDRE, and the Departments.

97. The items and services that Defendants falsely attest are "qualified item(s)

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and service(s) within the scope of the Federal IDR process" are patently ineligible, and Defendants know that they are ineligible when making their false attestations.

98. As noted above, the online process for initiating IDR is designed to—and does—notify initiating parties of the kinds of disputes that are ineligible to prevent them from submitting ineligible items or services. And Anthem frequently communicates that services are ineligible in its EOPs, during open negotiations, and after Defendants initiate the IDR process for ineligible services.

99. For example, Defendants know when services are subject to the California Surprise Billing Law and therefore ineligible for the IDR process. Defendants have an independent obligation to determine whether a service is eligible for IDR; before initiating open negotiations, they may review the patient's health insurance ID card or the EOP to determine whether the plan is subject to state law or contact Anthem for further information. When Defendants initiate open negotiations for services subject to California's Surprise Billing Laws, Anthem informs them that the dispute is not governed by the federal NSA. To prevent parties from inadvertently initiating the IDR process for services subject to a specified state law like California's Surprise Billing Laws, the first page of the IDR initiation process also (1) provides a link to information listing states—like California—that have surprise billing laws that may render the NSA inapplicable, and (2) informs initiating parties that they must submit an attestation that the services at issue are qualified IDR items or services within the scope of the Federal IDR process. And before initiating the IDR process, Defendants affirmatively attest that the services are "qualified item(s) and/or services(s) within the scope of the Federal IDR process." Defendants submit these fraudulent attestations for disputes clearly subject to California's Surprise Billing Laws with full knowledge of their falsity.

100. As another example, Defendants also know when they initiate disputes for services where no open negotiation occurred. As part of the IDR initiation process, initiating parties must also identify, among other things, the specific date that they initiated open negotiations and documentation supporting the open negotiations

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process. They then affirmatively attest that the "item(s) and service(s) at issue are qualified items and/or service(s) within the scope of the Federal IDR process." In order to push their ineligible services through the IDR process, Defendants must affirmatively make false statements; if they do not, the system prevents them from proceeding with their ineligible services. Of course, the IDR Portal cannot tell when the provider misrepresents information about the relevant plan, service, or dispute because it relies on truthful and accurate submissions by the initiating party. Defendants take advantage of this vulnerability in the system to carry out the NSA Scheme.

101. In addition, even when Defendants manage to push through ineligible claims by submitting false statements to the federal IDR portal, Anthem often directly notifies Defendants that the items or services at issue in their IDR initiation violate the NSA's eligibility requirements. Yet, despite receiving this information, Defendants routinely proceed with their IDR disputes anyway—demonstrating not only their knowledge of the fraud, but their intentional and ongoing participation in it.

102. Such disputes cannot proceed through the IDR Portal by mere inadvertence or neglect on the part of Defendants. Instead, Defendants knowingly make false statements and representations to bypass the system's safeguards. Each and every one of Defendants' electronic submissions to the Departments and the IDRE for these ineligible disputes constitutes an overt act in furtherance of their wire fraud scheme; Defendants had to input misrepresentations about the type of plan, service, or nature of the dispute and falsely attest that the "item(s) and service(s) at issue are qualified items and/or service(s) within the scope of the Federal IDR process" to overcome the IDR system's safeguards and get their disputes submitted.

103. Typically, the HaloMD Defendants make these false attestations of eligibility when initiating the IDR process on behalf and with full knowledge of the LaRoque Family Providers and the MPOWERHealth Defendants in furtherance of the NSA Scheme. Similarly, HaloMD makes these false attestations of eligibility when initiating the IDR process on behalf and with full knowledge of the Sound Physicians

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Providers in furtherance of the NSA Scheme. And the Sound Physicians Providers themselves sometimes make false attestations of eligibility when initiating the IDR process, further establishing their knowledge of and participation in the NSA Scheme.

104. In sum, the LaRoque Family Providers and the Sound Physicians Providers are fully aware of the false attestations that the HaloMD Defendants submit in their names and actively participate in the scheme by authorizing, directing, or ratifying the submissions. Their and the MPOWERHealth Defendants' coordination with the HaloMD Defendants is deliberate, sustained, and central to the execution of the NSA Schemes.

II. Defendants Strategically Initiate a Massive Volume of IDR Disputes Simultaneously.

105. To further ensure that the hundreds of knowingly ineligible, falsely attested-to disputes against Anthem go undetected and proceed to a payment determination, Defendants also initiate a massive number of fraudulent IDR disputes all at once to overwhelm the IDR system. This abuse of volume is not coincidental; it is strategic to secure favorable or default outcomes by ensuring that health plans have insufficient time to challenge eligibility, and IDREs cannot complete fulsome reviews in the timeline provided by the NSA, in furtherance of the NSA Schemes.

106. Overall, the NSA's IDR process has been overwhelmed by a staggering volume of disputes that far exceed the government's initial estimates.

107. Before the IDR process launched, CMS estimated that parties would initiate about 22,000 IDR process disputes in the first year.[13]

108. Providers have shattered those estimates. The most recent government statistics show that in the second half of 2024, disputing parties—virtually all of whom are providers—initiated **853,374 disputes**, 40 percent more than the first half of 2024

[13] *See* 86 Fed. Reg. 55,980, 56,068, 56,070 (Oct. 7, 2021).

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(610,498).[14] This figure from ***6 months*** is nearly ***39 times*** the volume of disputes that the government originally anticipated ***over a full year***.

109. Government reporting also shows that most disputes are initiated by a small number of providers and their representatives. The top ten initiating parties initiated about 71 percent of all disputes initiated in the last six months of 2024, and the top three initiating parties initiated about 43 percent of all disputes during that period. *Id.*

110. HaloMD is among the three most prolific filers of IDR process disputes. During the last six months of 2024, HaloMD initiated **134,318 disputes** through the IDR process—which by itself exceeded the government's original estimate for total annual disputes **more than sixfold**.[15] That means HaloMD was initiating an average of more than ***746 disputes against health plans per day***. *See id.*

111. As part of the NSA Scheme, Defendants strategically initiate hundreds of IDR process disputes against Anthem simultaneously on the same day, many of which are fraudulent as they do not involve qualified IDR items or services within the scope of the NSA's IDR process.

112. For example, on May 3, 2024, Defendants initiated 126 separate IDR proceedings against Anthem. Ninety-seven of the disputes were not eligible for IDR in the first place. Yet in 65 of the disputes, based on false attestations of eligibility provided by Defendants, Anthem was ordered to pay an additional $204,000 from what was originally reimbursed, plus more than $30,000 in fees associated with the IDR process.

[14] *Supplemental Background on the Federal IDR Public Use Files, July 1, 2024—Dec. 31, 2024* (as of May 28, 2025), available at https://www.cms.gov/files/document/federal-idr-supplemental-background-2024-q3-2024-q4.pdf.

[15] *See Federal IDR Supplemental Tables for Q3 2024* (as of May 28, 2025), available at https://www.cms.gov/files/document/federal-idr-supplemental-tables-2024-q3.xlsx; *Federal IDR Supplemental Tables for Q4 2024* (as of May 28, 2025), available at https://www.cms.gov/files/document/federal-idr-supplemental-tables-2024-q4-may-28-2025.xlsx.

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113. The baseball-style dispute resolution process, wherein the IDRE has no authority to modify the parties' bids, is premised on the notion that ineligible claims will be weeded out at the outset.

114. Defendants' goals are to interfere with Anthem's and the IDR process infrastructure's ability to effectively identify ineligible disputes and to overwhelm the IDR system and the IDREs that make cursory eligibility and payment determinations.

115. Through considerable operational burden and expense, Anthem has crafted workflows allowing it to identify most of the unqualified items or services and notify Defendants that the disputes do not quality for IDR. Yet despite Anthem's objections, most of Defendants' ineligible disputes reach a payment determination due to Defendants' knowingly false attestations of eligibility.

116. According to federal law, "the certified IDR entity selected must review the information submitted in the notice of IDR initiation"—including Defendants' false attestations of eligibility—"to determine whether the Federal IDR process applies." 45 C.F.R. § 149.510(c)(1)(v). And IDREs have no incentive to dismiss disputes due to ineligibility because they only receive compensation if a dispute reaches a payment determination. *See* 42 U.S.C. § 300gg-111(c)(5)(F). Defendants exploit this incentive structure to carry out their fraudulent scheme.

117. When receiving an avalanche of ineligible disputes from Defendants all at once, IDREs rely on Defendants' false attestations of eligibility to reach and issue a payment determination on ineligible disputes.

118. Since at least 2024, nearly half of disputes from Defendants that reached a payment determination were ineligible for the IDR process, often despite objections from Anthem. From these fraudulent submissions alone, Defendants have received millions of dollars in improper IDR award payments and related fees.

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III. Defendants Submit Outrageous Payment Offers to Fraudulently Inflate Payments on IDR Disputes.

119. The final step in Defendants' NSA Schemes involves inflating their reimbursement demand to levels far beyond commercially reasonable rates and sometimes even above the Provider Defendants' billed charges. Their goal is to manipulate IDREs into selecting inflated amounts by anchoring the dispute to a grossly exaggerated number. By submitting a grossly inflated offer, Defendants artificially shift the IDRE's frame of reference upward. And due to systemic issues with the IDR process, Defendants frequently prevail with their unreasonable offer—even if it is far above commercially reasonable rates or even above what the Provider Defendants had billed.

120. As noted, government data shows that IDRE payment determinations skew heavily in favor of providers and heavily in excess of the QPA that Congress directed IDREs to follow. In the most recent reporting period, providers prevailed in 85 percent of IDR payment determinations.[16] For line items in which the provider prevailed, the median payment determination was 459 percent of the QPA.[17]

121. Defendants know that IDREs select the provider's offer in more than eight out of every ten payment determinations, so they can frequently prevail with outrageous offers.

122. Defendants also know that IDREs cannot consider the provider's charges when making a payment determination. 42 U.S.C. § 300gg-111(c)(5)(D). Congress prohibited IDREs from considering "inflated," "non-market-based rates such as the providers' billed charges" because merely ***considering*** the provider's charge "may drive up consumer costs." H.R. Rep. No. 116-615, at 53, 57.

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[16] *Supplemental Background on the Federal IDR Public Use Files, July 1, 2024—Dec. 31, 2024*, CMS, *supra*.

[17] *See Independent Dispute Resolution Reports, Federal IDR PUF for 2024 Q4 (as of May 28, 2025)*, CMS, available at https://www.cms.gov/nosurprises/policies-and-resources/reports.

123. While shielding the IDRE from the inflated billed changes was supposed to offer a measure of protection for both payors and consumers, Defendants have turned the rule on its head to further exploit both. Defendants have taken to submitting offers that actually ***exceed billed charges*****,** knowing full well that the IDREs will necessarily be blind to their scheme.

124. For more than 380 IDR disputes, Defendants' payment offers exceeded the charges that they initially billed Anthem by more than $1.5 million. Of those disputes where Defendants prevailed with offers that exceeded their original billed charges (approximately 240), Anthem was ordered to pay over $980,000 more than the initial billed charges. One hundred eighteen such disputes were ineligible for IDR in the first place, accounting for more than $380,000 in payments above billed charges that Anthem was ordered to pay.

125. These amounts far exceed what the Provider Defendants could expect to receive for their services from patients or from health plans in a competitive market. Indeed, upon information and belief, prior to the enactment of the NSA, the Provider Defendants rarely, if ever, recovered their full billed charges from patients or health plans. But through their scheme to exploit the IDR process, Defendants' systematic requests for these exorbitant amounts intentionally exploit the IDR process for undue gains at Anthem's expense.

IV. Defendants' NSA Scheme Damages Anthem, Affiliated Health Plans, and Consumers.

126. As a result of Defendants' unlawful conduct, Anthem and its affiliated health plans have paid excessive amounts for medical services and incurred unnecessary administrative and dispute resolution fees. The financial harm caused by Defendants' abusive practices is ongoing and threatens the affordability and sustainability of health benefits for Anthem's members.

127. From January 4, 2024, to August 2025, Anthem's records show that Defendants initiated at least 1,500 IDR proceedings, consisting of more than 2,000

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separate services, against Anthem. However, the earliest publicly available data published by CMS shows that the Provider Defendants were parties to IDR determinations against Anthem in 2023, so the scheme likely began then or before.

128. Anthem determined that approximately 47 percent of these disputes were ineligible for IDR for reasons like failure to initiate mandatory open negotiations, California's Surprise Billing Laws governed the dispute, or the services were not covered by the patient's health plan. For these ineligible disputes catalogued in Anthem's data, Defendants illicitly secured millions of dollars in improper IDR awards.

129. Defendants' exploitation of the IDR process is contributing to billions of dollars in additional costs. From 2022 to 2024, the IDR process has led to at least $5 billion in total costs.[18] Of the $5 billion, $2.24 billion in costs arose from payment determinations in favor of the provider.[19] Administrative and IDR entity fees total $884 million.[20] "[T]he high costs will add to overall health system costs and will ultimately be paid by consumers."[21]

THE LAROQUE FAMILY ENTERPRISE

130. The members of the LaRoque Family Enterprise were organized pursuant to a structure that enabled the enterprise to make and carry out decisions in furtherance of the NSA Scheme. The LaRoque Family Enterprise functioned as a continuing unit with established duties that enabled it to design and coordinate the multifaceted NSA Scheme to defraud Anthem and other health care plans.

131. In doing so, the HaloMD Defendants, the MPOWERHealth Defendants, and the LaRoque Family Providers conducted the activities of an association-in-fact enterprise consisting of Defendants Alla LaRoque, HaloMD, Scott LaRoque,

[18] *The Substantial Costs of the No Surprises Act Arbitration Process*, HEALTH AFFAIRS, available at https://www.healthaffairs.org/content/forefront/substantial-costs-no-surprises-act-arbitration-process.
[19] *Id.*
[20] *Id.*
[21] *Id.*

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MPOWERHealth, Bruin, iNeurology, N Express, and NANA through a pattern of racketeering activity, including but not limited to wire fraud.

132. Since at least January 2024 to the present, the MPOWERHealth Defendants and the LaRoque Family Providers, with the intent to defraud, devised and willfully participated with the HaloMD Defendants, and with knowledge of fraudulent nature, in the scheme and artifice to defraud and obtain money and property from Anthem by materially false and fraudulent pretenses, and representations, as described herein.

133. The members of the LaRoque Family Enterprise do not operate as separate, independent actors. Rather, the HaloMD Defendants, the MPOWERHealth Defendants, and the LaRoque Family Providers function as participants in a unified scheme designed to exploit the IDR process and defraud Anthem.

134. Defendant Alla LaRoque and her husband, Defendant Scott LaRoque, are at the center of the LaRoque Family Enterprise. The LaRoque Family Enterprise operates via a web of interrelated corporate entities they directly or indirectly control, including Defendants HaloMD, MPOWERHealth, and the LaRoque Family Providers. Upon information and belief, the structure of the enterprise consists of Defendants Scott LaRoque, MPOWERHealth, and the LaRoque Family Providers' IONM entities, on the one hand, which provide the underlying services for the claims that are submitted to the IDR process, and Defendants Alla LaRoque and HaloMD, on the other, which process and fraudulently submit such services through the IDR process on a mass scale.

I. The MPOWERHealth Defendants

135. Defendant Scott LaRoque is the founder and CEO of MPOWERHealth. Upon information and belief, as the founder and CEO, Scott LaRoque exercises both managerial and operational control over MPOWERHealth and, by extension, the LaRoque Family Providers.

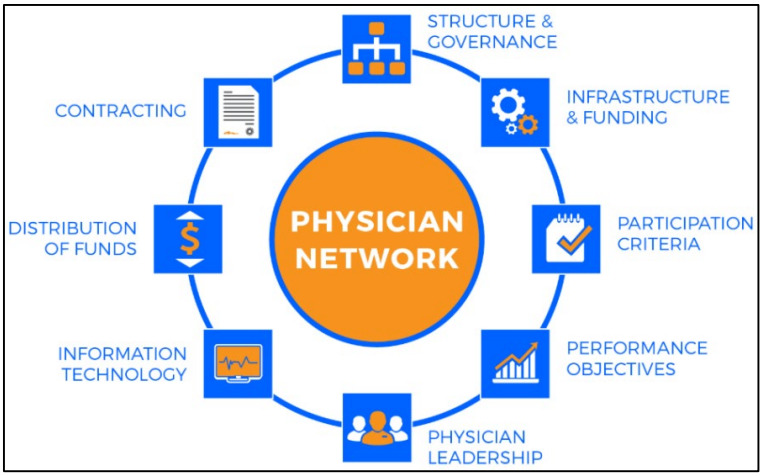
136. Based in Addison, Texas, MPOWERHealth purports to be an administrative services and staffing company with hundreds of physicians and

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technologists that cover more than 35,000 surgical cases annually in 22 states, including California.[22] MPOWERHealth is located at the 5080 Spectrum Address and, according to public records, is also associated with the 2915 W Bitters Address.

137. MPOWERHealth offers staffing of IONM physicians and technicians to its clients.[23] IONM involves the continuous monitoring of the "integrity of neural structures and consciousness during surgical procedures."[24] During surgery, an IONM technician attaches various sensors to the patient. A physician monitors those sensors' output while a technician monitors the performance of the equipment. Often, the physician's services and the technician's services are billed separately. Patients generally do not choose their IONM providers, and they are often out-of-network.

138. MPOWERHealth's business is multi-faceted. It solicits physicians to join MPOWERHealth's "clinically integrated physician networks," which purport to digitally scale individual physician practices by connecting them to other physicians to "improve quality, promote efficiency, manage costs and drive exceptional patient experience."[25] In this way, MPOWERHealth acts as a physician management organization:



[22] *See* https://mpowerhealth.com/our-purpose/.
[23] *See* https://mpowerhealth.com/intraoperative-neuromonitoring-services-hospitals/; https://mpowerhealth.com/intraoperative-neuromonitoring-services-physicians/
[24] D. Ghatol et al., *Intraoperative Neurophysiological Monitoring*, StatPearls Publishing (2025), *available at* https://www.ncbi.nlm.nih.gov/books/NBK563203/.
[25] https://mpowerhealth.com/physician-network/.

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139. Roxanna ("Roxy") LaRoque, the Director of Client Experience at MPOWERHealth,[26] is listed as the Authorized Official for approximately 320 separate providers—including each of the LaRoque Family Providers—most of which are IONM providers.[27]

140. The LaRoque Family Providers are all subsidiaries of MPOWERHealth, which centrally coordinates their IONM services and manages legal, billing, and IDR functions. According to National Plan and Provider Enumeration System ("NPPES") records, Defendant Bruin's Authorized Official is Dr. Robin Soffer, a neurologist who has been employed by Medsurant Monitoring since December 2015.[28] According to the National Provider Identifier ("NPI") registry, Defendant Bruin is associated with a 100 Front Street, Suite 280, West Conshohocken, Pennsylvania, an address also associated with Medsurant Health. Medsurant Health is an MPOWERHealth subsidiary that consists of a "family of neuromonitoring practices."[29]

II. The LaRoque Family Providers

141. The LaRoque Family Enterprise uses the LaRoque Family Providers' purported services as the basis for initiating IDR process disputes.

142. Public records show that the LaRoque Family Providers are all IONM providers affiliated with the same company: Defendant MPOWERHealth. Upon information and belief, as the founder and CEO of MPOWERHealth, Defendant Scott LaRoque, exercises operational control over its subsidiaries and affiliates, including, but not limited to, the LaRoque Family Providers.

[26] https://www.linkedin.com/in/roxy-LaRoque-88606340/

[27] CMS maintains a database of all providers who have registered to bill government healthcare programs. In return, providers receive a National Provider Identifier ("NPI"), which is publicly viewable via the National Plan and Provider Enumeration System ("NPPES") NPI Registry. *See* https://npiregistry.cms.hhs.gov/search

[28]

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143. Per California Secretary of State records, Defendant Bruin lists the 5080 Spectrum Address as its principal address and the 2915 W Bitters Address as its mailing address. According to the NPI registry, Bruin also has a mailing address of the 1141 N Loop Address. Upon information and belief, the 1141 N Loop Address is frequently associated with MPOWERHealth entities. The NPI registry's Authorized Official for Bruin is Roxy LaRoque, Director of Client Experience at MPOWERHealth.

144. Defendant Bruin is also affiliated with Medsurant, LLC ("Medsurant"), which operates under the trade name Medsurant Health. Upon information and belief, in or around January 2025, Medsurant was acquired by MPOWERHealth. According to the NPI registry, Medsurant also has a business address at the 5080 Spectrum Address. Roxy LaRoque of MPOWERHealth is listed as its Authorized Official. In addition, Medsurant recently filed a change of registered agent with the California Secretary State that shows it was filed by Emily Campbell from the 5080 Spectrum Address. Upon information and belief, Campbell is MPOWERHealth's Manager of Client Relations.

145. Dr. Robin Soffer, CEO of Bruin, holds herself out publicly on LinkedIn as a Medsurant employee. IDR disputes submitted on behalf of both Bruin and Medsurant use the same email address: medsurantarbitrationnsa@halomd.com. In addition, Medsurant holds a perfected security interest in all of Bruin's assets, as evidenced by publicly filed UCC-1 financing statements.

146. Defendant iNeurology lists the 1141 N Loop Address as its current mailing address and previously used the 2915 W Bitters Road Address for the same purpose. According to the NPI registry, its Authorized Official is Roxy LaRoque of MPOWERHealth.

147. Defendants N Express and NANA also use both the 2915 W Bitters and 1141 N Loop Addresses as their mailing address. According to the NPI registry, their Authorized Official is Roxy LaRoque of MPOWERHealth. NANA also lists Brenda Thiele on its Statement of Information, who holds herself out publicly on LinkedIn that she is MPOWERHealth's Senior Manager of Treasury and former Chief of Staff and

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Director of Operations.[30]

III. The HaloMD Defendants

148. Defendant Alla LaRoque, the wife of Defendant Scott LaRoque, is the founder and President of HaloMD. She sits on the board of MPOWERHealth[31] and previously served as MPOWERHealth's Chief Operating Officer ("COO").

149. Alla LaRoque is a self-described expert in the NSA whose "in-depth understanding of the law has allowed her to guide providers in navigating the complexities of the [NSA]" and "empower healthcare organizations to optimize their out-of-network revenue"[32] She is HaloMD's public face and directs HaloMD's operations.

150. On information and belief, as the founder and President of HaloMD, Alla LaRoque had personal knowledge about the core aspects of HaloMD's business operations, including the wrongful activities alleged herein. She runs HaloMD as a hands-on manager, overseeing the company's operations, business practices, and finances.

151. HaloMD is key to the LaRoque Family Enterprise's scheme to flood the IDR process with knowingly ineligible disputes, without which the LaRoque Family Enterprise could not operate. HaloMD serves as a key agent and operational partner of the enterprise, submitting disputes on behalf of the MPOWERHealth and the LaRoque Family Providers at scale using a standardized platform and shared communications infrastructure. Their coordinated actions, mutual financial incentives, and repeated patterns of conduct demonstrate a shared intent to pursue improper IDR payments on a mass scale. The HaloMD and MPOWERHealth Defendants, and the LaRoque Family Providers operate with integrated, enterprise-level coordination behind the scheme.

152. HaloMD claims to operate "[w]ith an exclusive focus on Independent

[30] https://www.linkedin.com/in/brenda-thiele-1a4a3361/
[31] https://mpowerhealth.com/board-members/#
[32] https://halomd.com/alla-LaRoque/

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Dispute Resolution (IDR)[.]"[33] The company markets itself as "the premier expert in Independent Dispute Resolution (IDR)" and claims to "empower out-of-network providers to secure sustainable, predictable revenue streams" and "deliver the financial outcomes that healthcare providers, practice leaders, and executives rely on for long-term financial stability."[34]

153. HaloMD solicits and represents many different types of out-of-network providers who were key drivers in surprise billing before the enactment of the NSA, including IONM, anesthesiology, and emergency providers. These provider groups frequently retain HaloMD to administer the IDR process on their behalf.

154. HaloMD touts its "proprietary platform" as one founded with "advanced technology and AI-driven infrastructure[.]"[35] HaloMD also represents that it "instantly assesses each case for eligibility under The No Surprises Act and relevant state regulations." Providers submit services for dispute in the IDR process through HaloMD's portal.[36]

155. HaloMD further represents that it "gathers and organizes the necessary documentation [from the provider], [and] prepar[es] a compelling case that highlights the provider's position, ensuring nothing is overlooked[.]"[37]

156. Upon information and belief, HaloMD leverages its AI-driven platform as part of its fraudulent billing scheme to flood the IDR system with ineligible disputes.

157. HaloMD operates on a commission-based reimbursement model. Its website states: "We don't get paid until you get paid."[38] HaloMD thus has a financial incentive to (1) push as many services as possible through the IDR process, regardless of the merits or the applicability of the NSA to those disputes, and (2) seek the highest

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[33] *See* https://halomd.com/
[34] *See id.*
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] *Id.*

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possible monetary award for its provider clients in the IDR process. The MPOWERHealth Defendants and the LaRoque Family Providers share these same financial incentives.

158. Social media posts confirm the family-run, tightly-coordinated nature of the enterprise. In one post from April 2025, Scott and Alla LaRoque are described as "[t]he magnificent couple, owner, founder of MPower [*sic*] Health and HaloMD." They routinely appear together at public events representing both companies. Both MPOWERHealth and HaloMD hosted their respective employees in early 2025 with a joint "annual achievement celebration":



159. Defendant Alla LaRoque was MPOWERHealth's COO from January 2014 to at least January 2024, a position she held while also serving as the President of HaloMD, which was founded in 2022.

160. Megan Rausch, now the COO of HaloMD from October 2022 to the present, also overlapped and served as the Vice President of Revenue Cycle

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Management for MPOWERHealth from November 2019 until at least March 2024, ensuring alignment and coordination across the scheme.

161. MPOWERHealth and HaloMD also appear to share a physical business address, reinforcing the operational integration. According to public records, HaloMD uses the same 2915 W Bitters Address that MPOWERHealth also uses. Mapping tools confirm that both HaloMD and MPOWERHealth list the 5080 Spectrum Address as their business address. This physical overlap further indicates that these entities are operating not independently, but as components of a single, centralized operation.

162. In or about June 2025, HaloMD publicly referred to Defendant Scott LaRoque as its "CEO."

163. The websites for HaloMD and MPOWERHealth are also nearly identical in design and structure, and their contact pages are directly linked. HaloMD's "Join Our Team" page directs applicants back to MPOWERHealth's domain.[39] Advertisements for jobs posted on the internet conflate the various entities. For example, one advertisement for an "IDR Specialist" lists the employer as MPOWERHealth, but the body of the description under the section "Who We Are" lists HaloMD as the employer and describes HaloMD.

164. In sum, the relationship between the HaloMD Defendants, the MPOWERHealth Defendants, and the LaRoque Family Providers is not passive. Through the coordination of the husband-wife team of Defendants Alla and Scott LaRoque—both of whom hold leadership positions in MPOWERHealth and HaloMD, respectively—HaloMD, MPOWERHealth, and the Provider Defendants acted with the common purpose of exploiting the IDR process to fraudulently obtain reimbursements from Anthem by maximizing the number of disputes submitted and inflating payment demands well beyond their billed charges or market rates. The use of HaloMD to submit ineligible disputes was not incidental or isolated; it was a deliberate component of the

[39] "Join Us" at https://halomd.com/careers/ (last visited Sept. 18, 2025).

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LaRoque Family Enterprise's strategy to bypass the limitations of individual-provider capacity, automate the submission of disputes en masse, and conceal the ineligibility embedded in each claim. And although HaloMD advertises the power of its AI-powered proprietary platform, it requires a key element that can only be provided by the MPOWERHealth Defendants and the LaRoque Family Providers—out-of-network patient services that can be billed to health care plans and subsequently submitted to the IDR process.

IV. The LaRoque Family Enterprise Fraudulently Exploits the IDR Process at the Expense of Anthem.

165. During the relevant time period, the LaRoque Family Enterprise transmitted or caused to be transmitted by wire communication or radio communication in interstate commerce, writings, signs, signals, pictures, and sounds, including false and fraudulent statements, representations, and attestations related to IDR disputes, from and between the state in which they operate—for example, California and Texas—to Certified Independent Dispute Resolution Entities located in various states, including, for example, Florida, Texas, Pennsylvania, Michigan, New York, and Maryland, in furtherance of the fraudulent scheme.

166. Specifically, since 2024, Anthem has identified more than 330 ineligible disputes that the LaRoque family Enterprise caused to be initiated against Anthem. These identified ineligible disputes represent an improper cost to Anthem of more than $125,000 in administrative and IDRE fees. Further, of the ineligible disputes identified, almost 200 IDR determinations were rendered against Anthem, resulting in required payments of nearly $1.9 million—a number which is $323,000 more than the charges the providers originally billed to Anthem.

167. Defendants made false and fraudulent statements, representations, and attestations related to the following illustrative fraudulent IDR disputes, including, but not limited to, the following:

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A. Bruin Neurophysiology

DISP-918898 (Untimely IDR Initiation)

168. The IDR proceeding captioned DISP-918898 involved a service that Bruin rendered on May 22, 2023, to a member of a health plan administered by ABCLH. On June 2, 2023, ABCLH issued payment of $129.32 using the remittance code AUQ, which provided specific instructions to the provider for initiating the mandatory open negotiation period.

AUQ	This claim was paid according to the Federal No Surprises Act. The member is only responsible for their in-network copay, percentage of the cost (co-insurance), and deductible. You cannot bill the member for more. If you disagree with our decision, you can initiate the 30-day open negotiation period through Availity.com. Log onto Availity.com and select the Claims & Payments tab. Use the Claims Status application to find your claim. Select the Dispute button to attach additional supporting documentation and press Submit Attachments. If the dispute button is not available, use the Chat with Payer button on Availity.com.

169. On July 17, 2023, HaloMD, acting on behalf of and in coordination with Bruin, sent a notice of open negotiation to ABCLH to initiate the federal IDR process. HaloMD sent a notice of Open Negotiation initiation to ABCLH via email to the Anthem IDR Email Address, using the email address medsurantarbitrationnsa@halomd.com with Ashonta.Whitehead@halomd.com copied. The open negotiation notice was signed by Megan Rausch (HaloMD), noted to be the "Provider Representative" at the 2915 W Bitters Address. HaloMD offered to negotiate an additional payment of $125.18 for each of the two instances of service code 95886 provided to the ABCLH member.

170. On September 25, 2023, Anthem Payment Disputes, on behalf of ABCLH, addressed its response to the notice of open negotiation to Bruin, ATTN: Megan Rausch, at the 2915 W. Bitters Address, stating that the services included on the request "were paid at the maximum amount as required by the member's health plan" and that "no additional payment can be considered." Neither HaloMD nor Bruin responded to this September 25, 2023, letter.

171. Nearly four months after this letter, on January 12, 2024, HaloMD, on behalf of and in coordination with Bruin, using the email address nsa@halomd.com,

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falsely attested to IDR eligibility. ABCLH submitted an objection to eligibility asserting that Bruin had not filed its IDR proceeding within the required time. The notice of ineligibility was sent to both Bruin and HaloMD, yet neither HaloMD nor Bruin withdrew the dispute.

172. As a result of HaloMD and Bruin's fraudulent attestations, ABCLH paid $12,993.28—103 times the QPA calculated by HaloMD and Bruin at the initiation of the IDR proceeding and over $12,000 more than HaloMD and Bruin initially valued the service during negotiations. ABCLH also paid $750 in unnecessary IDR-related fees.

B. North American Neurological Associates

DISP-1455557 (No Open Negotiation)

173. The IDR proceeding captioned DISP-1455557 involved a service that NANA rendered on March 11, 2024, to a member of a health plan administered by ABCLH

174. When ABCLH issued payment, which was equal to the QPA for the service, the EOB sent to NANA at the 1141 N Loop Address reflected that the claim was processed pursuant to explanation code AUQ. The description of this code, printed at the end of the EOB, indicated: "This claim was paid according to the Federal No Surprises Act. … If you disagree with our decision, you can initiate the 30-day open negotiation period[.]" Neither NANA, nor HaloMD acting on its behalf, initiated the 30-day open negotiation period as required.

175. Even though neither NANA nor HaloMD initiated open negotiations for this service, on June 21, 2024, HaloMD, using the email address nsa@halomd.com, on behalf of and in coordination with NANA, initiated IDR and falsely attested that the service was a qualified IDR item or service within the scope of the federal IDR Process and that NANA and/or HaloMD had complied with the requirements of the NSA in submitting the claim.

176. On December 11, 2024, Anthem Payment Disputes, on behalf of ABCLH, submitted an objection to eligibility, which was also addressed to the NANA provider

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who performed the service, stating, "The non-participating provider/facility failed to engage in the 30-business day open negotiation period, according to the NSA. Providers cannot pursue IDR unless and until the open negotiation period is properly initiated and completed." Neither HaloMD nor NANA withdrew the dispute following this explicit notice of ineligibility.

177. As a result of HaloMD's and NANA's fraudulent attestations, ABCLH paid $6,632.10 for the ineligible service along with $512 in unnecessary IDR-related fees.

DISP-1455555 (No Open Negotiation)

178. The IDR proceeding captioned DISP-1455555 involved a service that NANA rendered on March 11, 2024, to a member of a health plan administered by ABCLH

179. When ABCLH issued payment, which was equal to the QPA for the service, the EOB sent to NANA at the 1141 N Loop Address reflected that the claim was processed pursuant to explanation code AUQ. The description of this code, printed at the end of the EOB, indicated: "This claim was paid according to the Federal No Surprises Act. … If you disagree with our decision, you can initiate the 30-day open negotiation period[.]" Neither NANA, nor HaloMD acting on its behalf, initiated the 30-day open negotiation period as required.

180. Even though neither NANA nor HaloMD initiated open negotiations for this service, on June 21, 2024, HaloMD, using the email address nsa@halomd.com, on behalf of and in coordination with NANA, initiated IDR and falsely attested that the service was a qualified item or service within the scope of the federal IDR Process and that NANA and/or HaloMD had complied with the requirements of the NSA in submitting the claim.

181. On December 11, 2024, Anthem Payment Disputes, on behalf of ABCLH, submitted an objection to eligibility, which was also addressed to the NANA provider who performed the service, stating "The non-participating provider/facility failed to

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engage in the 30-business day open negotiation period, according to the NSA. Providers cannot pursue IDR unless and until the open negotiation period is properly initiated and completed." Neither HaloMD nor NANA withdrew the dispute following this explicit notice of ineligibility.

182. As a result of HaloMD and NANA's fraudulent attestations, ABCLH paid $9,843.83—***approximately $3,000 more than NANA's billed charges***—along with $512 in unnecessary IDR-related fees.

C. N Express

DISP-2193991 (Ineligible State Law Claim)

183. The IDR proceeding captioned DISP-2193991 involved a service that N Express rendered on October 23, 2023, to a member of a health plan administered by ABC. The member's plan is subject to state law, and therefore, California's Surprise Billing Laws—rather than the NSA—governed the reimbursement rate for services.

184. On December 12, 2023, HaloMD, on behalf of and in coordination with N Express, initiated open negotiations by emailing the Anthem IDR Email Address, using the email address nsa@halomd.com and copying keiasha.berry@halomd.com. HaloMD requested an additional payment of $1,790.55 for the service.

185. On December 26, 2023, ABC responded to HaloMD's notice of open negotiation, via the Anthem IDR Email Address, and indicated that "[a]fter a careful and thorough review, it [was] determined that the claim submitted does not meet the Federal No Surprises Act Guidelines." Neither HaloMD nor N Express responded to this notice of ineligibility.

186. Despite clear ineligibility due to application of California's Surprise Billing Laws, on December 2, 2024, "CJR" of HaloMD, using the email address nsa@halomd.com, on behalf of and in coordination with N Express, initiated IDR and falsely certified the service as IDR eligible.

187. On December 6, 2024, ABC submitted an objection to eligibility, which was also addressed to N Express, stating: "The claim(s) is ineligible for IDR under the

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NSA because a state surprise billing law applies." Neither HaloMD nor N Express withdrew the dispute following this explicit notice of ineligibility.

188. As a result of HaloMD and N Express's fraudulent attestations, ABC paid $7,745.56—***more than double the billed amount*** of $3,825—along with $510 in unnecessary IDR-related fees.

DISP-2193967 (Ineligible State Law Claim)

189. The IDR proceeding captioned DISP-2193967 involved a service that N Express rendered on October 23, 2023, to a member of a health plan administered by ABC. The member's plan is subject to state law and, therefore, California's Surprise Billing Laws—rather than the NSA—governed the reimbursement rate for services.

190. On December 12, 2023, HaloMD, on behalf of and in coordination with N Express, sent a notice of Open Negotiation to ABC via email to the Anthem IDR Email Address, using the email address nsa@halomd.com and copying keiasha.berry@halomd.com. HaloMD requested an additional payment of $2,547.53 for the service.

191. On December 26, 2023, ABC, via the Anthem IDR Email Address, responded to HaloMD's notice of open negotiation and indicated that "[a]fter a careful and thorough review, it [was] determined that the claim submitted does not meet the Federal No Surprises Act Guidelines." Neither HaloMD nor N Express responded to this notice of ineligibility.

192. December 2, 2024, "CJR" of HaloMD, using the email address nsa@halomd.com, on behalf of and in coordination with N Express, initiated IDR and falsely certified the service as IDR-eligible.

193. On December 6, 2024, ABC submitted an objection to eligibility, which was also addressed to N Express, stating: "The claim(s) is ineligible for IDR under the NSA because a state surprise billing law applies" Neither HaloMD nor N Express withdrew the dispute following this explicit notice of ineligibility.

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194. As a result of HaloMD and N Express's fraudulent attestations, ABC paid $12,293.84 for the ineligible service along with $510 in unnecessary IDR-related fees.

DISP-945678 (Ineligible State Law Claim)

195. The IDR proceeding captioned DISP-945678 involved a service that N Express rendered on October 23, 2023, to a member of a fully insured group health plan administered by ABC. The member's plan is subject to state law and, therefore, California's Surprise Billing Laws—rather than the NSA—governed the reimbursement rate for services.

196. On December 12, 2023, HaloMD, on behalf of and in coordination with N Express, sent a notice of Open Negotiation to ABC via email to the Anthem IDR Email Address, using the email address nsa@halomd.com and copying keiasha.berry@halomd.com. HaloMD requested an additional payment of $1,960.33 for the service.

197. On December 26, 2023, ABC, via the Anthem IDR Email Address, responded to HaloMD's notice of open negotiation and indicated that "[a]fter a careful and thorough review, it [was] determined that the claim submitted does not meet the Federal No Surprises Act Guidelines." Neither HaloMD nor N Express responded to this notice of ineligibility.

198. On December 2, 2024, HaloMD, using the email address nsa@halomd.com, on behalf of and in coordination with N Express, initiated IDR and falsely certified the service as IDR-eligible.

199. ABC submitted an objection to eligibility, which was also addressed to N Express, stating: "The claim(s) is ineligible for IDR under the NSA because a state surprise billing law applies." Neither HaloMD nor N Express withdrew the dispute following this explicit notice of ineligibility.

200. As a result of HaloMD and N Express's fraudulent attestations, ABC paid $8,585.29—***nearly double the billed amount*** of $3,825—along with $510 in unnecessary IDR-related fees.

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D. iNeurology

DISP-937342 (Non-Covered Service)

201. The IDR proceeding captioned DISP-937342 involved a service that iNeurology rendered on September 19, 2023, to a member of a health plan administered by ABC. ABC denied payment for the service. No QPA applied to this service given the denial.

202. On December 6, 2023, HaloMD, on behalf of and in coordination with iNeurology, sent a notice of Open Negotiation to ABC via email to the Anthem IDR Email Address, using the email address nsa@halomd.com and copying keiasha.berry@halomd.com. HaloMD requested an additional payment of $1,960.33 for the service. The notice of open negotiation was signed by Megan Rausch, noted to be the "Provider Representative," with a return address noted as the 2915 W. Bitters Address.

203. On December 19, 2023, ABC, via the Anthem Email Address, responded to HaloMD's open negotiation request and indicated that "[a]fter a careful and thorough review, it [was] determined that the claim submitted does not meet the Federal No Surprises Act Guidelines." Neither HaloMD nor iNeurology responded to this notice of ineligibility.

204. On January 22, 2024, HaloMD, using the email address nsa@halomd.com, on behalf of and in coordination with iNeurology, initiated IDR and falsely attested to IDR eligibility.

205. As a result of HaloMD and iNeurology's fraudulent attestations, ABC paid $7,309.58—***more than six times the billed amount*** of $1,275—along with $510.00 in unnecessary IDR-related fees, on a service for which no plan benefits were payable in the first place.

THE SOUND PHYSICIANS ENTERPRISE

206. Like the LaRoque Family Enterprise, the members of the Sound Physicians Enterprise were organized pursuant to a structure that enabled the enterprise to make

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and carry out decisions in furtherance of the NSA Scheme. The Sound Physicians Enterprise functioned as a continuing unit with established duties that enabled it to design and coordinate the multifaceted NSA Scheme to defraud Anthem and other health care plans.

207. In doing so, HaloMD and the Sound Physicians Providers conducted the activities of an association-in-fact enterprise consisting of Defendants HaloMD, SPAC, and SPEMSC, through a pattern of racketeering activity, including but not limited to wire fraud.

208. Since at least January 2024 to the present, the Sound Physicians Providers, with the intent to defraud, devised and willfully participated with HaloMD, and with knowledge of fraudulent nature, in the scheme and artifice to defraud and obtain money and property from Anthem by materially false and fraudulent pretenses, statements, and representations, as described herein.

209. The members of the Sound Physicians Enterprise do not operate as separate, independent actors. Rather, the Sound Physicians Providers and HaloMD function as participants in a unified scheme designed to exploit the IDR process and defraud Anthem.

I. Defendant HaloMD

210. Like the LaRoque Family Enterprise, HaloMD is the key to the Sound Physicians Enterprise's scheme to flood the IDR process with knowingly ineligible disputes.

211. Operating "[w]ith an exclusive focus on Independent Dispute Resolution (IDR)," HaloMD leverages AI and automation to effectuate the scheme "at scale."[40]

212. HaloMD solicits and represents out-of-network providers who were key drivers in surprise billing, including anesthesiology and emergency providers like the Sound Physicians Providers. Providers submit services for dispute in the IDR process through HaloMD's portal.

[40] *See* https://halomd.com/

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213. HaloMD operates on a commission-based reimbursement model. HaloMD thus has a financial incentive to (1) bring as many services as possible through the IDR process, regardless of the merits or the applicability of the NSA to those disputes, and (2) seek the highest possible monetary award for its provider clients in the IDR process. The Sound Physicians Providers share these same financial incentives.

II. The Sound Physicians Providers

214. HaloMD uses the Sound Physicians Providers' purported services as the basis for initiating IDR process disputes.

215. But HaloMD is not the only party initiating IDR for the Sound Physicians Providers. Rather, many IDRs pursued by the Sound Physicians Providers were initiated by Sound Physicians through its email address SoundFedIDR@SoundPhysicians.com. The character of IDRs pursued by Sound Physicians (as opposed to those submitted by HaloMD) follow the same pattern of systemic initiation of faulty and ineligible disputes.

216. The Sound Physicians Providers are subsidiaries or affiliates of Sound Physicians, a national multi-specialty medical group headquartered in Tacoma, Washington. Sound Physicians publicly claims to employ over 4,000 clinicians and to manage approximately 6 percent of all acute hospitalizations across more than 400 hospitals nationwide.[41]

217. The Sound Physicians Providers were all incorporated by persons located at 1498 Pacific Ave., Suite 400, in Tacoma, Washington 98402, which is also Sound Physicians' corporate headquarters.

218. The Sound Physicians Providers share resources and intermingle operations with respect to the submission of health care claims, payment for health care services, and pursuit of IDR. As noted below, Sound Physicians directly submitted open negotiations notices and initiated IDR proceedings on behalf of the Sound Physicians Providers using the email address SoundFedIDR@SoundPhysicians.com. Even in disputes initiated by HaloMD, the email address recorded by the initiating party for IDR

[41] *See* https://soundphysicians.com/about/why-sound/.

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involving the Sound Physicians Providers' services is soundnsa@halo.com.

219. Thus, the Sound Physicians Providers themselves falsely attested to eligibility in many disputes and, through their commingled operations, clearly had knowledge of the broader ongoing illegal scheme.

220. In sum, the relationship between HaloMD and the Sound Physicians Providers is not passive. Together, they coordinated to pursue shared financial interests—maximizing the number of disputes submitted and inflating payment demands well beyond their billed charges or market rates. The use of HaloMD as a submission engine was not incidental or isolated; it was a deliberate component of the Sound Physicians Enterprise's strategy to bypass the limitations of individual-provider capacity, automate the submission of disputes en masse, and conceal the ineligibility or inflation embedded in each claim.

III. The Sound Physicians Enterprise Exploits the IDR Process at the Expense of Anthem.

221. During the relevant time period, the Sound Physicians Enterprise transmitted or caused to be transmitted by wire communication or radio communication in interstate commerce, writings, signs, signals, pictures, and sounds, including false and fraudulent statements, representations, and attestations related to IDR disputes, from and between the state in which they operate—for example, California and Tennessee—to Certified Independent Dispute Resolution Entities located in various states, including, for example, Florida, Texas, Pennsylvania, Michigan, New York, and Maryland, in furtherance of the fraudulent scheme.

222. Specifically, since 2024, Anthem has identified nearly 400 ineligible disputes that the Sound Physicians Enterprise caused to be initiated against Anthem. These identified disputes represent an improper cost to Anthem of more than $150,00 in administrative and IDRE fees alone. Further, of the nearly 400 identified ineligible disputes, more than 250 IDR determinations were rendered against Anthem, resulting in required payments of nearly $820,000.

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223. The participants in the Sound Physicians Enterprise made false and fraudulent statements, representations, and attestations related to the following illustrative fraudulent IDR disputes, including, but not limited to, the following:

A. Sound Physicians Emergency Medicine of Southern California

DISP-932222 (Incorrect Batching)

224. The IDR proceeding captioned DISP-932222 involved emergency services that SPEMSC rendered between September 20, 2023, and October 31, 2023. Certain services disputed in this proceeding were rendered to members of health plans insured and administered by ABCLH, and other services disputed in this proceeding were rendered to members of health plans insured or administered by ABC. SPEMSC billed $1,761.00 in charges for each service.

225. ABCLH and ABC each approved payment for the service and sent corresponding EOBs to Sound Physicians at the address P.O. Box 748524, Los Angeles, California, 90074.

226. On November 30, 2023, SPEMSC, using the email address SoundFedIDR@SoundPhysicians.com, sent a notice of open negotiation, signed by Melissa Williams at Sound Physicians, to ABCLH and ABC at the Anthem IDR Email Address to initiate the federal IDR process. The notice of open negotiation attached a spreadsheet with dozens of claims that included the fully insured claim subject to DISP-932222. ABCLH and ABC, via the Anthem IDR Email Address, sent a response to SPEMSC offering additional payment to settle the dispute and inviting SPEMSC to submit additional information to support why it is entitled to greater reimbursement and to continue discussions. SPEMSC did not respond to this correspondence.

227. On November 13, 2024, SPEMSC initiated a batched IDR using the email soundfedidr@soundphysicians.com. SPEMSC falsely attested that the services were qualified and within the scope of the federal IDR process despite the fact the dispute was ineligible for multiple reasons, including that SPEMSC inappropriately included

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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.

228. ABCLH and ABC responded to the IDR initiation to assert that IDR was not applicable to the dispute, stating in part: "Batched services include multiple Membership types," and providing a chart of all disputed services with the membership type attributable to each claim (*e.g.*, "ASO" and "Fully Insured"). SPEMSC did not withdraw the dispute.

229. Nevertheless, as a result of SPEMSC's fraudulent attestation, ABCLH and ABC, each, paid $1,761 for each of the eighteen (18) specific unqualified services along with $900 in unnecessary IDR-related fees related to the improperly batched dispute.

DISP-1289721 (Ineligible Medicaid Claim)

230. The IDR proceeding captioned DISP-1289721 involved emergency services that SPEMSC rendered on February 9, 2024, to a member of a Medicaid managed care plan administered by ABC. ABC paid the Medicaid rate of $44.60 for the service. No QPA applied to this claim because the NSA and IDR were inapplicable.

231. When ABC initially approved payment of the claim, the February 23, 2024 remittance reflected that the member's plan was a Managed Medicaid plan, so SPEMSC and HaloMD were aware of the claim's ineligibility before they initiated open negotiations and IDR.

MEDI-CAL LA

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [redacted]				INSURED'S ID: [redacted]				PATIENT NAME: [redacted]					FOR INQUIRIES CALL:
PATIENT ACCOUNT#: [redacted]				CLAIM NUMBER: 2024050BA1297				RECEIVED DATE:			02/19/2024		(888) 285-7801
SERVICE PROVIDER NAME: MENSER JENNIFER R				SERVICE PROVIDER ID: 1700427671				EXPL CD:			APPEALS CODE: CA1		
NETWORK: OUT OF NETWORK				RELATIONSHIP TO INSURED: [redacted]				PLAN TYPE: HMO		DRG RCVD: N/A			
02/09/2024 02/09/2024	99283	23	1,260.00	44.60	0.00	0.00	0.00	1,215.40	1,215.40	AKD 45	0.00		44.60
	TOTAL:		1,260.00	44.60	0.00	0.00	0.00	1,215.40	1,215.40		0.00		44.60
INTEREST													0.00
	TOTAL NET PAID												44.60

TOTAL APPROVED AMOUNT 44.60
TOTAL INTEREST 0.00
TOTAL NET AMOUNT DUE: MEDI-CAL LA 44.60

232. On March 13, 2024 SPEMSC sent a notice of open negotiation to ABC at the Anthem IDR Email Address. The notice was signed by Melissa Williams, a Dispute Resolution Specialist with the return address of 120 Brentwood Commons Way, Suite 510 in Brentwood, Tennessee. The notice was accompanied by a lengthy spreadsheet

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with about eighty-eight (88) individual claims that SPEMSC purported to be "negotiating."

233. On October 23, 2024, HaloMD, using the email address soundnsa@halomd.com, on behalf of and in coordination with SPEMSC, initiated IDR and falsely attested to IDR eligibility.

234. ABC submitted an objection to eligibility, asserting that the dispute was ineligible for IDR under the NSA because it involved a "Medicare/ Medicaid claim ineligible for NSA." This notice of ineligibility was sent to both HaloMD and SPEMSC, yet neither HaloMD nor SPEMSC withdrew the dispute.

235. Nevertheless, as a result of HaloMD and SPEMSC's fraudulent attestations, ABC paid $1,880—***which was more than SPEMSC billed for the service and more than 42 times the Medicaid rate***—along with $915 in unnecessary IDR-related fees.

DISP-1568233 (Ineligible State Law Claim)

236. The IDR proceeding captioned DISP-1568233 involved emergency services that SPEMSC rendered on February 7, 2024, to a member of a fully insured health plan administered by ABCLH. The member's plan is subject to state law and, therefore, California's Surprise Billing Laws—rather than the NSA—governed the reimbursement rate for services.

237. On June 5, 2024, HaloMD, again acting on behalf of and in coordination with SPEMSC, sent a notice of open negotiation to ABCLH, at the Anthem IDR Email Address, to initiate the federal IDR process. HaloMD sent the open negotiation notice using the email address soundnsa@halomd.com with Eden.Dimayuga@halomd.com copied. The open negotiation notice offered $2,475 to resolve the dispute and was signed by Megan Rausch (HaloMD), noted to be the "Provider Representative," at the 2915 W Bitters Address.

238. On June 18, 2024, ABCLH, via the Anthem IDR Email Address, responded to the notice of open negotiation via email addressed to

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soundnsa@halomd.com and Eden.Dimayuga@halomd.com, which indicated "[a]fter a careful and thorough review, it [was] determined that the claim submitted does not meet the Federal No Surprises Act Guidelines."

239. On July 5, 2024, ABCLH, also responded to the notice of open negotiation in writing and addressed its response to the notice of open negotiation to SPEMSC at the address for Sound Physician's headquarters (P.O. Box 748524), stating that the dispute did not qualify for IDR under the NSA. Neither HaloMD nor SPEMSC responded to this assertion of ineligibility.

240. Despite the multiple communications indicating that the claim was ineligible for the federal IDR process, on July 22, 2024, HaloMD, on behalf of and in coordination with SPEMSC, and using the email address soundnsa@halomd.com, falsely attested to IDR eligibility. ABCLH submitted an objection to eligibility asserting that IDR was not applicable to the dispute because "a state surprise billing law applies." This notice of ineligibility was sent to both HaloMD and SPEMSC, yet neither HaloMD nor SPEMSC withdrew the dispute.

241. As a result of HaloMD and SPEMSC's fraudulent attestations, ABCLH paid $4,316.00, which was significantly more than HaloMD and SPEMSC had offered in open negotiations and after they had been informed that the services did not qualify for IDR. Anthem also paid $965 in unnecessary IDR-related fees.

B. Sound Physicians Anesthesiology of California

DISP-2639953 (Ineligible State Law Claim)

242. The IDR proceeding captioned DISP-2639953 involved anesthesia services that SPAC rendered on November 21, 2024, to a member of a fully insured health plan administered by ABC. As a fully insured plan, the member's plan is subject to state law, and therefore, California's Surprise Billing Laws—rather than the NSA—governed the reimbursement rate for services.

243. On January 8, 2025, HaloMD, on behalf of and in coordination with SPAC, sent a notice of open negotiation to ABC at the Anthem IDR Email Address. The open

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negotiation notice was signed by Megan Rausch, noted to be the "Provider Representative," at the 2915 W Bitters Address and with the email address soundnsa@halomd.com. HaloMD requested $1,006.24 to resolve the dispute.

244. ABC sent a response that was addressed to SPAC at P.O. Box 741658, Los Angeles, California 90074. The letter informed SPAC and HaloMD that the "[c]laim is not governed by the Federal No Surprises Act."

245. On January 9, 2025 ABC sent a response to SPAC, addressed to the Sound Physicians headquarters, asserting that the "Claim is not governed by the Federal No Surprises Act." SPAC did not respond to this assertion of ineligibility.

246. Even though the dispute clearly fell under state law and SPAC knew that the NSA did not apply, on February 25, 2025, HaloMD, on behalf of and in coordination with SPAC, using the email address soundnsa@halomd.com, initiated IDR and falsely attested to IDR eligibility.

247. On March 19, 2024, ABC submitted an objection to eligibility, which was also addressed to SPAC, asserting: "The claim(s) is ineligible for IDR under the NSA because a state surprise billing law applies." Again, neither HaloMD nor SPAC withdrew the dispute following this explicit notice of ineligibility.

248. As a result of HaloMD and SPAC's fraudulent attestations, ABC paid $1,636.40 for the ineligible service, which was greater than the $1,016.40 amount SPAC had billed for the same service and greater than HaloMD's $1,006.24 offer to resolve the claim in open negotiations. ABC also paid $503 in unnecessary IDR-related fees.

CLAIMS FOR RELIEF

COUNT I

VIOLATION OF RICO, 18 U.S.C. § 1962(d)

(Against the LaRoque Family Enterprise)

249. Anthem repeats and realleges the allegations in Paragraphs 1 through 248 in this Complaint as if fully set forth at length herein.

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250. The LaRoque Family Enterprise formed an association-in-fact enterprise, as that term is defined in 18 U.S.C. § 1961(4), for the purposes of stealing and defrauding funds from Anthem through the fraudulent submission of ineligible and inflated disputes under the federal IDR process. At all relevant times, the members of the LaRoque Family Enterprise have been "persons" under 18 U.S.C. § 1961(3) because they are capable of holding, and do hold, "a legal or beneficial interest in property."

251. The members of the LaRoque Family Enterprise have knowingly agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of the LaRoque Family Enterprise's affairs through a pattern of racketeering activity consisting of repeated violations of the wire fraud statute, 18 U.S.C. § 1343, based upon the use of interstate wire facilities to execute the profit-making fraudulent billing schemes described herein. The fraudulent disputes submitted to the IDR Portal for payment by Anthem that comprise the pattern of racketeering activity identified through the date of this Complaint are described in the Section titled "The LaRoque Family Enterprise," *supra*.

252. The members of the LaRoque Family Enterprise knew of, agreed to, and acted in furtherance of the common overall objective (*i.e.*, to defraud Anthem and its affiliated health plans of money) by submitting or facilitating the submission of fraudulent ineligible and inflated disputes to Anthem through the IDR process.

253. The LaRoque Family Enterprise's fraudulent conduct and participation in the racketeering activity described herein has directly and proximately caused Anthem and its affiliated health plans to incur millions of dollars in damages.

254. By reason of its injury, Anthem is entitled to compensatory, punitive, and treble damages, pre- and post-judgment interest, attorney's fees, costs incurred in bringing this action, and any other relief the Court deems just and proper.

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COUNT II

VIOLATION OF RICO, 18 U.S.C. § 1962(d)

(Against the Sound Physicians Enterprise)

255. Anthem repeats and realleges the allegations in Paragraphs 1 through 248 in this Complaint as if fully set forth at length herein.

256. The Sound Physicians Enterprise formed an association-in-fact enterprise, as that term is defined in 18 U.S.C. § 1961(4), for the purposes of stealing and defrauding funds from Anthem through the fraudulent submission of ineligible and inflated disputes under the federal IDR process. At all relevant times, the members of the Sound Physicians Enterprise have been "persons" under 18 U.S.C. § 1961(3) because they are capable of holding, and do hold, "a legal or beneficial interest in property."

257. The members of the Sound Physicians Enterprise have knowingly agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of the Sound Physicians Enterprise's affairs through a pattern of racketeering activity consisting of repeated violations of the wire fraud statute, 18 U.S.C. § 1343, based upon the use of interstate wire facilities to execute the profit-making fraudulent billing schemes described herein. The fraudulent disputes submitted to the IDR Portal for payment by Anthem that comprise the pattern of racketeering activity identified through the date of this Complaint are described in the Section titled "The Sound Physicians Enterprise," *supra*.

258. The Sound Physicians Enterprise Defendants knew of, agreed to, and acted in furtherance of the common overall objective (*i.e.*, to defraud Anthem and its affiliated health plans of money) by submitting or facilitating the submission of fraudulent ineligible and inflated disputes to Anthem through the IDR process.

259. The Sound Physicians Enterprise's fraudulent conduct and participation in the racketeering activity described herein has directly and proximately caused Anthem and its affiliated health plans to incur hundreds of thousands of dollars in damages.

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260. By reason of its injury, Anthem is entitled to compensatory, punitive, and treble damages, pre- and post-judgment interest, attorney's fees, costs incurred in bringing this action, and any other relief the Court deems just and proper.

COUNT III

VIOLATION OF RICO, 18 U.S.C. § 1962(c)

(Against the LaRoque Family Enterprise)

261. Anthem repeats and realleges the allegations in Paragraphs 1 through 248 in this Complaint as if fully set forth at length herein.

262. The LaRoque Family Enterprise formed an association-in-fact enterprise, as that term is defined in 18 U.S.C. § 1961(4), for the purposes of stealing and defrauding funds from Anthem through the fraudulent submission of ineligible and inflated disputes under the federal IDR process. At all relevant times, the members of the LaRoque Family Enterprise have been "persons" under 18 U.S.C. § 1961(3) because they are capable of holding, and do hold, "a legal or beneficial interest in property."

263. Since at least January 2024, the LaRoque Family Enterprise has sought to increase their profits by: (1) knowingly submitting false and fraudulent attestations of eligibility for services and disputes that they know are ineligible for the IDR process; (2) strategically initiating massive volumes of IDR disputes simultaneously against Anthem; and (3) improperly inflating payment offers that far exceed what the LaRoque Family Provider Defendants could have received from patients or health plans in a competitive market and, in many cases, exceed the LaRoque Family Provider Defendants' billed charges.

264. At all relevant times, the members of the LaRoque Family Enterprise: (a) functioned as a continuing unit with an ascertainable structure separate and distinct from the pattern of racketeering activity; (b) shared a common purpose of enriching themselves at the expense of Anthem by fraudulently inducing and compelling Anthem to pay exorbitant amounts for services that were not eligible for the IDR process and causing Anthem to pay inflated amounts for eligible services far exceeding their billed

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charges; (c) had systematic linkage to each other through interpersonal and contractual relationships, financial ties, shared correspondence, and continuing coordination of activities; and (d) had sufficient longevity for the enterprise to pursue its purpose. Each member of the LaRoque Family Enterprise participated in the operation and management of the enterprise, including a pattern of racketeering activity referred to herein as the NSA Scheme, and shared in the profits illicitly obtained due to the enterprise's fraudulent activity.

265. The LaRoque Family Enterprise is distinct from and has an existence beyond the pattern of racketeering that is described herein, namely by recruiting, employing, overseeing and coordinating individuals who have been responsible for facilitating and performing a variety of administrative and ostensibly professional functions beyond the acts of wire fraud (*i.e.*, the submission of the ineligible and inflated disputes to Anthem and through the IDR process), by creating and maintaining records, by negotiating and executing various agreements, and by maintaining the bookkeeping and accounting functions necessary to manage the receipt and distribution of the payments on IDR determinations.

266. The LaRoque Family Enterprise Defendants committed, conspired to commit, and/or aided and abetted in the commission of at least two predicate acts of racketeering activity (*i.e.*, wire fraud in violation of 18 U.S.C. § 1343) within the past ten years. The multiple acts of racketeering activity that these Defendants committed, or aided and abetted in the commission of, were related to each other and posed a threat of continued racketeering activity and therefore constitute a "pattern of racketeering activity." The predicate acts also had the same or similar results, participants, victims, and methods. The predicate acts were related and not isolated events.

267. The LaRoque Family Enterprise Defendants committed predicate acts of wire fraud by transmitting and/or receiving, or by causing to be transmitted and/or received, materials by interstate wires for the purpose of executing the unlawful scheme to defraud funds from Anthem by means of false pretenses, misrepresentations,

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promises, and omissions. Specifically, the disputes these Defendants submitted through the federal IDR process contained misrepresentations that the disputes were eligible for that process and often contained inflated amounts above even the LaRoque Family Provider's billed charges. The predicate acts all had the purpose of substantially harming Anthem's business and property, while simultaneously generating substantial revenues for the members of the LaRoque Family Enterprise. The predicate acts were committed or caused to be committed by the LaRoque Family Enterprise members through their participation in the LaRoque Family Enterprise, as applicable, and in furtherance of their fraudulent schemes.

268. The LaRoque Family Enterprise members' predicate acts of racketeering—which began no later than January 2024 and have occurred continuously and systematically through the present day—committed by interstate wires, include: (a) submitting disputes through the online IDR portal that were ineligible for the IDR process; (b) demanding outrageous payments in excess of their charges, much less a commercially reasonable amount; (c) initiating scores of disputes at the same time and in such a way as to make it difficult for Anthem to reasonably identify and object to all ineligible disputes; (d) engaging in the IDR process in bad faith; and (e) procuring payments on disputes that were ineligible for IDR and/or or grossly inflated. The fraudulent disputes submitted to Anthem that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the Sections titled "The LaRoque Family Enterprise," *supra*.

269. The members of the LaRoque Family Enterprises have profited, and continue to profit, substantially from the fraudulent billing scheme, ultimately receiving nearly $1.9 million in illicitly obtained reimbursements. These payments, disbursed through interstate wire facilities, each constitute a separate violation of 18 U.S.C. § 1343.

270. The LaRoque Family Enterprise's fraudulent conduct and participation in the racketeering activity described herein has directly and proximately caused Anthem

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and its affiliated health plans to incur millions of dollars in damages.

271. By reason of its injury, Anthem is entitled to compensatory, punitive, and treble damages, pre- and post-judgment interest, attorney's fees, costs incurred in bringing this action, and any other relief the Court deems just and proper.

COUNT IV

VIOLATION OF RICO, 18 U.S.C. § 1962(c)

(Against the Sound Physicians Enterprise)

272. Anthem repeats and realleges the allegations in Paragraphs 1 through 248 contained in this Complaint as if fully set forth at length herein.

273. The Sound Physicians Enterprise formed an association-in-fact enterprise, as that term is defined in 18 U.S.C. § 1961(4), for the purposes of stealing and defrauding funds from Anthem through the fraudulent submission of ineligible and inflated disputes under the federal IDR process. At all relevant times, the members of the Sound Physicians Enterprise have been "persons" under 18 U.S.C. § 1961(3) because they are capable of holding, and do hold, "a legal or beneficial interest in property."

274. Since at least January 2024, the Sound Physicians Enterprise has sought to increase their profits by: (1) knowingly submitting false and fraudulent attestations of eligibility for services and disputes that they know are ineligible for the IDR process; (2) strategically initiating massive volumes of IDR disputes simultaneously against Anthem; and (3) improperly inflating payment offers that far exceed what the Sound Physicians Provider Defendants could have received from patients or health plans in a competitive market and, in many cases, are twice or more the Sound Physicians Provider Defendants' billed charges.

275. At all relevant times, the members of the Sound Physicians Enterprise: (a) functioned as a continuing unit with an ascertainable structure separate and distinct from the pattern of racketeering activity; (b) shared a common purpose of enriching themselves at the expense of Anthem by fraudulently inducing and compelling Anthem

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to pay exorbitant amounts for services that were not eligible for the IDR process and causing Anthem to pay inflated amounts for eligible services far exceeding their billed charges; (c) had systematic linkage to each other through interpersonal and contractual relationships, financial ties, shared correspondence, and continuing coordination of activities; and (d) had sufficient longevity for the enterprise to pursue its purpose. Each member of the Sound Physicians Enterprise participated in the operation and management of the enterprise, including a pattern of racketeering activity referred to herein as the NSA Scheme, and shared in the profits illicitly obtained due to the enterprise's fraudulent activity.

276. The Sound Physicians Enterprise is distinct from and has an existence beyond the pattern of racketeering that is described herein, namely by recruiting, employing, overseeing and coordinating individuals who have been responsible for facilitating and performing a variety of administrative and ostensibly professional functions beyond the acts of wire fraud (*i.e.*, the submission of the ineligible and inflated disputes to Anthem and through the IDR process), by creating and maintaining records, by negotiating and executing various agreements, and by maintaining the bookkeeping and accounting functions necessary to manage the receipt and distribution of the payments on IDR determinations.

277. The Sound Physicians Enterprise Defendants committed, conspired to commit, and/or aided and abetted in the commission of at least two predicate acts of racketeering activity (*i.e.*, wire fraud in violation of 18 U.S.C. § 1343) within the past ten years. The multiple acts of racketeering activity that these Defendants committed, or aided and abetted in the commission of, were related to each other and posed a threat of continued racketeering activity and therefore constitute a "pattern of racketeering activity." The predicate acts also had the same or similar results, participants, victims, and methods. The predicate acts were related and not isolated events.

278. The Sound Physicians Enterprise Defendants committed predicate acts of wire fraud by transmitting and/or receiving, or by causing to be transmitted and/or

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received, materials by interstate wires for the purpose of executing the unlawful scheme to defraud funds from Anthem by means of false pretenses, misrepresentations, promises, and omissions. Specifically, the disputes these Defendants submitted through the federal IDR process contained misrepresentations that the disputes were eligible for that process and often contained inflated amounts above even the Sound Physicians Provider's billed charges. The predicate acts all had the purpose of substantially harming Anthem's business and property, while simultaneously generating substantial revenues for the members of the Sound Physicians Enterprise. The predicate acts were committed or caused to be committed by the Sound Physicians Enterprise members through their participation in the Sound Physicians Enterprise, as applicable, and in furtherance of their fraudulent schemes.

279. The Sound Physicians Enterprise members' predicate acts of racketeering—which began no later than January 2024 and have occurred continuously and systematically through the present day—committed by interstate wires, include: (a) submitting disputes through the online IDR portal that were ineligible for the IDR process; (b) demanding outrageous payments far in excess of their charges, much less a commercially reasonable amount; (c) initiating scores of disputes at the same time and in such a way as to make it difficult for Anthem to reasonably identify and object to all ineligible disputes; (d) engaging in the IDR process in bad faith; and (e) procuring payments on disputes that were ineligible for IDR and/or or grossly inflated. The fraudulent disputes submitted to Anthem that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the Sections titled "The Sound Physicians Enterprise," *supra*.

280. The members of the Sound Physicians Enterprises have profited, and continue to profit, substantially from the fraudulent billing scheme, ultimately receiving hundreds of thousands of dollars in illicitly obtained reimbursements. These payments, disbursed through interstate wire facilities, each constitute a separate violation of 18 U.S.C. § 1343.

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281. The Sound Physicians Enterprise's fraudulent conduct and participation in the racketeering activity described herein has directly and proximately caused Anthem and its affiliated health plans to incur hundreds of thousands of dollars in damages.

282. By reason of its injury, Anthem is entitled to compensatory, punitive, and treble damages, pre- and post-judgment interest, attorney's fees, costs incurred in bringing this action, and any other relief the Court deems just and proper.

COUNT V

FRAUDULENT MISREPRESENTATION

(Against All Members of the LaRoque Family Enterprise)

283. Anthem repeats and realleges the allegations in Paragraphs 1 through 248 contained in this Complaint as if fully set forth at length herein.

284. HaloMD, on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, knowingly and willfully executed the schemes described herein with the intent to defraud Anthem by (1) submitting knowingly false attestations of IDR eligibility to Anthem, the IDREs, and the Departments and (2) falsely representing to Anthem, the IDREs, and the Departments that the disputes were eligible for IDR prior to initiating the IDR process, all done with the intent to obtain money owned or controlled by Anthem and its affiliated health plans under the false pretense that the disputes were eligible for resolution through the IDR process.

285. For each of the IDRs initiated, HaloMD, on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, submitted a completed version of the mandatory IDR notice of initiation to Anthem, the IDREs, and the Departments, which, in part, contained the following attestation:

> I, the undersigned initiating party (or representative of the initiating party), attests that to the best of my knowledge…the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) within the scope of the Federal IDR process.

286. Yet as discussed herein, hundreds of the attestations submitted by the HaloMD, on behalf of and coordination with MPOWERHealth and the LaRoque Family

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Providers, were clearly false, as the underlying services were not qualified items or services, and in fact, the disputes were ineligible for resolution through the NSA's IDR process.

287. HaloMD, on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, submitted the IDR notice of initiation in each such dispute with full knowledge of the falsity of this attestation. From the patient's insurance cards, Anthem's EOPs, the plain text of federal laws and regulations, CMS publications and resources, HaloMD's preparation of IDR initiation forms and notices, their participation in the IDR process, and the specific objections to eligibility that Anthem submitted to the LaRoque Family Providers and to HaloMD, among other sources, the MPOWERHealth Defendants, the LaRoque Family Providers, and HaloMD knew that the services and disputes HaloMD was initiating were ineligible for the IDR process.

288. HaloMD, on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, nevertheless submitted these false attestations and did so with the intent that Anthem, the IDREs, and the Departments rely on them. Anthem was, in fact, compelled to rely on the false attestations because it was forced to proceed to a payment determination, despite the dispute's ineligibility.

289. According to federal law, "the certified IDR entity selected must review the information submitted in the notice of IDR initiation"—including HaloMD's false attestations of eligibility submitted on behalf of and in coordination with the LaRoque Family Providers—"to determine whether the Federal IDR process applies." 45 C.F.R. § 149.510(c)(1)(v). Even if Anthem contested eligibility, the MPOWERHealth Defendants, the LaRoque Family Providers, and HaloMD knew and expected their deliberate misrepresentations would force Anthem to reasonably and foreseeably rely on the misrepresentations and proceed to a payment determination, despite the ineligibility of the dispute.

290. As described above, these misrepresentations were submitted by corporate agents using corporate email addresses—namely, nsa@halomd.com—which, upon

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information and belief, was an attempt to conceal the identity of the individuals submitting the false attestations. As parties to IDR have no ability to engage in discovery—in fact, the parties submit final offers and supporting evidence in a blind process without the right or ability to see the other party's submission—the submission of false attestations achieved the concealment of the corporate actors filing the false attestations, save for DISP-2193991 where, on December 2, 2024, HaloMD's employee "CJC" initiated IDR through the IDR portal using a false attestation of eligibility on behalf of and in coordination with N Express despite being on notice that the dispute was subject to California's State Surprise Billing Laws.

291. From January 4, 2024, to August 2025, HaloMD on behalf of and in coordination with the MPOWERHealth Defendants and the LaRoque Family Providers, submitted hundreds of false attestations, including, for example, the disputes specifically referenced above.

292. These false attestations of eligibility pertain to material facts in the IDR process because they bypass the safeguards that the Departments created to prevent ineligible disputes and go to the heart of the IDRE's jurisdiction to even hear the dispute.

293. HaloMD, on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, submitted the false attestations to receive a windfall for themselves, namely, IDR payment determinations in favor of the LaRoque Family Providers and against Anthem regarding items or services that were ineligible for resolution through the IDR process.

294. At all times when submitting the false attestations and engaging in the relevant IDR disputes, HaloMD was acting within the scope of HaloMD's agreements with the LaRoque Family Providers and/or MPOWERHealth to handle the IDR process for the LaRoque Family Providers in connection with the identified disputes.

295. HaloMD, on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, also fraudulently misrepresented to Anthem during the

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statutorily required open negotiations process that the disputes were eligible for IDR and involved qualified IDR items and services meeting the NSA and regulatory definitions of that term.

296. Anthem reasonably, foreseeably, and justifiably relied on HaloMD's misrepresentations during the open negotiations and IDR initiation process. As part of the fraudulent scheme described herein, Defendants' tactic to strategically flood the IDR process and overwhelm the system precluded Anthem from investigating each and every aspect of the hundreds of disputes they submitted within the 30-day open negotiations window or within three days of IDR initiation, intending that Anthem would rely on these false representations of eligibility. Additionally, in some cases (such as when the patient waived balance billing protections), Defendants are the only entities in possession of information critical to Anthem's ability to assess a claim for IDR eligibility, such as information pertaining to the provider, types of services rendered, and patient records. Thus, MPOWERHealth, the LaRoque Family Providers, and HaloMD knew Anthem was often incapable of knowing the falsity of HaloMD's misrepresentations. As a result, Anthem justifiably relied on these misrepresentations that the disputes were eligible for IDR and incurred significant monetary losses, including through incurring fees required by the NSA and in the form of IDR payment determinations finding against Anthem.

297. As a direct and proximate result of these misrepresentations by HaloMD on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, Anthem and its affiliated plans have suffered substantial damages, including in the form of payment on IDR payment determinations that were ineligible for resolution through the NSA's IDR process, along with payment of required administrative and IDRE fees in connection with the ineligible disputes.

298. Each member of the LaRoque Family Enterprise formed and operated in a conspiracy to defraud Anthem through these schemes, and each committed acts in furtherance thereof, resulting in the above-stated damages to Anthem.

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COUNT VI

FRAUDULENT MISREPRESENTATION

(Against All Members of the Sound Physicians Enterprise)

299. Anthem repeats and realleges the allegations in Paragraphs 1 through 248 contained in this Complaint as if fully set forth at length herein.

300. The Sound Physicians Providers, or HaloMD on behalf of and in coordination with the Sound Physicians Providers, knowingly and willfully executed the schemes described herein with the intent to defraud Anthem by (1) submitting knowingly false attestations of IDR eligibility to Anthem, the IDREs, and the Departments and (2) falsely representing to Anthem, the IDREs, and the Departments that the disputes were eligible for IDR prior to initiating the IDR process, all done with the intent to obtain money owned or controlled by Anthem and its affiliated health plans under the false pretense that the disputes were eligible for resolution through the IDR process.

301. For each of the IDRs initiated, the Sound Physicians, or HaloMD on behalf of and in coordination with the Sound Physicians Providers, submitted a completed version of the mandatory IDR notice of initiation to Anthem, the IDREs, and the Departments, which, in part, contained the following attestation:

> I, the undersigned initiating party (or representative of the initiating party), attests that to the best of my knowledge…the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) within the scope of the Federal IDR process.

302. Yet as discussed herein, hundreds of the attestations submitted by the Sound Physicians Providers, or HaloMD on their behalf, were clearly false, as the underlying services were not qualified items or services, and in fact, the disputes were ineligible for resolution through the NSA's IDR process.

303. The Sound Physicians Providers, or HaloMD on behalf of and in coordination with the Sound Physicians Providers, submitted the IDR notice of

initiation in each such dispute with full knowledge of the falsity of this attestation. From the patient's insurance cards, Anthem's EOPs, the plain text of federal laws and regulations, Anthem's EOPs, CMS publications and resources, the Sound Physicians Providers' and/or HaloMD's preparation of IDR initiation forms and notices, their participation in the IDR process, and the specific objections to eligibility that Anthem submitted to the Sound Physicians Providers and to HaloMD, among other sources, the Sound Physicians Providers and HaloMD knew that the services and disputes they were initiating were ineligible for the IDR process.

304. The Sound Physicians Providers, or HaloMD on behalf of and in coordination with the Sound Physicians Providers, nevertheless submitted these false attestations and did so with the intent that Anthem, the IDREs, and the Departments rely on them. Anthem was, in fact, compelled to rely on the false attestations because it was forced to proceed to a payment determination, despite the dispute's ineligibility.

305. According to federal law, "the certified IDR entity selected must review the information submitted in the notice of IDR initiation"—including the Sound Physicians Providers' and HaloMD's false attestations of eligibility—"to determine whether the Federal IDR process applies." 45 C.F.R. § 149.510(c)(1)(v). Even if Anthem contested eligibility, the Sound Physicians Providers and HaloMD knew and expected their deliberate misrepresentations would force Anthem to reasonably and foreseeably rely on the misrepresentations and proceed to a payment determination, despite the ineligibility of the dispute.

306. As described above, these misrepresentations were submitted by corporate agents using corporate email addresses—including nsa@halomd.com, soundnsa@halomd.com, and soundfedidr@soundphysicians.com—which, upon information and belief, was an attempt to conceal the identity of the individuals submitting the false attestations. As parties to IDR have no ability to engage in discovery—in fact, the parties submit final offers and supporting evidence in a blind process without the right or ability to see the other party's submission—the submission

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of false attestations achieved the concealment of the corporate actors filing the false attestations.

307. From January 4, 2024, to August 2025, the Sound Physicians Providers, and HaloMD on behalf of and in coordination with the Sound Physicians Providers, submitted hundreds of false attestations, including, for example, the disputes specifically referenced above.

308. These false attestations of eligibility pertain to material facts in the IDR process because they bypass the safeguards that the Departments created to prevent ineligible disputes and go to the heart of the IDRE's jurisdiction to even hear the dispute.

309. The Sound Physicians Providers, or HaloMD on behalf of and in coordination with the Sound Physicians Providers, submitted the false attestations to receive a windfall for themselves, namely, IDR payment determinations in favor of the Sound Physicians Providers and against Anthem regarding items or services that were ineligible for resolution through the IDR process.

310. At all times when submitting the false attestations and engaging in the relevant IDR disputes, HaloMD was acting within the scope of HaloMD's agreements with the Sound Physicians Providers to handle the IDR process for the Sound Physicians Providers in connection with the identified disputes.

311. The Sound Physicians Providers, or HaloMD on behalf of and in coordination with the Sound Physicians Providers, also fraudulently misrepresented to Anthem during the statutorily required open negotiations process that the disputes were eligible for IDR and involved qualified IDR items and services meeting the NSA and regulatory definitions of that term.

312. Anthem reasonably, foreseeably, and justifiably relied on the Sound Physicians Providers' and HaloMD's misrepresentations during the open negotiations and IDR initiation process. As part of the fraudulent scheme described herein, Defendants' tactic to strategically flood the IDR process and overwhelm the system

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precluded Anthem from investigating each and every aspect of the hundreds of disputes they submitted within the 30-day open negotiations window or within three days of IDR initiation, intending that Anthem would rely on these false representations of eligibility. Additionally, in some cases (such as when the patient waived balance billing protections), Defendants are the only entities in possession of information critical to Anthem's ability to assess a claim for IDR eligibility, such as information pertaining to the provider, types of services rendered, and patient records. Thus, Sound Physicians Providers and HaloMD knew Anthem was often incapable of knowing the falsity of the Sound Physicians Providers' and HaloMD's misrepresentations. As a result, Anthem justifiably relied on these misrepresentations that the disputes were eligible for IDR and incurred significant monetary losses through incurring fees required by the NSA and in the form of IDR payment determinations finding against Anthem.

313. As a direct and proximate result of these misrepresentations by the Sound Physicians Providers and HaloMD on behalf of the Sound Physicians Providers, Anthem and its affiliated plans have suffered substantial damages, including in the form of payment on IDR payment determinations that were ineligible for resolution through the NSA's IDR process, along with payment of required administrative and IDRE fees in connection with the ineligible disputes.

314. Each member of the Sound Physicians Enterprise formed and operated in a conspiracy to defraud Anthem through these schemes, and each committed acts in furtherance thereof, resulting in the above-stated damages to Anthem.

COUNT VII

NEGLIGENT MISREPRESENTATION

(Against All Members of the LaRoque Family Enterprise)

315. Anthem repeats and realleges the allegations in Paragraphs 1 through 248 contained in this Complaint as if fully set forth at length herein.

316. In submitting the false attestations of eligibility, HaloMD on behalf of and in coordination with the MPOWERHealth Defendants and the LaRoque Family

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Providers, misrepresented material facts to Anthem, the IDREs, and the Departments regarding eligibility of the disputes to proceed to the IDR payment determination stage. From the patient's insurance cards, Anthem's EOPs, the plain text of federal laws and regulations, CMS publications and resources, HaloMD's preparation of IDR initiation forms and notices, their participation in the IDR process, and the specific objections to eligibility that Anthem submitted to the LaRoque Family Providers and to HaloMD, among other sources, MPOWERHealth, the LaRoque Family Providers, and HaloMD had no reasonable grounds on which to believe and represent that the services and disputes they were initiating were ineligible for the IDR process.

317. As described above, these misrepresentations were submitted by corporate agents using corporate email addresses—namely, nsa@halomd.com—which, upon information and belief, was an attempt to conceal the identity of the individuals submitting the false attestations. As parties to IDR have no ability to engage in discovery—in fact, the parties submit final offers and supporting evidence in a blind process without the right or ability to see the other party's submission—the submission of false attestations achieved the concealment of the corporate actors filing the false attestations, save for DISP-2193991 where, on December 2, 2024, HaloMD Defendant's employee "CJC" initiated IDR through the IDR portal using a false attestation of eligibility on behalf of and in coordination with N Express despite being on notice that the dispute was subject to California's state specified law.

318. MPOWERHealth, the LaRoque Family Providers, and HaloMD owed a duty of reasonable care to Anthem, under which they were required to conduct reasonable investigations, ensure the eligibility of the services for which they were initiating the IDR process, and guard against the submission of false attestations of eligibility leading IDREs to erroneously issue payment determinations in favor of the LaRoque Family Providers for items or services that were not eligible for the IDR process. MPOWERHealth, the LaRoque Family Providers, and HaloMD owed Anthem a duty of care to submit accurate information to Anthem, the IDREs, and the

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Departments when they sought payment or additional payment on the medical claims underlying the IDR disputes. Specifically, in making the false representations to Anthem, the IDREs, and the Departments, HaloMD, on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, were acting in the course of their business or profession and had a pecuniary interest in the underlying medical claims at issue. Moreover, they possessed superior knowledge of the facts underlying the services they (or their clients and co-conspirators in the case of HaloMD) provided.

319. HaloMD, on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers submitted these false attestations and did so with the intent that Anthem, the IDREs, and the Departments rely on them. Anthem was, in fact, compelled to rely on the false attestations because it was forced to proceed to a payment determination, despite the disputes' ineligibility.

320. Even if Anthem contested eligibility, the MPOWERHealth Defendants, the LaRoque Family Providers, and HaloMD knew and expected their deliberate misrepresentations would force Anthem to reasonably and foreseeably rely on the misrepresentations and proceed to a payment determination, despite the ineligibility of the dispute.

321. At all times when submitting the false attestations and engaging in the relevant IDR disputes, HaloMD was acting within the scope of HaloMD's agreements with MPOWERHealth and/or the LaRoque Family Providers to handle the IDR process for the LaRoque Family Providers in connection with the identified disputes.

322. HaloMD, on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, also falsely represented to Anthem during the statutorily required open negotiations process that the disputes were eligible for IDR and involved qualified IDR items and services meeting the NSA and regulatory definitions of that term when, in fact, they did not.

323. Anthem reasonably, foreseeably, and justifiably relied on the LaRoque Family Providers' and HaloMD's misrepresentations during the open negotiations and

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IDR initiation process. As part of the fraudulent schemes described herein, Defendants' tactic was to flood the IDR process and overwhelm the system such that Anthem would be unable to investigate each and every aspect of the hundreds of disputes often submitted on the same day within the 30-day open negotiations window or within days after IDR initiation. Additionally, MPOWERHealth, HaloMD, and the LaRoque Family Providers are in some circumstances the only entities in possession of information critical to Anthem's ability to assess a claim for IDR eligibility, such as information pertaining to the provider, types of services rendered, and patient records. Thus, MPOWERHealth, HaloMD, and the LaRoque Family Providers knew Anthem was often incapable of knowing the falsity of these misrepresentations. As a result, Anthem justifiably relied on the misrepresentations by HaloMD on behalf of MPOWERHealth and/or the LaRoque Family Providers, that the disputes were eligible for IDR and incurred significant monetary losses through incurring administrative and IDRE fees required by the NSA and in the form of IDR payment determinations finding against Anthem.

324. MPOWERHealth, HaloMD, and the LaRoque Family Providers owed Anthem a duty of reasonable care to provide accurate information as to the claims and services they were seeking to negotiate in good faith, as they were acting in the course of their business or profession and had a pecuniary interest in the underlying medical claims at issue. Moreover, MPOWERHealth, HaloMD, and the LaRoque Family Providers possessed superior knowledge of the facts underlying the services they (or their clients and co-conspirators in the case of HaloMD) provided.

325. As a direct and proximate result of these misrepresentations by HaloMD, on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, Anthem and its affiliated health plans have suffered substantial damages, including in the form of payment on IDR payment determinations that were ineligible for resolution through the NSA's IDR process, along with payment of required administrative and IDRE fees.

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326. Each member of the LaRoque Family Enterprise formed and operated in a conspiracy to defraud Anthem through these schemes, and each committed acts in furtherance thereof, resulting in the above-stated damages to Anthem.

COUNT VIII

NEGLIGENT MISREPRESENTATION

(Against All Members of the Sound Physicians Enterprise)

327. Anthem repeats and realleges the allegations in Paragraphs 1 through 248 contained in the Complaint as if fully set forth at length herein.

328. In submitting the false attestations of eligibility, the Sound Physicians Providers, or HaloMD on behalf of and in coordination with the Sound Physicians Providers, misrepresented material facts to Anthem, the IDREs, and the Departments regarding eligibility of the disputes to proceed to the IDR payment determination stage. From the patient's insurance cards, Anthem's EOPs, the plain text of federal laws and regulations, CMS publications and resources, the Sound Physicians Providers' and HaloMD's preparation of IDR initiation forms and notices, their participation in the IDR process, and the specific objections to eligibility that Anthem submitted to the Sound Physicians Providers and to HaloMD, among other sources, the Sound Physicians Providers and HaloMD had no reasonable grounds on which to believe and represent that the services and disputes they were initiating were ineligible for the IDR process.

329. As described above, these misrepresentations were submitted by corporate agents of the Sound Physicians Providers and HaloMD using corporate email addresses—including nsa@halomd.com, soundnsa@halomd.com, and soundfedidr@soundphysicians.com—which, upon information and belief, was an attempt to conceal the identity of the individuals submitting the false attestations. As parties to IDR have no ability to engage in discovery—in fact, the parties submit final offers and supporting evidence in a blind process without the right or ability to see the other party's submission—the submission of false attestations achieved the

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concealment of the corporate actors filing the false attestations.

330. The Sound Physicians Providers and HaloMD owed a duty of reasonable care to Anthem, under which they were required to conduct reasonable investigations, ensure the eligibility of the services for which they were initiating the IDR process, and guard against the submission of false attestations of eligibility leading IDREs to erroneously issue payment determinations in favor of the Sound Physicians Providers for items or services that were not eligible for the IDR process. The Sound Physicians Providers and HaloMD owed Anthem a duty of care to submit accurate information to Anthem, the IDREs, and the Departments when they sought payment or additional payment on the medical claims underlying the IDR disputes. Specifically, in making the false representations to Anthem, the IDREs, and the Departments, the Sound Physicians Providers and HaloMD were acting in the course of their business or profession and had a pecuniary interest in the underlying medical claims at issue. Moreover, the Sound Physicians Providers and HaloMD possessed superior knowledge of the facts underlying the services they (or their clients and co-conspirators in the case of HaloMD) provided.

331. The Sound Physicians Providers, or HaloMD on behalf of and in coordination with the Sound Physicians Providers, submitted these false attestations and did so with the intent that Anthem, the IDREs, and the Departments rely on them. Anthem was, in fact, compelled to rely on the false attestations because it was forced to proceed to a payment determination, despite the dispute's ineligibility.

332. Even if Anthem contested eligibility, the MPOWERHealth Defendants, the LaRoque Family Providers, and HaloMD knew and expected their deliberate misrepresentations would force Anthem to reasonably and foreseeably rely on the misrepresentations and proceed to a payment determination, despite the ineligibility of the dispute.

333. At all times when submitting the false attestations and engaging in the relevant IDR disputes, HaloMD was acting within the scope of HaloMD's agreements

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with the Sound Physicians Providers to handle the IDR process for the Sound Physicians Providers in connection with the identified disputes.

334. The Sound Physicians Providers, or HaloMD on behalf of and in coordination with the Sound Physicians Providers, also falsely represented to Anthem during the statutorily required open negotiations process that the disputes were eligible for IDR and involved qualified IDR items and services meeting the NSA and regulatory definitions of that term when, in fact, they did not.

335. Anthem reasonably, foreseeably, and justifiably relied on the Sound Physicians Providers' and HaloMD's misrepresentations during the open negotiations and IDR initiation process. As part of the fraudulent schemes described herein, Defendants' tactic was to flood the IDR process and overwhelm the system such that Anthem would be unable to investigate each and every aspect of the hundreds of disputes often submitted on the same day within the 30-day open negotiations window or within days after IDR initiation. Additionally, HaloMD and the Sound Physicians Providers are in some circumstances the only entities in possession of information critical to Anthem's ability to assess a claim for IDR eligibility, such as information pertaining to the provider, types of services rendered, and patient records. Thus, Sound Physicians Providers and HaloMD knew Anthem was often incapable of knowing the falsity of these misrepresentations. As a result, Anthem justifiably relied on the misrepresentations by the Sound Physicians Providers, or HaloMD on their behalf, that the disputes were eligible for IDR and incurred significant monetary losses through incurring administrative and IDRE fees required by the NSA and in the form of IDR payment determinations finding against Anthem.

336. The Sound Physicians Providers and HaloMD owed Anthem a duty of reasonable care to provide accurate information as to the claims and services they were seeking to negotiate in good faith, as they were acting in the course of their business or profession and had a pecuniary interest in the underlying medical claims at issue. Moreover, the Sound Physicians Providers and HaloMD possessed superior knowledge

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of the facts underlying the services they (or their clients and co-conspirators in the case of HaloMD) provided.

337. As a direct and proximate result of the Sound Physicians Providers' and HaloMD's misrepresentations, and Anthem's reasonable reliance on the same, Anthem and its affiliated health plans have suffered substantial damages in the form of payment on IDR payment determinations that were ineligible for resolution through the NSA's IDR process, along with payment of required administrative and IDRE fees.

338. Each member of the Sound Physicians Enterprise formed and operated in a conspiracy to defraud Anthem through these schemes, and each committed acts in furtherance thereof, resulting in the above-stated damages to Anthem.

COUNT IX

BUSINESS ACTS OR PRACTICES IN VIOLATION OF CAL. BUS. & PROF. CODE §§ 17200 et seq.

(Against All Members of the LaRoque Family Enterprise)

339. Anthem repeats and realleges the allegations in Paragraphs 1 through 248 contained in the Complaint as if fully set forth at length herein.

340. HaloMD, on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, engaged in unlawful, unfair, and fraudulent business acts or practices by misrepresenting information to Anthem, the IDREs, and the Departments throughout the NSA dispute resolution process, including by submitting the false attestations of eligibility regarding the disputes. From January 4, 2024, to August 2025, HaloMD, on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, submitted hundreds of ineligible disputes through the NSA dispute resolution process, including in the exemplar disputes identified above, in which they knowingly and willfully represented that the disputes were eligible through IDR when they knew they were not.

341. From the patient's insurance cards, Anthem's EOPs, the plain text of federal laws and regulations, CMS publications and resources, HaloMD's preparation

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of IDR initiation forms and notices, their participation in the IDR process, and the specific objections to eligibility that Anthem submitted to the LaRoque Family Providers and to HaloMD, among other sources, the MPOWERHealth Defendants, the LaRoque Family Providers, and HaloMD knew that the services and disputes they were initiating were ineligible for the IDR process.

342. HaloMD on behalf of and in coordination with the MPOWERHealth Defendants and the LaRoque Family Providers, submitted these false attestations with the intent that Anthem, the IDREs, and the Departments rely on them. Anthem was, in fact, compelled to rely on the false attestations because it was forced to proceed to a payment determination, despite the dispute's ineligibility.

343. The actions of the LaRoque Family Providers in coordination with the MPOWERHealth Defendants, and HaloMD on behalf of and coordination with the MPOWERHealth Defendants and the LaRoque Family Providers, violated the following statutes:

- California Penal Code § 550, which makes it unlawful to knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim; conspire to or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact; or conspire to prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact, among other things.

- The Federal Health Care Fraud Statute, as set forth in 18 U.S.C. § 1347, which prohibits individuals and entities from executing or attempting to execute a scheme to defraud a health care benefit program, whether or not it is a federal program.

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- The NSA, 29 U.S.C. § 1185e and 42 U.S.C. § 300gg-111, and its implementing regulations, 29 C.F.R. § 2590.716-8 and 45 C.F.R. § 149.510, including by submitting false attestations that items and services under dispute are qualified IDR items and services, initiating the IDR process for items and services that are not qualified IDR items and services, and procuring IDR determinations and payment for items and services that are not qualified IDR items and services, as alleged herein.

- RICO, 18 U.S.C. § 1962(c), (d), as alleged herein.

- California common law regarding fraudulent and/or negligent misrepresentations, as alleged herein.

344. In addition to being unlawful, the conduct of HaloMD on behalf of and in coordination with MPOWERHealth and the LaRoque Family Providers, described herein, is immoral, unethical, oppressive, and unscrupulous. Moreover, through the significant financial harm this conduct causes to Anthem and its affiliated plans, it also disrupts the insurance market and causes significant downstream harm to consumers through the increased cost of health care services.

345. As a result of these unlawful, unfair, and fraudulent practices, Anthem and its affiliated health plans have suffered substantial damages.

346. Each member of the LaRoque Family Enterprise formed and operated in a conspiracy to defraud Anthem through these schemes, and each committed acts in furtherance thereof, resulting in the above-stated damages to Anthem.

COUNT X

BUSINESS ACTS OR PRACTICES IN VIOLATION OF CAL. BUS. & PROF. CODE §§ 17200 et seq.

(Against All Members of the Sound Physicians Enterprise)

347. Anthem repeats and realleges the allegations in Paragraphs 1 through 251 contained in the Complaint as if fully set forth at length herein.

348. The Sound Physicians Providers, or HaloMD on behalf of and in coordination with the Sound Physicians Providers, engaged in unlawful, unfair, and

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fraudulent business acts or practices by misrepresenting information to Anthem, the IDREs, and the Departments throughout the NSA dispute resolution process, including by submitting the false attestations of eligibility regarding the disputes. From January 4, 2024, to August 2025, the Sound Physicians Providers, or HaloMD on behalf of and in coordination with the Sound Physicians Providers, submitted hundreds of ineligible disputes through the NSA dispute resolution process, including in the exemplar disputes identified above, in which they knowingly and willfully represented that the disputes were eligible through IDR when they knew they were not.

349. From the patient's insurance cards, Anthem's EOPs, the plain text of federal laws and regulations, CMS publications and resources, the Sound Physicians Providers' and HaloMD's preparation of IDR initiation forms and notices, their participation in the IDR process, and the specific objections to eligibility that Anthem submitted to the Sound Physicians Providers and to HaloMD, among other sources, the Sound Physicians Providers and HaloMD knew that the services and disputes they were initiating were ineligible for the IDR process.

350. The Sound Physicians Providers, or HaloMD on behalf of the Sound Physicians Providers, submitted these false attestations and did so with the intent that Anthem, the IDREs, and the Departments rely on them. Anthem was, in fact, compelled to rely on the false attestations because it was forced to proceed to a payment determination, despite the dispute's ineligibility.

351. The actions of the Sound Physicians Providers, and HaloMD on behalf of the Sound Physicians Providers, violated the following statutes:

- California Penal Code § 550, which makes it unlawful to knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim; conspire to or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact; or conspire to prepare or make any written or oral statement that is intended to be

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presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact, among other things.

- The Federal Health Care Fraud Statute, as set forth in 18 U.S.C. Section 1347, which prohibits individuals and entities from executing or attempting to execute a scheme to defraud a health care benefit program, whether or not it is a federal program.

- The NSA, 29 U.S.C. § 1185e and 42 U.S.C. § 300gg-111, and its implementing regulations, 29 C.F.R. § 2590.716-8 and 45 C.F.R. § 149.510, including by submitting false attestations that items and services under dispute are qualified IDR items and services, initiating the IDR process for items and services that are not qualified IDR items and services, and procuring IDR determinations and payment for items and services that are not qualified IDR items and services, as alleged herein.

- RICO, 18 U.S.C. § 1962(c), (d), as alleged herein.

- California common law regarding fraudulent and/or negligent misrepresentations, as alleged herein.

352. In addition to being unlawful, the conduct by Sound Physicians Providers and HaloMD, described herein, is immoral, unethical, oppressive, and unscrupulous. Moreover, through the significant financial harm this conduct causes to Anthem and its affiliated plans, it also disrupts the insurance market and causes significant downstream harm to consumers through the increased cost of health care services.

353. As a result of these unlawful, unfair, and fraudulent practices, Anthem and its affiliated health plans have suffered substantial damages.

354. Each member of the Sound Physicians Enterprise formed and operated in a conspiracy to defraud Anthem through these schemes, and each committed acts in furtherance thereof, resulting in the above-stated damages to Anthem.

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COUNT XI

VACATUR OF IDR DETERMINATIONS

(Brought in the Alternative Against all Defendants)

355. Anthem repeats and realleges the allegations in Paragraphs 1 through 248 contained in the Complaint as if fully set forth at length herein.

356. In the alternative to seeking relief on the aforementioned counts, Anthem seeks vacatur of individual IDR determinations under 42 U.S.C. § 300gg-111(c)(5)(E).

357. Each individual IDR determination at issue was procured by undue means and fraud, warranting vacatur pursuant to 42 U.S.C. § 300gg-111(c)(5)(E) and 9 U.S.C. § 10(a)(1).

358. For each individual IDR determination at issue, 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. This warrants vacatur pursuant to 42 U.S.C. § 300gg-111(c)(5)(E) and 9 U.S.C. § 10(a)(4).

359. The Provider Defendants, and HaloMD on their behalf, continue to obtain awards by undue means and fraud, and the IDREs continue to exceed 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. Thus, the list of IDR payment determinations subject to vacatur is expected to increase during the pendency of the case.

COUNT XII

ERISA CLAIM FOR EQUITABLE RELIEF

(Against All Defendants)

360. Anthem repeats and realleges the allegations in Paragraphs 1 through 248 contained in this Complaint as if fully set forth at length herein.

361. Anthem provides claims administration services for certain health benefit plans governed by ERISA. Those health benefit plans and their employer sponsors delegate to Anthem discretionary authority to recover overpayments, including those

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resulting from fraud, waste, or abuse. They also delegate the authority to Anthem to administer the IDR process for the plans, including the discretionary authority to perform other services incident or necessary to Anthem's administration of the IDR process.

362. ERISA authorizes a fiduciary of a health plan to bring a civil action to "enjoin any act or practice which violates any provision of this subchapter or the terms of the plan" or "to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3).

363. Section 1185e of ERISA sets out the rights and obligations of plans and medical providers with respect to the IDR process, including that the IDR process does not apply in situations where there is a specified state law, where the provider is a participating provider, and where the provider has not initiated or engaged in open negotiations. 29 U.S.C. § 1185e.

364. Through the acts described herein, Defendants have caused and continue to cause the overpayment of funds on behalf of ERISA-governed benefit plans through conduct that violates Section 1185e of ERISA.

365. Defendants are continuing to engage in such improper conduct, including but not limited to failing to properly initiate or engage in open negotiations prior to initiating the IDR process, initiating IDR for services subject to California's specified state law, initiating IDR with respect to claims that Anthem denied and thus are exempt from the IDR process, and failing to comply with other NSA requirements such as the IDR batching rules or the cooling off period. This conduct causes ongoing harm to Anthem and the ERISA-governed benefit plans.

366. There is an actual case and controversy between Anthem and Defendants relating to the claims fraudulently submitted and arbitrated as part of the NSA's IDR process.

367. Anthem seeks an order enjoining Defendants from:

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a. Initiating IDR without first properly initiating and engaging in open negotiations;

b. Initiating IDR for services subject to California's specified state laws;

c. Initiating IDR for services that Anthem denied and thus are not eligible for IDR; and

d. Initiating IDR for services when Defendants failed to comply with other NSA requirements such as the deadline to initiate IDR following open negotiations.

COUNT XIII

DECLARATORY AND INJUNCTIVE RELIEF

(Against All Defendants)

368. Anthem repeats and realleges the allegations in Paragraphs 1 through 248 contained in this Complaint as if fully set forth at length herein.

369. Anthem seeks a declaration that the Provider Defendants' and HaloMD's conduct of submitting false attestations and initiating IDR for unqualified IDR items or services, and each Defendant's conduct causing the same, is unlawful. Anthem additionally seeks a declaration that IDR determinations for such unqualified IDR items or services are not binding or subject to payment. It further seeks an injunction prohibiting the Provider Defendants and HaloMD from continuing to submit false attestations and initiate IDR for items or services that are not qualified for IDR, or from seeking to enforce non-binding IDR determinations entered on items and services not qualified for IDR.

370. With respect to health plans and claims governed by ERISA, this cause of action is alleged in the alternative to the previous cause of action, in the event that the Court determines that relief under Section 1132(a)(3) of ERISA is not available.

371. There is no adequate remedy at law to prevent the ongoing harm caused by Defendants' conduct.

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PRAYER FOR RELIEF

WHEREFORE, Anthem respectfully requests that the Court:

a. Award monetary damages to the full extent allowed by law, including, but not limited to, compensatory damages, punitive damages, and treble damages;

b. Relief from all improperly-obtained NSA IDR awards;

c. Declaratory relief in the form of an order finding that Defendants' conduct in submitting false attestations and initiating IDR for unqualified IDR items or services is unlawful;

d. Declaratory relief in the form of an order finding that IDR awards for such unqualified IDR items or services are not binding;

e. Injunctive relief prohibiting Defendants from continuing to submit false attestations and from continuing to initiate IDR for items or services that are not qualified for IDR, or from seeking to enforce non-binding awards entered on items and services not qualified for IDR;

f. Declare that IDR awards issued on unqualified IDR items or services are non-binding and are not payable on a go-forward basis; and

g. Award pre- and post-judgment interest;

h. Award costs, attorney's fees, and interest;

i. In the alternative, grant vacatur of the underlying IDR determinations; and

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

JURY DEMAND

Anthem demands a trial by jury on all issues so triable.

DATED: October 17, 2025

By: */s/ Jason T. Mayer*

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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

Anthem Blue Cross Life and Health Insurance Company, a California corporation; Blue Cross of California dba Anthem Blue Cross, a California corporation,

Plaintiffs,

v.

HaloMD, LLC; Alla Laroque; Bruin Neurophysiology, P.C.; iNeurology, P.C.; Los Angeles Neurological Associates, P.C.; N Express, P.C.; North American Neurological Associates, P.C.; Sound Physicians Emergency Medicine of Southern California, P.C.; and Sound Physicians Anesthesiology of California, P.C.,

Defendants.

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

~~[PROPOSED]~~ ORDER EXTENDING RESPONSE DEADLINES DUE TO FORTHCOMING AMENDED COMPLAINT

Judge: Hon. Karen E. Scott
Complaint Filed: July 7, 2025

This matter comes before the Court on the Stipulation to Modify Word Limits for Memoranda in Support of Motions to Dismiss the Amended Complaint (the "Stipulation") filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California d/b/a Blue Cross (together "Anthem"); Defendants HaloMD, LLC, and Alla LaRoque (together "HaloMD"); Bruin Neurophysiology, P.C., iNeurology, PC, Los Angeles Neurological Associates, PC; NExpress, PC, and North American Neurological Associates, PC (together "iNeuorology"); and Sound Physicians Emergency Medicine of Southern California, P.C. and Sound Physicians Anesthesiology of California, P.C. (together "Sound Physicians"). Having considered the Stipulation and good cause appearing therefore:

The Court GRANTS the Stipulation and ORDERS the following:

1. Defendants' October 10, 2025 deadline to respond to the Complaint is stayed.

2. Plaintiffs may amend the Complaint on or before October 17, 2025.

3. Once the Amended Complaint is filed, Defendants will have twenty-eight days to respond.

4. Plaintiffs will have at least thirty-five days to respond to any motions to dismiss.

Nothing herein shall be deemed to constitute a waiver of any rights, objections or defenses (including, but not limited to, jurisdictional defenses) that any party may have with respect to this action or to the claims asserted in any complaint, and is without prejudice to any other or further application by a party to this Court or any other court.

DATED: October 8, 2025

Karen E. Scott

Hon. Karen E. Scott
United States Magistrate Judge

MCDERMOTT WILL & SCHULTE LLP
TALA JAYADEVAN (SBN 288121)
tjayadevan@mwe.com
2049 Century Park East, Suite 3200
Los Angeles, CA 90067-3206
Telephone: (310) 277-4110
Facsimile: (310) 277-4730

LAURA MCLANE (appearing *pro hac vice*)
lmclane@mwe.com
MATTHEW KNOWLES (appearing *pro hac vice*)
mknowles@mwe.com
MEGAN CORRIGAN (appearing *pro hac vice*)
mcorrigan@mwe.com
200 Clarendon Street
Boston, MA 02116
Telephone: (617) 535-3885

Attorneys for Defendants Sound Physicians Emergency Medicine of Southern California, P.C. and Sound Physicians Anesthesiology of California, P.C.

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

Anthem Blue Cross Life and Health Insurance Company, a California corporation; Blue Cross of California dba Anthem Blue Cross, a California corporation,

Plaintiffs,

v.

HaloMD, LLC; Alla Laroque; Bruin Neurophysiology, P.C.; iNeurology, P.C.; Los Angeles Neurological Associates, P.C.; N Express, P.C.; North American Neurological Associates, P.C.; Sound Physicians Emergency Medicine of Southern California, P.C.; and Sound Physicians Anesthesiology of California, P.C.,

Defendants.

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

STIPULATION TO EXTEND OR STAY RESPONSE DEADLINES DUE TO FORTHCOMING AMENDED COMPLAINT

Filed concurrently herewith: Declaration of Tala Jayadevan; and [Proposed] Order.

Judge: Hon. Karen E. Scott
Complaint Filed: July 7, 2025

WHEREAS, Plaintiffs Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California d/b/a Blue Cross (collectively, "Plaintiffs") and Defendants HaloMD, LLC; Alla LaRoque; Bruin Neurophysiology, P.C.; iNeurology, PC; Los Angeles Neurological Associates, PC; NExpress, PC; North American Neurological Associates, PC; Sound Physicians Emergency Medicine of Southern California, P.C.; and Sound Physicians Anesthesiology of California, P.C. (collectively, "Defendants"), stipulate and consent to the relief sought, as indicated by the signatures of their respective counsel below;

WHEREAS, on July 7, 2025, Plaintiffs filed a 70-page Complaint ("Original Complaint") against ten Defendants, asserting eight counts (Docket No. 1);

WHEREAS, Plaintiffs intend to amend the Original Complaint, and will do so by October 17, 2025;

WHEREAS, Defendants consent to Plaintiffs amending the Original Complaint by October 17, 2025;

WHEREAS, for efficiency, the Parties agree that Defendants need not respond to the Original Complaint;

WHEREAS, Federal Rule of Civil Procedure 15(a)(3) allows fourteen days to respond to an amended pleading, but the Parties propose an enlargement of time to respond to the forthcoming Amended Complaint given the numerous legal theories in Plaintiffs' Original Complaint;

WHEREAS, the Parties agree once the Amended Complaint is filed, Defendants will have twenty-eight days to respond;

WHEREAS, the Parties agree that the Defendants will arrange a hearing date that affords Plaintiffs at least thirty-five days to respond to any motions to dismiss;

WHEREAS, the modification of deadlines proposed herein is not intended to delay the proceedings and will not prejudice any party;

NOW THEREFORE, IT IS HEREBY STIPULATED AND AGREED, by and between the Parties, that, subject to the Court's approval:

1. Defendants' October 10, 2025 deadline to respond to the Original Complaint is stayed, as Plaintiffs intend to amend the Complaint.

2. Plaintiffs may amend the Original Complaint on or before October 17, 2025.

3. Defendants will have twenty-eight days from the filing of the Amended Complaint to respond to the Complaint.

4. Plaintiffs will have at least thirty-five days to respond to any motions to dismiss.

I, Tala Jayadevan, attest that all other signatories below, and on whose behalf this filing is also submitted, concur in the filing's content and have authorized the filing.

Dated: October 7, 2025

MCDERMOTT WILL & SCHULTE LLP

By: */s/ Tala Jayadevan*
Tala Jayadevan
Laura McLane (appearing *pro hac vice*)
Matthew Knowles (appearing *pro hac vice* application)
Megan Corrigan (appearing *pro hac vice*)

Attorneys for Defendants Sound Physicians Emergency Medicine of Southern California, P.C. and Sound Physicians Anesthesiology of California, P.C.

Dated: October 7, 2025

POLSINELLI LLP

By: */s/ Gregory Jones*
Gregory Jones
Noel Scott Cohen

Attorneys for Defendant HaloMD LLC and Alla LaRoque

Dated: October 7, 2025

JONES DAY

By: */s/ James Poth*
James Poth

Attorneys for Defendants Bruin Neurophysiology, P.C., iNeurology, PC, Los Angeles Neurological Associates, PC, NExpress, PC, and North American Neurological Associates, PC

Dated: October 7, 2025

CROWELL & MORING LLP

By: */s/ Jason Mayer*
Amir Shlesinger
Alexander M. Lucas (appearing *pro hac vice*)
Jason Theodore Mayer (*appearing pro hac vice*)
Martin J. Bishop (appearing *pro hac vice*)

Counsel for Plaintiffs Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California d/b/a Anthem Blue Cross

NAME, ADDRESS & TELEPHONE NUMBER OF ATTORNEY(S) OR PRO PER
Gregory R. Jones (#229858)
Polsinelli LLP
2049 Century Park East, Suite 2900
Los Angeles, California 90067
(310) 556-1801

ATTORNEY(S) FOR: HaloMD, L.L.C. and Alla LaRoque

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Anthem Blue Cross Life & Health Insurance Company, et al., Plaintiff(s) v. HaloMD, LLC, et al. Defendant(s).	CASE NUMBER: 8:25-cv-01467 **STATEMENT OF CONSENT TO PROCEED BEFORE A UNITED STATES MAGISTRATE JUDGE (For use in Direct Assignment of Civil Cases to Magistrate Judges Program Only)**

(THIS FORM SHALL BE USED ONLY FOR CASES IN WHICH A MAGISTRATE JUDGE IS INITIALLY ASSIGNED PURSUANT TO LOCAL RULE 73-2.)

In accordance with General Order 12-02 and Local Rule 73-2 the above-captioned civil matter has been randomly assigned to Magistrate Judge Karen E. Scott . All parties to the above-captioned civil matter are to select one of the following two options and file this document with the Clerk's Office.

☒ The party or parties listed below to the above-captioned civil matter **consent** pursuant to the provisions of 28 U.S.C. § 636(C) and F.R.Civ.P. 73(b), to have the assigned Magistrate Judge conduct all further proceedings in this case, including trial and entry of final judgment.

Any appeal from a judgment of the assigned Magistrate Judge shall be taken to the United States Court of Appeals in the same manner as an appeal from any other judgment of the District Court in accordance with 28 U.S.C. § 636(c)(3).

☐ The party or parties listed below to the above-captioned civil matter **do not consent** to proceed before the assigned Magistrate Judge.

The party or parties listed below acknowledge that they are free to withhold consent without adverse substantive consequences.

Name of Counsel (**OR** Party if Pro Per)	Signature and date	Counsel for (Name of Party or Parties)
Gregory R. Jones	/s/ Gregory R. Jones, August 18, 2025	HaloMD, L.L.C.
Gregory R. Jones	/s/ Gregory R. Jones, August 18, 2025	Alla LaRoque

NOTICE TO COUNSEL FROM CLERK:

All parties having consented to proceed before the assigned Magistrate Judge, this case will remain assigned to United States Magistrate Judge Karen E. Scott for all further proceedings.

Amir Shlesinger (SBN 20413)
ashlesinger@reedsmith.com
REED SMITH LLP
515 South Flower Street
Suite 4300
Los Angeles, CA 90071-1514
Telephone: +1 213 457 8000
Facsimile: +1 213 457 8080

Mark E. Bini (*pro hac vice* forthcoming)
New York Bar No. 3995156
Reed Smith LLP
599 Lexington Avenue
New York, NY 10022
Tel: 212.521.5400
mbini@reedsmith.com

Martin J. Bishop (*pro hac vice* forthcoming)
Illinois Bar No. 6269425
Alexandra M. Lucas (*pro hac vice* forthcoming)
Illinois Bar No. 6313385
Jason T. Mayer (*pro hac vice* forthcoming)
Illinois Bar No. 6309633
Reed Smith LLP
10 S. Wacker Dr. Suite 4000
Chicago, IL 60606
Tel: 312.207.1000
mbishop@reedsmith.com
alucas@reedsmith.com
jmayer@reedsmith.com

Attorneys for Plaintiffs

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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA, SOUTHERN DIVISION

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

Plaintiff,

vs.

HALOMD, LLC; ALLA LAROQUE; BRUIN NEUROPHYSIOLOGY, P.C.; iNEUROLOGY, PC; LOS ANGELES NEUROLOGICAL ASSOCIATES, PC; N EXPRESS, PC; NORTH AMERICAN NEUROLOGICAL ASSOCIATES, PC; SOUND PHYSICIANS EMERGENCY MEDICINE OF SOUTHERN CALIFORNIA, P.C.; and SOUND PHYSICIANS ANESTHESIOLOGY OF CALIFORNIA, P.C.,

Defendants.

No.: 25-cv-1467

COMPLAINT AND DEMAND FOR JURY TRIAL

VIOLATION OF RICO, 18 U.S.C. § 1962(c); VIOLATION OF RICO, 18 U.S.C. § 1962(d); FRAUDULENT MISREPRESENTATION; NEGLIGENT MISREPRESENTATION; BUSINESS ACTS OR PRACTICES IN VIOLATION OF CAL. BUS. & PROF. CODE § 17200, *ET SEQ.;* VACATUR OF NSA ARBITRATION AWARDS; ERISA CLAIM FOR EQUITABLE RELIEF; DECLARATORY AND INJUNCTIVE RELIEF

Plaintiffs Anthem Blue Cross Life and Health Insurance Company ("**ABCLH**") and Blue Cross of California d/b/a Anthem Blue Cross ("**ABC**") (collectively, "**Anthem**") submit this Complaint against the following groups of defendants: (1) HaloMD, LLC ("**HaloMD**") and Alla LaRoque (collectively, the "**HaloMD Defendants**"); (2) Bruin Neurophysiology, P.C., iNeurology, PC, Los Angeles Neurological Associates, PC, N Express, PC, and North American Neurological Associates, PC (collectively, the "**LaRoque Family Providers**"); and (3) Sound Physicians Emergency Medicine of Southern California, P.C. and Sound Physicians Anesthesiology of California, P.C. (collectively, the "**Sound Providers**"). The LaRoque Family Providers and the Sound Providers are collectively referred to herein as the "**Provider Defendants**" and together with the HaloMD Defendants, the "**Defendants**."

INTRODUCTION

1. Anthem brings this action for damages and to enjoin coordinated efforts by two enterprises that have systematically exploited the federal No Surprises Act's ("**NSA**") independent dispute resolution ("**IDR**") process to fraudulently extract millions of dollars from Anthem and the health plans it insures or administers.

2. Although the two enterprises are separate, their scheme to exploit the IDR system follows the same pattern: they (1) use interstate wires to knowingly submit false and fraudulent attestations of eligibility for services and disputes that they know are plainly ineligible for the IDR process, (2) strategically initiate massive volumes of IDR disputes simultaneously against Anthem, and (3) improperly inflate payment offers that far exceed what the Provider Defendants could have received from patients or health plans in a competitive market—and in many cases, multiples above the Provider Defendants' *billed charges*.

3. The first group of defendants, members of the "**LaRoque Family Enterprise**," consist of a web of interrelated companies directly or indirectly owned by Defendant Alla LaRoque and her husband, Scott LaRoque. Alla LaRoque is the founder

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and President of HaloMD, the platform that the LaRoque Family Enterprise participants use to systematically and knowingly flood the IDR process with ineligible and inflated disputes. The LaRoque Family Providers—whose services form the basis of these ineligible disputes—are connected to MPOWERHealth; Defendant Alla LaRoque sits on MPOWERHealth's board, and her husband, Scott LaRoque, is MPOWERHealth's founder and CEO.[1]

4. The second group of defendants, referred to here as the "**Sound Physicians Enterprise**," consist of entities affiliated with Sound Physicians, a national hospitalist staffing company with a documented history of overbilling federal healthcare programs. Sound Physicians previously settled with the U.S. Department of Justice to resolve allegations under the False Claims Act that the providers systematically inflated the level of services billed to government payors. Despite that prior enforcement action, the Sound Physicians Enterprise has adopted a new—but strikingly similar—scheme to defraud, this time by abusing the NSA's IDR process. Rather than submitting legitimate out-of-network claims for eligible services, the Sound Providers, acting through and in concert with the HaloMD Defendants, have flooded the IDR system with knowingly ineligible and inflated disputes.[2]

5. Together, the LaRoque Family and Sound Physicians Enterprises have corrupted the IDR process for financial gain. Since no later than January 2024, Defendants have initiated thousands of ineligible disputes against Anthem. Approximately ***55%*** of disputes on which Defendants received an IDR payment

[1] As alleged in this Complaint, the HaloMD Defendants and the LaRoque Family Providers knowingly and intentionally acted in concert and conspired with others who are not currently named as Defendants; namely, Scott LaRoque and MPOWERHealth, as well as other persons and entities known and unknown, being persons employed by and associated with the LaRoque Family Enterprise, to conduct and participate, directly and indirectly, in the conduct of the enterprise's affairs, including the wrongful acts of wire fraud alleged herein.

[2] In addition, the HaloMD Defendants and the Sound Providers knowingly and intentionally acted in concert and conspired with others who are not currently named as Defendants; namely, Sound Physicians, as well as other persons and entities known and unknown, being persons employed by and associated with the Sound Physicians Enterprise, to conduct and participate, directly and indirectly, in the conduct of the enterprise's affairs, including the wrongful acts of wire fraud alleged herein.

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determination against Anthem were clearly ineligible for the process. Defendants knew that these disputes were ineligible and had to deliberately lie to bypass the IDR safeguards, including by selecting false dates and uploading fictitious supporting documentation. Defendants illicitly secured several millions of dollars in improper IDR awards from these ineligible disputes, hundreds of thousands of dollars of which the Provider Defendants improperly recovered after fraudulently inflating their payment offers far above their billed charges.

6. But Defendants' fraud did not stop at ineligible disputes. Even on the eligible IDR disputes, Defendants deliberately exploited the IDR system to extract more than what the Provider Defendants billed Anthem. Defendants actually sought and received payments for services from Anthem that were more than one million dollars greater than the Provider Defendants' inflated, non-market-based billed charges, let alone the actual cost or market value of their services.

7. Defendants are guilty of violating the federal Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1961 *et seq.*, as well as other federal and state laws. Anthem brings this lawsuit to end Defendants' ongoing criminal enterprises and recover resulting damages.

THE PARTIES

I. Plaintiffs

8. Plaintiff ABC is a health care service plan licensed by the California Department of Managed Health Care and governed by the requirements of the Knox-Keene Health Care Service Plan Act of 1975, Cal. Health & Safety Code §§ 1340, *et seq.* Its principal place of business is in Woodland Hills, California.

9. Plaintiff ABCLH is an insurance company regulated by the California Department of Insurance. Its principal place of business is in Woodland Hills, California.

II. HaloMD Defendants

10. Defendant HaloMD is a Delaware limited liability company with a business address at 5080 Spectrum Drive, Suite 1100E, in Addison, Texas.

11. Defendant Alla LaRoque is the founder and President of HaloMD. She is a resident of Texas.

III. LaRoque Family Provider Defendants

12. Defendant Bruin Neurophysiology, P.C. ("**Bruin**") is a California professional corporation that provides intraoperative neuromonitoring ("**IONM**") services, including for California residents. Bruin is has its principal place of business at 5080 Spectrum Drive, Suite 1100E, Addison, Texas, with a mailing address at 100 Front Street, Suite 280, in Conshohocken, Pennsylvania.

13. Defendant iNeurology, PC ("**iNeurology**") is a California professional corporation that provides IONM services, including for California residents. iNeurology principal place of business is located at 218 Foothills Road, Beverly Hills, California 90210.

14. Defendant Los Angeles Neurological Associates, PC ("**LANA**") is a California professional corporation that provides IONM services, including for California residents. LANA is located at 7320 Woodlake Avenue, Suite 215, in West Hills, California.

15. Defendant N Express, PC ("**N Express**") is a California professional corporation that provides IONM services, including for California residents. N Express principal place of business is located at 1213 Walnut Avenue, Manhattan Beach, California 90266.

16. Defendant North American Neurological Associates, PC ("**NANA**") is a California professional corporation that provides IONM services, including for California residents. NANA is located at 701 Palomar Airport Road, Suite 300, in Carlsbad, California.

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IV. Sound Provider Defendants

17. Defendant Sound Physicians Anesthesiology of California, P.C. ("**SPAC**") is a California professional corporation with its principal place of business at 120 Brentwood Commons Way, Suite 510, in Brentwood, Tennessee. SPAC is located at 4002 Vista Way in Oceanside, California.

18. Defendant Sound Physicians Emergency Medicine of Southern California, P.C. ("**SPEMSC**") is a California professional corporation with its principal place of business at 120 Brentwood Commons Way, Suite 510, in Brentwood, Tennessee. SPEMSC is located at 2615 Chester Avenue in Bakersfield, California.

JURISDICTION AND VENUE

19. This Court has subject matter jurisdiction pursuant to 18 U.S.C. § 1964, which gives federal district courts jurisdiction over civil RICO actions. This Court also has subject-matter jurisdiction pursuant to 28 U.S.C. § 1331, as this action arises under federal law, including the NSA, 42 U.S.C. § 300gg-111, and the Employee Retirement Income Security Act of 1974 ("**ERISA**"), 29 U.S.C. § 1001 et seq. The Court has supplemental jurisdiction over state law claims pursuant to 28 U.S.C. § 1367.

20. Venue is proper in this District under 28 U.S.C. § 1391 because: (i) a substantial part of the events or omissions giving rise to the claims set forth herein occurred in, and were directed toward, this District; (ii) Anthem is headquartered in this District and has suffered injury here; and (iii) one or more of the Defendants reside here.

BACKGROUND

I. Anthem Administers Health Care Claims and IDR Proceedings for Members, Plan Sponsors, Government Programs, and BlueCard Plans.

21. Anthem offers a broad range of health care and related plans and insurance contracts and services to its plan sponsors and its members and insureds who enroll in an Anthem plan, including fully insured and self-funded employee health benefit plans. Anthem processes tens of millions of health care claims annually and is responsible for ensuring that claims are paid accurately and in accordance with plan terms. As a critical

part of that responsibility, Anthem is authorized to undertake efforts to safeguard and protect themselves, their members and insureds, and the various employer group health plans they administer from fraud, waste, and abuse—like the fraud and misrepresentations Defendants perpetrated here.

22. Anthem administers claims and benefits for several different types of health care plans relevant to this Complaint. First, Anthem issues and administers health plans and insurance contracts, where Anthem collects premiums and is financially responsible for any benefits paid out under the plan terms or pursuant to law. Anthem sells these products either directly to consumers, such as through the federal Health Care Exchange, or to small or large employer groups who offer coverage to their employees but do not themselves insure the loss under the plan. These products are typically subject to state regulation, such as state laws prohibiting surprise billing and mandating payment for certain out-of-network claims.

23. Second, Anthem administers self-funded plans, typically offered by large employers to their employees. These employers self-insure the plan and are financially responsible for any payment of benefits or other losses. Because employers often lack infrastructure to provide health insurance to their consumers, these plans contract with Anthem to receive administrative services, such as provider network development, customer service, and claims pricing and adjudication. These plans often delegate authority to Anthem to administer the IDR process on behalf of the plans, and the plans typically (though not always) reimburse Anthem for any awards resulting from IDR. These plans are generally exempt from state insurance laws, including state surprise billing regulation. Instead, the plans are subject to ERISA.

24. Third, Anthem administers government program claims, such as through the Medicare Advantage program or Medicaid managed care. Government program claims are exempt from NSA requirements and ineligible for IDR.

25. Fourth, pursuant to the BlueCard program, Anthem acts as a "Host Plan" to other independent Blue Cross and/or Blue Shield "Home Plans" whose members

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obtain treatment from providers in Anthem's service area in California. As a Host Plan, Anthem manages and participates in IDR proceedings that are initiated by providers in Anthem's California service area for non-Anthem plans whose members received treatment from the initiating California provider.

26. While Anthem administers different types of health plans and claims, providers generally know what type of health care coverage the patient has. Providers require proof of insurance at the point of service to submit claims to the health plan, and the member's health insurance card identifies the nature of the member's coverage. Anthem will also issue an explanation of benefits ("**EOB**") to the provider that may provide coverage information for the member, among other information.

II. Before the NSA, Out-of-Network Physicians Exploited American Consumers with Surprise Medical Bills.

27. Health plans like Anthem contract with a network of health care providers, including hospitals and physicians, from whom their members may obtain "in-network" care. Generally, patients receive better and more affordable health care coverage when receiving treatment from these in-network providers, since they have a contract with their health plan that governs the rate for the relevant services and that prohibits the providers from billing patients above that amount. Patients can choose to obtain treatment from out-of-network providers, which have no contract with their health plan, but typically, the care from out-of-network providers is more expensive.

28. In some situations—such as in case of a medical emergency, receiving physician services in the course of treatment at an in-network hospital, or utilizing air ambulance transport—patients have limited ability to select an in-network provider. Before the passage of the NSA in 2022, certain out-of-network providers like the Provider Defendants—especially IONM providers, emergency medicine providers, air ambulance providers, critical care providers, pathology providers, anesthesiology providers, and radiology providers—capitalized on patients' lack of meaningful choice in these situations.

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29. Prior to the enactment of the NSA, these types of out-of-network providers widely engaged in the aggressive and financially devastating practice of "surprise billing." Specifically, the providers would exploit patients' lack of choice in selecting an in-network provider and bill the patient for the difference between their "inflated," "non-market-based rates"—known as "billed charges"—and the amounts paid by health plans. H.R. Rep. No. 116-615 (2020), at 53, 57.

30. Surprise billing was particularly rampant among IONM, emergency, and anesthesiology providers like the Provider Defendants. Surprise billing providers like the Provider Defendants held "substantial market power" and "face[d] highly inelastic demands for their services because patients lack the ability to meaningfully choose or refuse care." Thus, surprise billing providers like the Provider Defendants could "charge amounts for their services that … result[ ] in compensation far above what is needed to sustain their practice." *Id.* at 53. Because surprise billing providers like the Provider Defendants could reap massive profits by issuing surprise medical bills to patients, they had little incentive to contract with health plans like Anthem and offer more affordable health care services to American consumers.

31. Congress labeled this a "market failure" that was having "devastating financial impacts on Americans and their ability to afford needed health care." *Id.* at 52. In an attempt to resolve these problems, Congress enacted the NSA.

III. The No Surprises Act Creates an IDR Process for Specific Qualified IDR Items and Services.

32. 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. To be subject to the NSA and IDR, health care services must fall into one of these three categories and meet other statutory and regulatory requirements described below.

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33. When enacting the NSA, Congress also found "that any surprise billing solution must comprehensively protect consumers by 'taking the consumer out of the middle' of surprise billing disputes." H.R. Rep. No. 116-615, at 55. Thus, the 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 binding payment determination from private parties called certified IDR entities ("**IDREs**").

34. When a health plan receives a claim for out-of-network services subject to the NSA (*i.e.*, emergency services, services provided at an in-network facility, or air ambulance services), the health plan will 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). The health plan's EOB includes, among other information, a phone number and email address for providers to seek further information or initiate open negotiations. *See* 45 C.F.R. § 149.140(d)(2).

35. 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). 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. *See id.*

36. 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). The IDR process is only available to providers who first initiate and exhaust open negotiations with the health plan. *See*

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id. Providers must initiate the IDR process within four business days after the open negotiations period has been exhausted. *See id.*

37. The 30-day open negotiations period is a central requirement of the IDR process. Indeed, Congress explained that one of the primary purposes of the NSA was to ensure that health care providers, including hospitals and doctors, and payors, including insurance companies and self-funded plans, are incentivized to resolve their differences amongst themselves. *See* Brady Opening Statement at Full Committee Markup of Health Legislation (Feb. 12, 2020), available at https://waysandmeans.house.gov/2020/02/12/brady-opening-statement-at-full-committee-markup-of-health-legislation-3/.

38. Further, the IDR process is also only available for a "qualified IDR item or service" eligible for the process. 42 U.S.C. § 300gg-111(c)(1); 45 C.F.R. § 149.510(a)(2)(xi), (b)(1), (b)(2). To be considered a qualified IDR item or service within the scope of the IDR process, 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, and also of a coverage type subject to the NSA (*e.g.*, not government programs like Medicare or Medicaid);
b. A state surprise billing law (referred to as a "specified state law" in the NSA) does not apply to the dispute;
c. The underlying services were covered by the patient's health benefit plan (*i.e.*, payment was not denied);
d. The patient did not waive the NSA's balance billing protections;
e. The provider initiated and exhausted open negotiations;
f. The provider initiated the IDR process within 4 business days after the open negotiations period was exhausted; and

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

42 U.S.C. § 300gg-111(c)(1)(B); 45 C.F.R. § 149.510(a)(2)(xi), (b)(2).

39. Relevant to state surprise billing laws, which impact eligibility for IDR, the NSA defines a specified state law as "a State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively … in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility." 42 U.S.C. § 300gg-111(a)(3)(I); 45 C.F.R. § 149.30 (same).

40. The Centers for Medicare & Medicaid Services ("**CMS**"), the federal agency within the Department of Health and Human Services ("**HHS**") that is primarily charged with implementing the IDR process, has issued several resources to aid interested parties in determining whether a state surprise billing law exists. *See*, *e.g.*, CAA Enforcement Letters, available at https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/consolidated-appropriations-act-2021-caa; Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process (Jan. 13, 2023), available at https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf.

41. California has two specified state laws (collectively referred to herein as "**California's Surprise Billings Laws**"). First, the Knox-Keene Act (California Health and Safety Code Section 1371.4 and its implementing regulations-California Code of Regulations Title 28, Section 1300.71), as applied through case law, is a specified state law that concerns emergency services. Case law and the Knox-Keene Act require reimbursement for out-of-network emergency services at the reasonable and customary value, based on statistically credible information taking into consideration (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the

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services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case. This specified state law applies to Plaintiff ABC. Second, AB 72, codified at California Health and Safety Code sections 1371.30 and 1371.31, applies to non-emergency services by non-participating providers in participating facilities and (1) requires payment of the greater of the payor's average contracted rate or 125% of Medicare rates, and (2) provides for an independent dispute resolution process to resolve any payment disputes regarding such services. *See also* California CAA Enforcement Letter (Dec. 22, 2021), available at https://www.cms.gov/files/document/cms-letter-ca-caa-enforcement-and-dispute-resolution.pdf. This specified state law applies to both Plaintiffs.

42. Finally, the NSA imposes certain other requirements for services submitted to IDR in addition to the fact they are qualified IDR items or services. For example, when a party submits multiple separate services to different patients in a single dispute, they must comply with the NSA's "batching rules." These batching rules require that the services be rendered to members of the same insurer or self-funded health plan during a 30-business-day period by the same provider and for treatment of the same or similar medical condition. *See* 42 U.S.C. § 300gg-111(c)(3)(A). Further, parties are prohibited from initiating IDR disputes involving the same parties and items or services during a 90-day period following an IDR determination, also known as the "cooling off period." *See id*. at § 300gg-111(c)(5)(E)(ii).

43. 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. *See* 45 C.F.R. § 149.510(b)(2)(iii)(A)(6); *see also* Notice of IDR Initiation Form, U.S. Dep't of Labor, available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/

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notice-of-idr-initiation.pdf. A copy of the IDR initiation form, including the attestation, is provided to the non-initiating party, the IDRE, and the Departments.[3]

IV. The IDR Initiation Process Notifies Parties of Ineligible Disputes.

44. Parties must initiate the IDR process online through a federal "IDR Portal." The website for submissions is https://nsa-idr.cms.gov/paymentdisputes/s/.

45. The online process for initiating IDR is designed to notify initiating parties of facts that render services and disputes ineligible and prevent parties from inadvertently submitting ineligible items or services.

46. The first page of the website specifies that parties may "[u]se this form if you participated in an open negotiation period that has expired without agreement for an out-of-network total payment amount for the qualified IDR item or service."

> Use this form if you participated in an open negotiation period that has expired without an agreement for an out-of-network total payment amount for the qualified IDR item or service.
>
> You can start the Federal Independent Dispute Resolution (IDR) process within 4 business days after the end of the 30-business-day open negotiation period if a determination of the total payment for the qualified IDR item(s) or service(s), including cost-sharing, wasn't reached.
>
> You will need to **provide information for both parties involved** in the dispute.

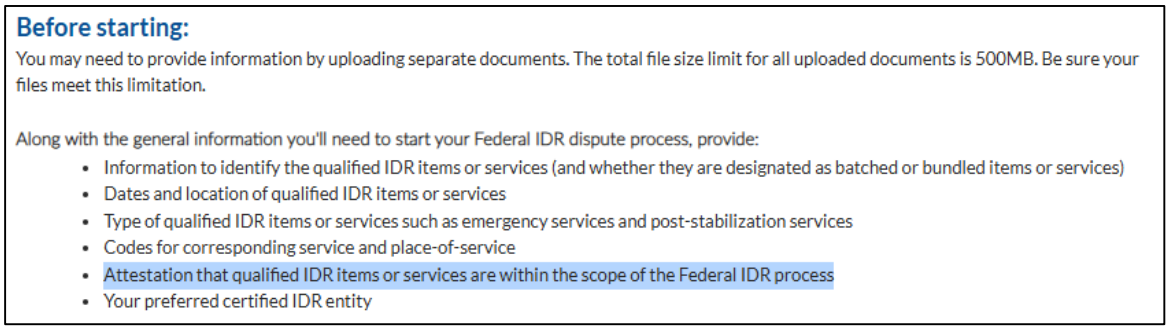
47. The first page also provides a link to a list of states with specified state laws that render certain disputes ineligible for the IDR process:

> Review the IDR State list to determine which states will have processes that apply to payment determinations for the items, services, and parties involved. FEHB plans are subject to the Federal IDR process unless OPM contracts with FEHB carriers to include terms that adopt state law as governing for this purpose.

48. Before initiating the IDR process, parties must agree to certain terms and conditions. The terms and conditions include a notice that the initiating party must submit an "[a]ttestation that qualified IDR items or services are within the scope of the Federal IDR process."

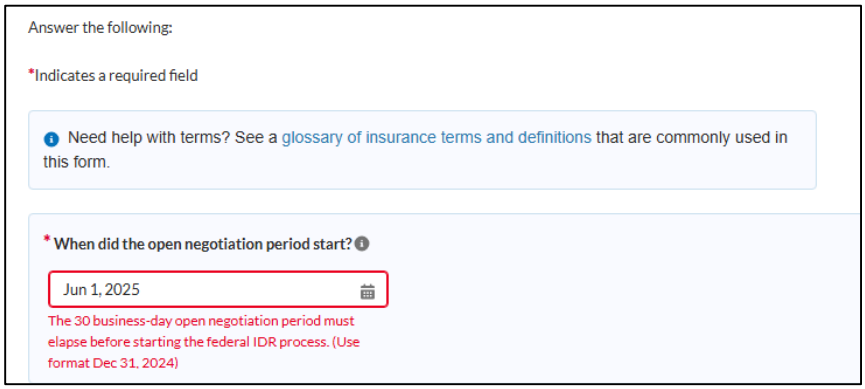
[3] The "Departments" include HHS, the Department of Labor, and the Department of the Treasury.

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49. After agreeing to the terms and conditions, initiating parties must answer certain "Qualification Questions" through an online form. If the answers to the Qualifications Questions indicate that the dispute is not eligible for IDR, the form will provide an alert and prevent the initiating party from proceeding.

50. For example, one of the key Qualification Questions on the federal IDR website asks when the party began the open negotiation process. That question as it appears on the website is below:

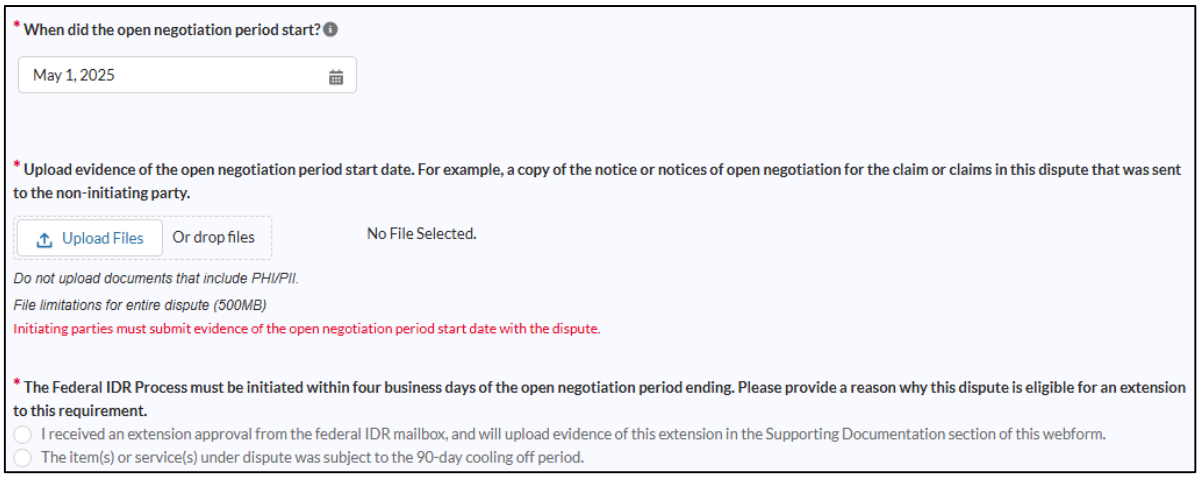


51. Parties must exhaust a 30-business-day open negotiation period before either party may initiate the federal IDR process. If the initiating party enters a date that is not at least 31 days before the date of website submission, the federal IDR website will not permit the initiating party to proceed and seek payment for the service.

52. The initiating party must also upload proof of open negotiation. To push an ineligible dispute past this step, the initiating party must upload a fictitious document to support a fabricated open negotiation start date.

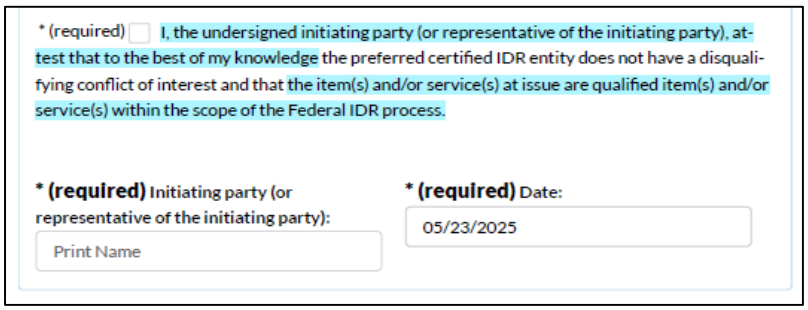
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53. Further, if the IDR initiation is not within four business days of the end of the 30-day open negotiation period, the initiating party must provide a reason why they are eligible for an extension and provide supporting documentation.



54. After successfully completing the Qualification Questions, the initiating party is asked to complete the Notice of IDR Initiation. The initiating party must provide a variety of relevant information, including the name and contact information of the health care provider, the claim number, the date of the service, the Qualifying Payment Amount ("**QPA**")—generally their median in-network rate for the same service in the same geographic area—for the qualified IDR item or services at issue, and documentation supporting these facts.

55. At the end of this process, the submitting 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."



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56. A copy of the Notice of IDR Initiation—including the initiating party's attestation that 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"—is provided to the non-initiating party (*i.e.*, the health plan), the IDRE, and the Departments.

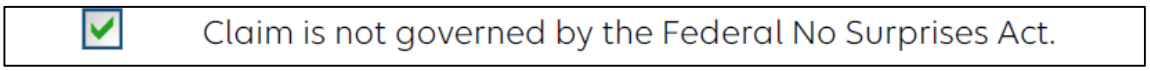
57. As illustrated above, at every stage of this online process, the initiating party must make false statements to submit a dispute for services that are not eligible for IDR, or the initiation process cannot continue. As such, when a party initiates the IDR process, it has full knowledge of the requirements and limits of the IDR process.

58. HHS administers the IDR initiation process. Any submission made through this system is a statement made to the federal government, and any attestation made as part of the submission process is also made to the federal government. False attestations to the federal government violate 18 U.S.C. § 1001.

V. Anthem Also Informs Providers of Ineligible Disputes, including Those Subject to California's Surprise Billing Laws.

59. In addition to the Qualifications Questions and IDR initiation process, Anthem sends multiple communications informing providers when services are ineligible for the IDR process.

60. For example, when providers initiate negotiations for items and services subject to California's Surprise Billing Laws, Anthem notifies the provider that the "***[c]laim is not governed by the Federal No Surprises Act***."



61. And even when providers ignore Anthem's negotiations communications for items and services subject to California's Surprise Billing Laws, Anthem informs the provider or designee that the items or services are "***ineligible for IDR under the NSA because a state surprise billing law applies***."

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> The Independent Dispute Resolution (IDR) Team has received an IDR initiation notice for the above DISP Number. After review, the claim(s) is/are out of the scope (OOS) of the Federal No Surprises Act (NSA), due to the following reason(s). Please refer to the addendum for more information.
>
> ☑ The claim(s) is ineligible for IDR under the NSA because a state surprise billing law applies. Per CMS guidelines, where a specified state law provides a method for determining the total amount payable for out-of-network items and services, providers may not engage in the federal IDR process for resolving payment disputes under the NSA.

62. Like the Qualifications Questions and IDR initiation process, Anthem's communications of ineligibility during open negotiations and after IDR initiation ensure that providers do not mistakenly pursue the IDR process for non-qualified items or services that are outside the scope of the process.

VI. If Applicable, IDREs Make Payment Determinations Subject to Judicial Review When Procured by Fraud

63. After the provider initiates the IDR process, the parties select, or HHS appoints, an IDRE. 42 U.S.C. § 300gg-111(c)(4)(F). The IDRE performs two tasks.

64. *First*, the IDRE is required by regulation to "determine whether the Federal IDR process applies." 45 C.F.R. § 149.510(c)(1)(v). In making the determination that the IDR process applies, the IDRE is directed to "review the information submitted in the notice of IDR initiation" with the provider's attestation of eligibility. 45 C.F.R. § 149.510(c)(1)(v). In practice, this is a cursory review by the IDRE based on incomplete information and rife with errors due to an overwhelmed system from the high volume of disputes.

65. *Second*, if the IDRE determines the IDR process applies, then the IDRE proceeds to a payment determination. 42 U.S.C. § 300gg-111(c)(5)(A).

66. IDR payment determinations resemble a baseball-style arbitration 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).

67. In making its determination, the IDRE must consider the QPA—which, through a detailed calculation methodology prescribed by federal regulation, approximates the health plan's median in-network contracting rate for the services—

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and several "additional circumstances," such as training, experience, and quality of the provider, its market share, and the acuity of the patient, among others. 42 U.S.C. § 300gg-111(c)(5)(C). IDREs cannot consider, among other things, the provider's charges. 42 U.S.C. § 300gg-111(c)(5)(D) (IDREs "shall not consider … the amount that would have been billed by such provider or facility …"). Congress reasoned that permitting IDREs to "consider non-market-based rates such as the providers' billed charges … may drive up consumer costs." H.R. Rep. No. 116-615, at 57.

68. The NSA provides that IDR determinations are "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).

69. Parties to IDR proceedings are responsible for payment of two fees. First, both parties must pay a non-refundable administrative fee of $115 when the dispute is initiated (previously a $50 fee). This fee is be recoverable even when the IDRE determines that the dispute is not qualified for IDR, or even when the initiating party 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. The party whose offer is selected by the IDRE is refunded its IDRE fee, meaning it is only responsible for the $115 administrative fee. The non-prevailing party is responsible for both the administrative fee and the IDRE fee.

70. Notably, IDREs are only compensated when a dispute reaches a payment determination. *See* 42 U.S.C. § 300gg-111(c)(5)(F). They do not receive compensation when dismissing a dispute due to the ineligibility of the service. *See id.* And because IDREs are compensated on a per-dispute basis, they receive greater compensation when there are a greater total number of disputes.

71. The NSA permits judicial review "in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9" of the Federal Arbitration Act ("**FAA**"). 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). This includes the following:

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a. where the award was procured by corruption, fraud, or undue means;

b. where there was evident partiality or corruption in the arbitrators, or either of them;

c. 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

d. 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).

DEFENDANTS' FRAUDULENT BILLING SCHEMES

72. With the passage of the NSA, surprise billing providers could no longer exploit American consumers through surprise medical bills. But as detailed further below, through two similar but distinct RICO enterprises—the LaRoque Family Enterprise and the Sound Physicians Enterprise—Defendants found a new target to exploit for massive profits: the NSA's IDR process, and by extension, health plans like Anthem.

73. Beginning no later than January 2024, Defendants commenced coordinated schemes to exploit the IDR process and fraudulently submit thousands of ineligible and inflated disputes to Anthem, misrepresenting their eligibility for IDR under the NSA. These disputes were not merely erroneous; they were fraudulent.

74. The core of the criminal enterprises relies on a basic lie: that the submitted disputes met the criteria for the federal IDR process. But they did not. Approximately ***55%*** of the disputes submitted by Defendants—comprising thousands of disputes—were categorically ineligible for the IDR process. As a result of these ineligible disputes,

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Defendants have fraudulently secured improper IDR payments totaling several millions of dollars.

75. As explained above, IDR is only available for specific categories of disputes, subject to strict statutory and regulatory criteria. However, Defendants submit false attestations through the IDR portal, claiming eligibility for disputes involving: (1) services and disputes governed by a specified state law; (2) Medicaid or Medicare-governed services for which the NSA does not apply; (3) services not covered by the patient's plan; (4) disputes for which Defendants failed to initiate or pursue open negotiations; and (5) disputes already resolved or barred by timing rules.

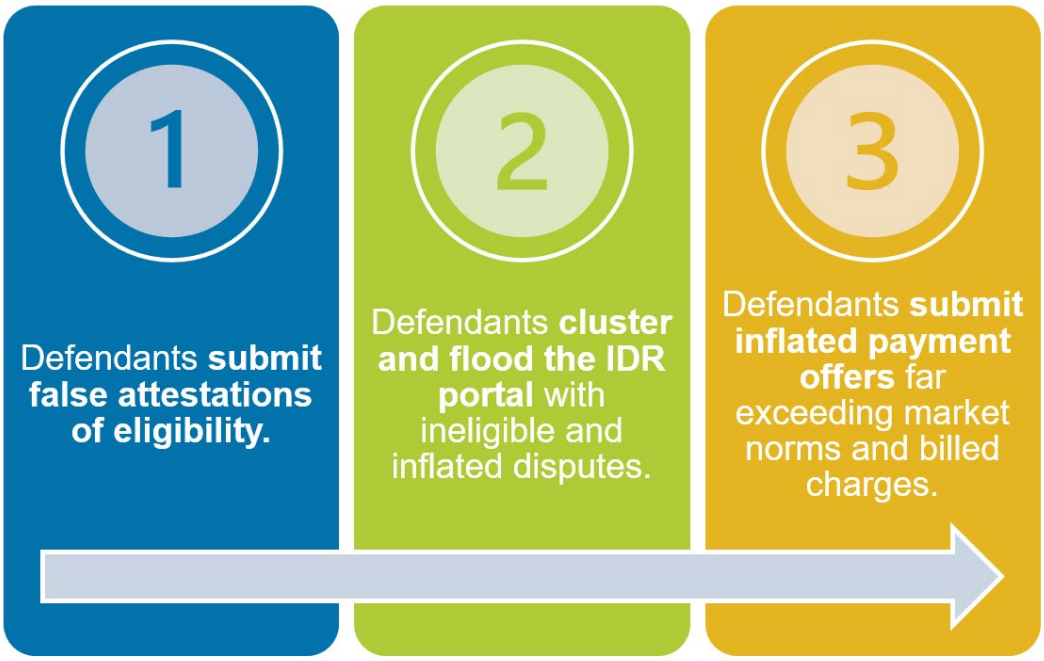
76. How have the Defendants pulled off these brazen fraud schemes? By exploiting the scale and automation of Artificial Intelligence. Promoting their use of AI in IDR submissions, the HaloMD Defendants, on behalf of and in coordination with the Provider Defendants, have flooded the IDR system with disputes at an industrial scale, deliberately overwhelming IDR safeguards and enabling payment on their fraudulent disputes.

77. Defendants' continuous and ongoing schemes to exploit the IDR process involve three related tactics. ***First***, using interstate wires, Defendants make repeated false representations and attestations of eligibility to Anthem, the IDREs, and the Departments. ***Second***, Defendants strategically submit massive numbers of open negotiations and IDR initiations—most of which are 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. ***Third***, Defendants capitalize on flaws in the IDR process by submitting outrageous payment offers that they could never receive on the open market, including many that exceed the Provider Defendants' billed charges. *See* H.R. Rep. No. 116-615, at 53, 57 (noting that billed charges should not be considered in the IDR process because they are "inflated," arbitrary, and "non-market-based" figures).

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78. Through this step-by-step campaign of deception, Defendants intentionally turned the NSA's IDR process into a vehicle for their fraud scheme.

79. This multi-step process is depicted visually in the diagram below:



I. Defendants Knowingly Make False Attestations of Eligibility to Initiate the IDR Process

80. When initiating ineligible disputes against Anthem through the IDR process, Defendants make repeated false attestations and representations that the items or services in dispute are "qualified item(s) and/or service(s) within the scope of the Federal IDR process" when, in fact, they are not. 45 C.F.R. § 149.510(b)(2)(iii)(A)(6); *see also* Notice of IDR Initiation Form, U.S. DEP'T OF LABOR, available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/notice-of-idr-initiation.pdf. Defendants make these false attestations and representations to Anthem, the IDRE, and the Departments.

81. The items and services that Defendants falsely attest are "qualified item(s) and service(s) within the scope of the Federal IDR process" are clearly ineligible, and Defendants know that they are ineligible when making their false attestations.

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82. As noted above, the online process for initiating IDR is designed to notify initiating parties of facts that render services and disputes ineligible and prevent parties from inadvertently submitting ineligible items or services. Initiating parties must identify, among other things, the specific date that they initiated open negotiations, the type of health plan coverage for the patient who received the services, and an affirmative attestation that the "item(s) and service(s) at issue are qualified items and/or service(s) within the scope of the Federal IDR process." ***At every stage of the initiation process***, Defendants must make ***affirmative false statements*** to proceed with the dispute or the process cannot continue for these plainly ineligible services.

83. In addition, Anthem often directly notifies the HaloMD Defendants and the Provider Defendants that the items or services at issue in their IDR initiation are ineligible. These notifications inform Defendants that their submissions violate the NSA's eligibility requirements. Yet despite receiving this information, Defendants routinely proceed with their IDR disputes anyway—demonstrating not only their knowledge of the fraud, but their intentional and ongoing participation in it. This further underscores the knowing, coordinated nature of their schemes.

84. For example, Defendants routinely initiate the IDR process despite failing to initiate or pursue open negotiations. Open negotiation is a prerequisite to IDR; providers must attempt to negotiate a resolution with health plans before initiating the IDR process. Yet from 2024 to present, the Defendants submitted hundreds of disputes for services ***where no open negotiation occurred***.

85. Defendants cannot initiate the IDR process by mistake when they do not pursue open negotiation. As noted, the federal IDR portal's Qualifications Questions require Defendants to (1) identify the date on which they initiated open negotiations, and (2) upload documentation of open negotiations. But Defendants deliberately lie to get past this step by selecting a false and arbitrary start date for the open negotiation period and/or by generating a fictitious justification for an extension. Defendants' electronic submissions for each of these disputes was an instance of wire fraud;

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Defendants had to put in a fabricated date, upload false documentation, generate a fictitious justification for an extension, and/or otherwise overcome the IDR system's safeguards to get their disputes submitted. As a result of these disputes alone, the Defendants recovered hundreds of thousands of dollars in improper IDR awards.

86. As another example, Defendants initiated IDR disputes that were subject to California's Surprise Billing Laws and therefore ineligible. Defendants knew that these disputes were ineligible; Anthem's responses to negotiations, and objections to eligibility after IDR initiation, informed Defendants that the items and services were subject to California's Surprise Billing Laws and therefore ineligible for the federal IDR process. Moreover, the first page of the IDR initiation process provides a link to states that have surprise billing laws, and CMS also publishes charts and other resources to inform providers of the states with surprise billing laws and the scope and applicability of those laws. *See* Notice of IDR Initiation, HHS, available at https://nsa-idr.cms.gov/paymentdisputes/s/; *see also, e.g.*, CAA Enforcement Letters, CMS, *supra*; Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process, CMS, *supra*.

87. Typically, the HaloMD Defendants—the vehicle for this fraud operation—make these false attestations of eligibility when initiating the IDR process on behalf of the Provider Defendants. But the Provider Defendants know full well that the services at issue are ineligible and that HaloMD's attestations are false.

88. As described below, in the case of the LaRoque Family Enterprise, HaloMD and the LaRoque Family Providers are under common control and operate as a unified enterprise, making the distinction between submitter and provider largely artificial. The relationship between HaloMD and the LaRoque Family Providers is so deeply entangled that the LaRoque Family Providers are, for all practical purposes, making the false attestations themselves.

89. In the case of the Sound Physicians Enterprise, the Sound Providers know that many of the disputes HaloMD submits on their behalf are ineligible based on the

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nature of the services and Anthem's communications to the Sound Providers. And in some instances, the Sound Providers initiate the knowingly ineligible IDRs themselves.

90. In sum, the Provider Defendants are fully aware of the false attestations that HaloMD submits in their name and actively participate in the scheme by authorizing, directing, or ratifying the submissions. Their coordination with HaloMD is deliberate, sustained, and central to the execution of the fraudulent schemes.

II. Defendants Strategically Initiate a Massive Volume of IDR Disputes Simultaneously.

91. To push thousands of ineligible disputes against Anthem through the IDR process with their false attestations of eligibility, Defendants also initiate a massive number of IDR disputes all at once to overwhelm the IDR system. This abuse of volume is not incidental; it is strategic to secure favorable or default outcomes when health plans and IDREs cannot keep up.

92. Overall, the NSA's IDR process has been overwhelmed by a staggering volume of disputes that far exceed the government's initial estimates. Before the IDR process launched, CMS estimated that parties would initiate about 22,000 IDR process disputes in the first year. *See* 86 Fed. Reg. 55,980, 56,068, 56,070 (Oct. 7, 2021).

93. The reality has shattered those estimates. The most recent government statistics show that in the second half of 2024, disputing parties—virtually all of whom are providers—initiated **853,374 disputes**, 40% more than the first half of 2024 (610,498). *Supplemental Background on the Federal IDR Public Use Files, July 1, 2024—Dec. 31, 2024* (as of May 28, 2025), available at https://www.cms.gov/files/document/federal-idr-supplemental-background-2024-q3-2024-q4.pdf. This figure from ***six months*** is nearly ***39 times*** the volume of disputes that the government originally anticipated ***over a full year***.

94. Government reporting also shows that most disputes are initiated by a small number of providers and their representatives. The top ten initiating parties

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initiated about 71% of all disputes initiated in the last six months of 2024, and the top three initiating parties initiated about 43% of all disputes during that period. *Id.*

95. HaloMD is among the three most prolific filers of IDR process disputes. During the last six months of 2024, HaloMD initiated 134,318 disputes through the IDR process—which by itself exceeded the government's original estimate for total annual disputes **more than sixfold**. *See Federal IDR Supplemental Tables for Q3 2024* (as of May 28, 2025), available at https://www.cms.gov/files/document/federal-idr-supplemental-tables-2024-q3.xlsx; *Federal IDR Supplemental Tables for Q4 2024* (as of May 28, 2025), available at https://www.cms.gov/files/document/federal-idr-supplemental-tables-2024-q4-may-28-2025.xlsx. That means HaloMD was initiating an average of more than 746 disputes against health plans ***per day***. *See id.*

96. As between just the Defendants and Anthem, Defendants did not merely initiate a steady volume of IDR process disputes each day. Instead, Defendants strategically initiate hundreds of IDR process disputes against Anthem on the same day, most of which do not involve qualified IDR items or services within the scope of the NSA's IDR process. For example, on January 5, 2024, Defendants initiated 129 separate IDR proceedings against Anthem.

97. Defendants' goals are to interfere with Anthem's ability to effectively identify ineligible disputes and submit inappropriate payment offers, and to overwhelm the IDR system and the IDREs tasked with making applicability and payment determinations.

98. Through considerable operational burden and expense, Anthem has crafted workflows allowing it to identify most of the unqualified items or services and notify Defendants that the disputes do not quality for IDR. Yet despite Anthem's objections, most of Defendants' ineligible disputes reach a payment determination due to Defendants' knowingly false attestations of eligibility.

99. According to federal law, "the certified IDR entity selected must review the information submitted in the notice of IDR initiation"—including Defendants' false

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attestations of eligibility—"to determine whether the Federal IDR process applies." 45 C.F.R. § 149.510(c)(1)(v). IDREs also complain that they spend 50% to 80% of their time on eligibility determinations. 88 Fed. Reg. 75,744, 75,753 (Nov. 3, 2023). And IDREs have no incentive to dismiss disputes due to ineligibility because they only receive compensation if a dispute reaches a payment determination. *See* 42 U.S.C. § 300gg-111(c)(5)(F).

100. Thus, when receiving an avalanche of ineligible disputes from Defendants all at once, IDREs frequently rely on Defendants' false attestations of eligibility to reach and issue a payment determination on ineligible disputes.

101. Since at least 2024, about ***55%*** of disputes from Defendants that reached a payment determination were ineligible for the IDR process, often despite objections from Anthem. From these fraudulent submissions alone, Defendants have received several millions of dollars in illicitly obtained reimbursements.

III. Defendants Submit Outrageous Payment Offers—Frequently Above Billed Charges—to Inflate Payments on Both Eligible and Ineligible Disputes.

102. The final step in Defendants' scheme involves inflating their reimbursement demand to levels far beyond what was billed or what the market would support. The goal is to manipulate IDREs into selecting inflated amounts by anchoring the dispute to a grossly exaggerated number. By submitting a grossly inflated offer, Defendants artificially shift the IDRE's frame of reference upward. And due to systemic issues with the IDR process, Defendants frequently prevail with their unreasonable offer—even if it is far above market rates or even above what the Provider Defendants had billed.

103. Congress directed IDR payment determinations to be made according to the QPA and several "additional circumstances," such as the training, experience, and quality of the provider, its market share, and the acuity of the patient, among others. 42 U.S.C. § 300gg-111(c)(5)(C). In practice, however, IDRE payment determinations skew heavily in favor of providers and heavily in excess of the QPA.

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104. In the most recent reporting period, providers prevailed in ***85%*** of IDR payment determinations. *Supplemental Background on the Federal IDR Public Use Files, July 1, 2024—Dec. 31, 2024*, CMS, *supra*. During that period, prevailing offers exceeded the QPA ***85%*** of the time. *See id.* And studies from 2024 show that when providers prevail in IDR, they prevail at a median rate of over three times the QPA. *See* Zachary L. Baron et al., O'NEILL INSTITUTE, GEORGETOWN LAW, *2023 Data from the Independent Dispute Resolution Process: Select Providers Win Big*, available at https://oneill.law.georgetown.edu/publications/2023-data-from-the-independent-dispute-resolution-process-selectproviders-win-big/.

105. Defendants know that IDREs select the provider's offer in more than 8 out of every 10 payment determinations, so they can frequently prevail with outrageous offers.

106. Defendants also know that IDREs cannot consider the provider's charges when making a payment determination. 42 U.S.C. § 300gg-111(c)(5)(D). Congress prohibited IDREs from considering "inflated," "non-market based rates such as the providers' billed charges" because merely ***considering*** the provider's charge "may drive up consumer costs." H.R. Rep. No. 116-615, at 53, 57.

107. With full knowledge that IDREs cannot consider the Provider Defendants' billed charges, Defendants do not disclose their billed charges to the IDRE and then submit offers that ***actually exceed the Provider Defendants' charges***.

108. Since at least 2024, Defendants fraudulently submitted thousands of inflated disputes through the IDR process where they requested and received an IDR award exceeding their billed charges. On average, Defendants' offers of payment in IDR represent an astonishing ***8,609%*** more than Anthem's QPA—***resulting in IDR determinations exceeding billed charges by over $2.5 million***.

109. These amounts far exceed what the Provider Defendants could expect to receive for their services from patients or from health plans in a competitive market. Indeed, upon information and belief, prior to the enactment of the NSA, the Provider

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Defendants rarely, if ever, recovered their full billed charges from patients or health plans. They ***never*** collected amounts above their charges. But through their scheme to exploit the IDR process, Defendants' systematic requests for these exorbitant amounts intentionally exploit the IDR process for undue gains at Anthem's expense.

IV. Defendants' Fraudulent Scheme Damages Anthem, Affiliated Health Plans, and Consumers.

110. As a result of Defendants' unlawful conduct, Anthem and its affiliated health plans have paid excessive amounts for medical services and incurred unnecessary administrative and arbitration fees. The financial harm caused by Defendants' abusive practices is ongoing and threatens the affordability and sustainability of health benefits for Anthem's members.

111. For a period from January 4, 2024, to April 30, 2025, Anthem's records show that Defendants initiated at least 2,205 IDR proceedings against Anthem. However, the earliest publicly available data published by CMS shows that the Provider Defendants were parties to IDR determinations against Anthem in 2023, so the scheme likely began then or before.

112. Anthem determined that approximately ***55%*** of the disputes from this period were ineligible for IDR for reasons like failure to initiate mandatory open negotiations, the services were not covered by the patient's health plan, or California's Surprise Billings Laws governed the dispute, among others. For these ineligible disputes catalogued in Anthem's data, Defendants illicitly secured ***several millions of dollars*** in improper IDR awards (hundreds of thousands of dollars which the Provider Defendants improperly recovered as a result of fraudulently inflating their payment offers far above their billed charges).

113. Anthem also determined that Defendants fraudulently inflated their offers above the Provider Defendants' billed charges in over one hundred eligible disputes from this period. For these inflated offers catalogued in Anthem's data, Defendants improperly recovered ***more than one million dollars*** above the billed charges.

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THE LAROQUE FAMILY ENTERPRISE

114. The LaRoque Family Providers and the HaloMD Defendants do not operate as separate, independent actors. Rather, they are components of a single fraudulent enterprise, controlled and directed by a closely-knit group of individuals with overlapping roles, shared infrastructure, and a unified financial interest in exploiting the IDR process and defrauding payors like Anthem. Their supposed separateness is a façade designed to conceal the coordinated nature of the scheme.

115. Defendant Alla LaRoque and her husband, Scott LaRoque, are at the center of the LaRoque Family Enterprise. The LaRoque Family Enterprise operates via a web of interrelated corporate entities they directly or indirectly control, including HaloMD and the LaRoque Family Providers.

116. Scott LaRoque, a Texas resident, is the founder and Chief Executive Officer of MPOWERHealth. Based in Addison, Texas, MPOWERHealth serves more than 400 physicians, 55,000-plus patients and over 300 facilities in 24 states, including California. MPOWERHealth is located at 5080 Spectrum Drive, Suite 1100E, Addison, Texas, 75001 (the "**5080 Spectrum Address**") and, according to public records, is also associated with the address 2915 W Bitters Rd, San Antonio, Texas, 78248 (the "**2915 W Bitters Address**").

117. Alla LaRoque, HaloMD, and the LaRoque Family Providers have discrete connections to the LaRoques and MPOWERHealth and specific roles within the LaRoque Family Enterprise.

I. Defendant Alla LaRoque

118. Defendant Alla LaRoque, the wife of Scott LaRoque, is the founder and President of HaloMD. She sits on the board of MPOWERHealth and previously served as MPOWERHealth's Chief Operating Officer.

119. As the founder and President of HaloMD, Alla LaRoque had intimate knowledge about the core aspects of HaloMD's business operations, including the

wrongful activities alleged herein. She runs HaloMD as a hands-on manager, overseeing the company's operations, business practices, and finances.

120. Alla LaRoque presents herself as an authority on the NSA's IDR process and frequently appears at public events to bolster her profile. However, behind the scenes, her actions subvert and exploit the NSA and the IDR process.

121. Under the guise of "fair reimbursement," she has repeatedly pushed agendas that undermine the balance of the IDR process, often guiding providers to exploit loopholes and procedural gaps in the IDR framework—giving providers "tactical tools to optimize reimbursement," regardless of the merit of their claims.

122. She also has, on multiple occasions, argued that payors (like Anthem) should face punitive consequences for asserting eligibility objections—even when such objections are valid.

II. Defendant HaloMD

123. HaloMD is the vehicle through which Defendants flood the IDR process with knowingly ineligible disputes.

124. HaloMD markets itself as "the premier expert in Independent Dispute Resolution (IDR) … Our deep expertise, advanced technology, and strategic legal approaches position us as leaders in this space … [W]e empower out-of-network providers to secure sustainable, predictable revenue streams. Backed by a dedicated team and industry-leading success rates, we deliver the financial outcomes that health care providers, practice leaders, and executives rely on for long-term financial stability." *See* https://halomd.com/ (last visited June 1, 2025).

125. HaloMD represents out-of-network providers who were key drivers in surprise billing, including IONM, anesthesiology, and emergency providers, and administers the IDR process on their behalf.

126. HaloMD touts its "proprietary platform" as one founded with "advanced technology and AI-driven infrastructure[.]" *Id*. HaloMD also represents that it "instantly assesses each case for eligibility under The No Surprises Act and relevant state

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regulations." Providers submit services for dispute in the IDR process through HaloMD's portal. *Id.*

127. HaloMD further represents that it "gathers and organizes the necessary documentation [from the provider], [and] prepar[es] a compelling case that highlights the provider's position, ensuring nothing is overlooked[.]" *Id.*

128. Upon information and belief, HaloMD leverages AI as part of its fraudulent billing scheme to flood the IDR system with ineligible disputes.

129. HaloMD operates on a commission-based reimbursement model. Its website states: "We don't get paid until you get paid." *Id*. HaloMD thus has a financial incentive to (1) bring as many services as possible through the IDR process, regardless of the merits or the applicability of the NSA to those disputes, and (2) seek the highest possible monetary award for its provider clients in the IDR process. The LaRoque Family Providers and the Sound Providers share these same financial incentives.

130. In addition to serving as the fraud vector for massive volumes of NSA IDR filings, HaloMD is connected to the LaRoque Family Enterprise through Alla LaRoque, its founder and President. By serving as the founder and President of HaloMD and board member for MPOWERHealth, Alla LaRoque oversees and directs the activities of both the platform submitting IDR disputes and the LaRoque Family Providers on whose behalf those disputes are submitted.

131. Social media posts confirm the family-run, tightly coordinated nature of the enterprise. In one post from April 2025, Scott and Alla LaRoque are described as "[t]he magnificent couple, owner, founder of MPower Health and HaloMD." They routinely appear together at public events representing both companies.

132. Megan Rausch, the Chief Operating Officer of HaloMD, also serves as the Vice President of Revenue Cycle Management for MPOWERHealth, ensuring alignment and coordination across the scheme.

133. MPOWERHealth and HaloMD also appear to share a physical business address, reinforcing the integration between the two companies. According to public

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records, HaloMD uses the 2915 W Bitters Address that MPOWERHealth also uses. MapQuest and other mapping tools confirm that both HaloMD and MPOWERHealth list the 5080 Spectrum Address as their business address. This physical overlap is additional confirmation that these entities are operating not independently, but as components of a single, centralized operation.

134. The websites for HaloMD and MPOWERHealth are also nearly identical in design and structure, and their contact pages are directly linked. HaloMD's "Join Our Team" page links applicants back to MPOWERHealth's domain. Advertisements for jobs posted on the internet conflate the various entities. For example, one advertisement for a "State IDR Specialist" lists the employer as MPOWERHealth, but in the body of the description under the section "Who We Are" lists HaloMD as the employer and describes HaloMD.

III. The LaRoque Family Providers

135. The LaRoque Family Enterprise uses the LaRoque Family Providers' purported services as the basis for initiating IDR process disputes.

136. Public records show that the LaRoque Family Providers are all IONM providers affiliated with the same company: MPOWERHealth. In addition, each of the LaRoque Family Providers is connected with the LaRoque Family Enterprise in a variety of ways, including physical addresses, shared personnel, shared assets and various employment and consulting arrangements.

137. Per California Secretary of State records, Defendant Bruin lists the 5080 Spectrum Address as its principal address and the 2915 W Bitters Address as its mailing address. According to the National Provider Identifier ("**NPI**") registry, Bruin also has a mailing address of 1141 N Loop 1604 E #105-612, San Antonio, Texas, 78232 (the "**1141 N Loop Address**"). Upon information and belief, the 1141 N Loop Address is frequently associated with MPOWERHealth entities. The NPI registry's Authorized Official for Bruin is Roxanna ("**Roxy**") Laroque, Director of Client Experience at MPOWERHealth.

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138. Bruin is also affiliated with Medsurant, LLC ("**Medsurant**"), which operates under the trade name Medsurant Health. Upon information and belief, in or around January 2025, Medsurant was acquired by MPOWERHealth. According to the NPI registry, Medsurant also has a business address at the 5080 Spectrum Address. Roxy Laroque of MPOWERHealth is listed as its Authorized Official. In addition, Medsurant recently filed a change of registered agent with the California Secretary State that shows it was filed by Emily Campbell from the 5080 Spectrum Address. Upon information and belief, Campbell is MPOWERHealth's Manager of Client Relations.

139. Dr. Robin Soffer, CEO of Bruin, lists herself on LinkedIn as a Medsurant employee. IDR disputes submitted on behalf of both Bruin and Medsurant use the same email address: medsurantarbitrationnsa@halomd.com. In addition, Medsurant holds a perfected security interest in all of Bruin's assets, as evidenced by a UCC-1 financing statement.

140. Defendant iNeurology lists 1141 N Loop as its current mailing address and previously used 2915 W Bitters Road for the same purpose. According to the NPI registry, its Authorized Official is Roxy LaRoque of MPOWERHealth.

141. Defendant LANA uses both the 2915 W Bitters and 1141 N Loop Addresses as its mailing address. Its CEO, Dr. Jared Ament, is also a lead research consultant at MPOWERHealth and has spoken publicly about the company. Emily Campbell from MPOWERHeath is listed on LANA's Statement of Information filed with the California Secretary of State. And according to the NPI registry, its Authorized Official is Roxy LaRoque of MPOWERHealth.

142. Defendants N Express and NANA also use both the 2915 W Bitters and 1141 N Loop Addresses as their mailing address. According to the NPI registry, their Authorized Official is Roxy LaRoque of MPOWERHealth. NANA also lists Brenda Thiele on its Statement of Information, whose LinkedIn reflects she is MPOWERHealth's Senior Manager of Treasury and former Chief of Staff and Director of Operations.

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143. In sum, the LaRoque Family Providers are not independent clients of HaloMD. They are closely linked through shared ownership, leadership, staff, branding, web infrastructure, and physical office space. MPOWERHealth connects and coordinates the activities of all Defendants. HaloMD, far from being a neutral billing platform, operates as an engine of fraud—instrumental in executing a scheme designed to exploit the IDR process for unlawful financial gain.

THE SOUND PHYSICIANS ENTERPRISE

144. Like the LaRoque Family Enterprise, the Sound Providers and the HaloMD Defendants do not operate as separate, independent actors. Rather, they function as interdependent participants in a unified scheme designed to exploit the IDR process and defraud Anthem. The Sound Providers are not autonomous local practices; they are integrated components of a national hospitalist staffing enterprise that centrally manages legal, billing, and IDR functions. HaloMD serves as a key agent and operational partner of the enterprise, submitting disputes on behalf of the Sound Providers using a standardized platform and shared communications infrastructure. Their coordinated actions, mutual financial incentives, and repeated patterns of conduct demonstrate a shared intent to pursue improper IDR payments on a mass scale. The HaloMD Defendants and the Sound Providers operated with integrated, enterprise-level coordination behind the scheme.

145. The Sound Providers are subsidiaries or affiliates of Sound Inpatient Physicians, Inc. d/b/a Sound Physicians ("**Sound Physicians**"), a national multi-specialty medical group headquartered in Tacoma, Washington. Sound Physicians publicly claims to employ over 4,000 clinicians and to manage approximately 6% of all acute hospitalizations across more than 400 hospitals nationwide. *See* https://soundphysicians.com/about/why-sound/.

146. Lindsay Vaughan, Associate General Counsel of Sound Physicians, served as incorporator for both Sound Providers. She also signed annual registration statements

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for the two entities, confirming their centralized legal oversight from within the parent organization.

147. The Sound Providers share resources and intermingle operations with respect to the submission of healthcare claims, payment for healthcare services, and pursuit of IDR. Anthem has identified multiple claims and IDR submissions across the Sound Providers that used the same remittance address—P.O. Box 748996, Los Angeles, CA 90074-8996—a centralized billing address listed on Sound Physicians' own website for emergency medicine payments. *See* https://soundphysicians.com/patient-resources/. The open negotiation notices for NSA disputes involving the Provider Defendants also originated from this same national billing address, confirming the shared infrastructure and control over the dispute process.

148. HaloMD filed IDR disputes for the Sound Providers using a centralized, Sound-branded email address: soundnsa@halomd.com. This address appears repeatedly in NSA filings involving the Sound Providers.

149. In sum, the relationship between the Sound Providers and the HaloMD Defendants was not passive. Together, they coordinated to pursue shared financial interests—maximizing the number of disputes submitted and inflating payment demands well beyond their billed charges or market rates. The use of HaloMD as a submission engine was not incidental or isolated; it was a deliberate component of the Sound Physicians Enterprise's strategy to bypass the limitations of individual-provider capacity, automate the submission of disputes en masse, and conceal the ineligibility or inflation embedded in each claim.

IV. The Enterprises Exploit the IDR Process at the Expense of Anthem.

150. Defendants formed the LaRoque Family Enterprise and the Sound Physicians Enterprise for the common purpose of enriching themselves at the expense of Anthem by fraudulently inducing and compelling Anthem to pay for services that

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were not eligible for the IDR process, and inflating the amounts required to be paid on ineligible and eligible services above the amounts billed to patients.

151. Beginning no later than January 2024, the LaRoque Family Enterprise and the Sound Physicians Enterprise both commenced a pattern of fraudulent, intentional, and reckless activity whereby they: (1) knowingly submitted thousands of ineligible and inflated disputes to Anthem, misrepresenting their eligibility for IDR under the NSA; (2) strategically initiated massive volumes of IDR disputes simultaneously against Anthem; and (3) improperly inflated payment offers that far exceeded what the Provider Defendants could have received from patients or health plans in a competitive market and, in many cases, exceeded the Provider Defendants' billed charges.

152. These disputes included services governed by state law, services for which no open negotiation had been initiated, or services otherwise barred from IDR. Despite these disqualifying facts, Defendants knowingly submitted formal attestations to Anthem, the Departments, and the IDRE asserting that the disputes were eligible—false statements that enabled the disputes to advance through the IDR system. In many instances, Anthem had previously notified Defendants that the claims were ineligible, and that state law governed reimbursement, yet Defendants proceeded anyway. Each step of the schemes was designed to bypass the statutory and regulatory prerequisites of the NSA while creating the illusion of compliance.

153. Between January 4, 2024, and April 30, 2025, the LaRoque Family Enterprise and the Sound Physicians Enterprise submitted thousands of ineligible disputes against Anthem via interstate wires for which it illicitly secured millions of dollars in improper IDR awards. On each occasion, Defendants knowingly misrepresented the eligibility of their disputes.

154. In addition, between January 4, 2024, and April 30, 2025, the LaRoque Family Enterprise and the Sound Physicians Enterprise submitted inflated payment offers in over one hundred eligible disputes against Anthem via interstate wires for

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which it received over one million dollars above the Provider Defendants' billed charges.

155. The LaRoque Family Enterprise's and the Sound Physicians Enterprise's fraudulent schemes are evidenced by numerous specific predicate acts of wire fraud, including but not limited to the following:

A. Los Angeles Neurological Associates

DISP-801389 (No Open Negotiation; Misrepresentation of QPA)

156. The IDR proceeding captioned DISP-801389 involved a service that LANA rendered on August 24, 2023, to a member of a health plan administered by Anthem. LANA billed $6,800 for this service.

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE
INSURED'S NAME: [redacted] PATIENT ACCOUNT#: SERVICE PROVIDER NAME: LOS ANGELES NEUROLOGICAL NETWORK: OUT OF NETWORK			RI
08/24/2023 08/24/2023	95939	21	6,800.00

157. Neither LANA nor HaloMD pursued open negotiations under the federal process, which is a mandatory prerequisite to IDR for eligible services. Despite no open negotiation and the dispute not being subject to IDR for that reason, HaloMD, on behalf of and in coordination with LANA, ***falsely certified that the open negotiation period started on October 21, 2023,*** when it submitted the claim to IDR.

> **When did the open negotiation period start?**
> 10/21/2023

158. On December 6, 2023, HaloMD on behalf of and in coordination with LANA, using the email address nsa@halomd.com, initiated IDR and falsely attested that the services were a qualified item or service within the scope of the federal IDR process.

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159. When initiating IDR, HaloMD, on behalf of and in coordination with LANA, also falsely certified that the QPA for the claim was $3,840.18. This was ***nearly 20 times*** the correct QPA, which, per Anthem, was calculated at $198.70. As noted, the NSA directs IDREs to consider the QPA and several "additional circumstances" when making payment determinations. 42 U.S.C. § 300gg-111(c)(5)(C).

Qualifying Payment Amount (QPA):
$3840.18

160. Anthem submitted an objection to eligibility, which was also addressed to LANA, stating that "[t]he non-participating provider/facility failed to engage in the 30-business day open negotiation period." Neither HaloMD nor LANA withdrew the dispute following Anthem's explicit notice of ineligibility.

September 30, 2024

LOS ANGELES NEUROLOGICAL

DISP ID: DISP-801389

Dear CIDRE,
The Independent Dispute Resolution (IDR) Team has received an IDR initiation notice for the above DISP Number. After review, the claim(s) is/are out of the scope (OOS) of the Federal No Surprises Act (NSA), due to the following reason(s). Please refer to the addendum for more information.

☐ The claim(s) is ineligible for IDR under the NSA because a state surprise billing law applies. Per CMS guidelines, where a specified state law provides a method for determining the total amount payable for out-of-network items and services, providers may not engage in the federal IDR process for resolving payment disputes under the NSA.

☑ The non-participating provider/facility failed to engage in the 30-business day open negotiation period, according to the NSA. Providers cannot pursue IDR unless and until the open negotiation period is properly initiated and completed. Per CMS regulations, providers must submit open negotiation notices to the contact information set forth in their initial payment or denial of payment. [Insert HealthPlan] accepts open negotiation notices through the following: Availity, Mail to a specified address,Fax to a specified number, Email to a specified address Via phone to a specified number

161. As a result of HaloMD and LANA's fraudulent attestations, Anthem was required to pay $9,843.3 for the ineligible services—***nearly 50 times the correct QPA for the service and more than $3,000 more than the amount LANA originally billed Anthem for the service***—along with $698 in unnecessary IDR-related fees.

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DISP-807329 (No Open Negotiation)

162. The IDR proceeding captioned DISP-807329 involved an electroencephalogram monitoring service that LANA rendered on August 24, 2023, to a member of a health plan administered by Anthem.

163. Neither LANA nor HaloMD pursued open negotiations under the federal process, which is a mandatory prerequisite to IDR for eligible services. Despite no open negotiation and the dispute not being subject to the NSA, HaloMD, on behalf of and in coordination LANA, certified that the open negotiation period started on October 21, 2023, when it submitted the claim to arbitration.

164. On December 8, 2023, HaloMD, on behalf of and in coordination with LANA, using the email address nsa@halomd.com, initiated IDR and falsely attested that the services were a qualified item or service within the scope of the federal IDR process.

165. Anthem submitted an objection to eligibility, which was also addressed to LANA, stating that the "[t]he non-participating provider/facility failed to engage in the 30-business day open negotiation period." Neither HaloMD nor LANA withdrew the dispute following Anthem's explicit notice of ineligibility.

166. As a result of HaloMD and LANA's fraudulent attestations, Anthem was required to pay $5,100 for the ineligible service, equal to LANA's billed charge for the service, along with $445 in unnecessary IDR-related fees.

B. Bruin Neurophysiology

DISP-1151152 (No Open Negotiation)

167. The IDR proceeding captioned DISP-1151152 involved a service that Bruin rendered on October 10, 2023, to a member of a health plan administered by Anthem.

168. Neither Bruin nor HaloMD pursued open negotiations under the federal process as required. Yet on March 14, 2024, HaloMD, on behalf of and in coordination with Bruin, initiated IDR and falsely attested to IDR eligibility. Notably, HaloMD

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initiated the IDR using the email address medsurantarbitrationnsa@halomd.com, a company owned by MPOWERHealth, despite Bruin providing the service.

169. Anthem submitted an objection to eligibility, which was also addressed to Robin Soffer at Bruin, stating that Bruin "failed to engage in the 30-business day open negotiation period" required by the NSA. Neither HaloMD nor Bruin withdrew the dispute following Anthem's explicit notice of ineligibility.

170. As a result of HaloMD and Bruin's fraudulent attestations, Anthem was required to pay $8,746.30 for the service along with $765 in unnecessary IDR-related fees.

DISP-918898 (Late Filing)

171. The IDR proceeding captioned DISP-918898 involved a service that Bruin rendered on May 22, 2023, to a member of a health plan administered by Anthem.

172. On July 17, 2023, HaloMD, acting on behalf of and in coordination with Bruin, sent a notice of open negotiation to Anthem to initiate the federal IDR process. HaloMD sent the open negotiation notice using the email address medsurantarbitrationnsa@halomd.com with Ashonta.Whitehead@halomd.com copied. The open negotiation notice was signed by Megan Rausch (HaloMD), noted to be the "Provider Representative," at the 2915 W Bitters Address.

173. On September 25, 2023, Anthem addressed its response to the notice of open negotiation to Bruin, ATTN: Megan Rausch, at the 2915 W. Bitters Address, stating that the services included on the request "were paid at the maximum amount as required by the member's health plan" and that "no additional payment can be considered." Neither HaloMD nor Bruin responded to Anthem's September 25, 2023, letter.

174. More than ***one full year*** after Anthem's letter, on January 15, 2025, HaloMD, on behalf of and in coordination with Bruin, using the email address nsa@halomd.com, falsely attested to IDR eligibility. Anthem submitted an objection to eligibility asserting that Bruin had not filed its IDR proceeding within the required time.

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The notice of ineligibility was sent to both Bruin and HaloMD, yet neither HaloMD nor Bruin withdrew the dispute.

175. As a result of HaloMD and Bruin's fraudulent attestations, Anthem was required to pay $12,993.28—***103 times the QPA calculated by HaloMD and Bruin at the initiation of the IDR proceeding***. Anthem also paid $750 in unnecessary IDR-related fees.

C. North American Neurological Associates

DISP-1455557 (No Open Negotiation)

176. The IDR proceeding captioned DISP-1455557 involved a service that NANA rendered on March 11, 2024, to a member of a health plan administered by Anthem.

177. When Anthem issued payment, which was equal to the QPA for the service, the EOB sent to NANA at the 1141 N Loop Address reflected that the claim was processed pursuant to explanation code AUQ. The description of this code, printed at the end of the EOB, indicated: "This claim was paid according to the Federal No Surprises Act. … If you disagree with our decision, you can initiate the 30-day open negotiation period[.]" Neither NANA, nor HaloMD acting on its behalf, initiated the 30-day open negotiation period as required.

178. Even though neither NANA nor HaloMD initiated open negotiations for this service, on June 27, 2024, HaloMD, using the email address nsa@halomd.com, on behalf of and in coordination with NANA, initiated IDR and falsely attested that the service was a qualified item or service within the scope of the federal IDR Process and that NANA and/or HaloMD had complied with the requirements of the NSA in submitting the claim.

179. On December 11, 2024, Anthem submitted an objection to eligibility, which was also addressed to NANA, stating, "The non-participating provider/facility failed to engage in the 30-business day open negotiation period, according to the NSA. Providers cannot pursue IDR unless and until the open negotiation period is properly

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initiated and completed." Neither HaloMD nor NANA withdrew the dispute following Anthem's explicit notice of ineligibility.

180. As a result of HaloMD's and NANA's fraudulent attestations, Anthem was required to pay $7,369 for the ineligible service along with $512 in unnecessary IDR-related fees.

DISP-1455555 (No Open Negotiation)

181. The IDR proceeding captioned DISP-1455555 involved a service that NANA rendered on March 11, 2024, to a member of a health plan administered by Anthem.

182. When Anthem issued payment, which was equal to the QPA for the service, the EOB sent to NANA at the 1141 N Loop Address reflected that the claim was processed pursuant to explanation code AUQ. The description of this code, printed at the end of the EOB, indicated: "This claim was paid according to the Federal No Surprises Act. … If you disagree with our decision, you can initiate the 30-day open negotiation period[.]" Neither NANA, nor HaloMD acting on its behalf, initiated the 30-day open negotiation period as required.

183. Even though neither NANA nor HaloMD initiated open negotiations for this service, on June 27, 2024, HaloMD, using the email address nsa@halomd.com, on behalf of and in coordination with NANA, initiated IDR and falsely attested that the service was a qualified item or service within the scope of the federal IDR Process and that NANA and/or HaloMD had complied with the requirements of the NSA in submitting the claim.

184. On December 11, 2024, Anthem submitted an objection to eligibility, which was also addressed to NANA, stating "The non-participating provider/facility failed to engage in the 30-business day open negotiation period, according to the NSA. Providers cannot pursue IDR unless and until the open negotiation period is properly initiated and completed." Neither HaloMD nor NANA withdrew the dispute following Anthem's explicit notice of ineligibility.

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185. As a result of HaloMD and NANA's fraudulent attestations, Anthem was required to pay $9,843.83—***approximately $3,000 more than NANA's billed charges***—along with $512 in unnecessary IDR-related fees.

D. N Express

DISP-2193991 (No Open Negotiation; Ineligible State Law Claim)

186. The IDR proceeding captioned DISP-2193991 involved a service that N Express rendered on October 23, 2023, to a member of a health plan administered by Anthem. The member's plan is subject to state law, and therefore, California's Surprise Billing Laws—rather than the NSA—governed the reimbursement rate for services.

187. Neither N Express nor HaloMD pursued open negotiations under the federal process, which is a mandatory prerequisite to IDR for eligible services. Despite no open negotiation and clear application of California's Surprise Billing Laws, on December 2, 2024, "CJR" of HaloMD, using the email address nsa@halomd.com, on behalf of and in coordination with N Express, initiated IDR and falsely certified the service as IDR-eligible.

188. On December 6, 2024, Anthem submitted an objection to eligibility, which was also address to N Express, stating: (1) "The claim(s) is ineligible for IDR under the NSA because a state surprise billing law applies" and (2) "The non-participating provider/facility failed to engage in the 30-business day open negotiation period, according to the NSA. Providers cannot pursue IDR unless and until the open negotiation period is properly initiated and completed." Neither HaloMD nor N Express withdrew the dispute following Anthem's explicit notice of ineligibility.

189. As a result of HaloMD and N Express's fraudulent attestations, Anthem was required to pay $7,769.59—***more than double the billed amount*** of $3,825—along with $510 in unnecessary IDR-related fees.

DISP-2193967 (No Open Negotiation; Ineligible State Law Claim)

190. The IDR proceeding captioned DISP-2193967 involved a service that N Express rendered on October 23, 2023, to a member of a health plan administered by

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Anthem. The member's plan is subject to state law and, therefore, California's Surprise Billing Laws—rather than the NSA—governed the reimbursement rate for services.

191. Neither N Express nor HaloMD pursued open negotiations under the federal process, which is a mandatory prerequisite to IDR for eligible services. Yet despite no open negotiation and clear application of California's Surprise Billing Laws, on December 2, 2024, "CJR" of HaloMD, using the email address nsa@halomd.com, on behalf of and in coordination with N Express, initiated IDR and falsely certified the service as IDR-eligible.

192. On December 6, 2024, Anthem submitted an objection to eligibility, which was also address to N Express, stating: (1) "The claim(s) is ineligible for IDR under the NSA because a state surprise billing law applies" and (2) "The non-participating provider/facility failed to engage in the 30-business day open negotiation period, according to the NSA. Providers cannot pursue IDR unless and until the open negotiation period is properly initiated and completed." Neither HaloMD nor N Express withdrew the dispute following Anthem's explicit notice of ineligibility.

193. As a result of HaloMD and N Express's fraudulent attestations, Anthem was required to pay $12,330.78 for the ineligible service along with $510 in unnecessary IDR-related fees.

DISP-945678 (No Open Negotiation; Ineligible State Law Claim)

194. The IDR proceeding captioned DISP-945678 involved a service that N Express rendered on October 23, 2023, to a member of a fully insured group health plan administered by Anthem. The member's plan is subject to state law and, therefore, California's Surprise Billing Laws—rather than the NSA—governed the reimbursement rate for services.

195. Neither N Express nor HaloMD pursued open negotiations under the federal process, which is a mandatory prerequisite to IDR for eligible services. Yet despite no open negotiation and clear application of California's Surprise Billing Laws, on December 2, 2024, HaloMD, using the email address nsa@halomd.com, on behalf

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of and in coordination with N Express, initiated IDR and falsely certified the service as IDR-eligible.

196. Anthem submitted an objection to eligibility, which was also address to N Express, stating: (1) "The claim(s) is ineligible for IDR under the NSA because a state surprise billing law applies" and (2) "The non-participating provider/facility failed to engage in the 30-business day open negotiation period, according to the NSA. Providers cannot pursue IDR unless and until the open negotiation period is properly initiated and completed." Neither HaloMD nor N Express withdrew the dispute following Anthem's explicit notice of ineligibility.

197. As a result of HaloMD and N Express's fraudulent attestations, Anthem was required to pay $7,769.59—***nearly double the billed amount*** of $3,825—along with $510 in unnecessary IDR-related fees.

E. iNeurology

DISP-1568048 (No Open Negotiation)

198. The IDR proceeding captioned DISP-1568048 involved a service that iNeurology rendered on August 14, 2023, to a member of a health plan administered by Anthem.

199. When Anthem issued payment, the EOB sent to iNeurology at the 2915 W Bitters Address reflected that the claim was processed pursuant to explanation code AUQ. The description of this code, printed at the end of the EOB, indicated: "This claim was paid according to the Federal No Surprises Act. … If you disagree with our decision, you can initiate the 30-day open negotiation period[.]" Neither iNeurology, nor HaloMD acting on its behalf, initiated the 30-day open negotiation period as required.

200. Even though neither iNeurology nor HaloMD initiated open negotiations for this service, on April 11, 2025, HaloMD, using the email address nsa@halomd.com, on behalf of and in coordination with iNeurology, initiated IDR and falsely attested to IDR eligibility.

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201. On April 24, 2025, Anthem submitted an objection to eligibility, which was also addressed to iNeurology, stating: "The non-participating provider/facility failed to engage in the 30-business day open negotiation period, according to the NSA. Providers cannot pursue IDR unless and until the open negotiation period is properly initiated and completed." Neither HaloMD nor iNeurology withdrew the dispute following Anthem's explicit notice of ineligibility.

202. As a result of HaloMD and N Express's fraudulent attestations, Anthem was required to pay $12,330.78 for the ineligible service along with $490 in unnecessary IDR-related fees.

DISP-937342 (No Open Negotiation; Non-Covered Service)

203. The IDR proceeding captioned DISP-937342 involved a service that iNeurology rendered on September 19, 2023, to a member of a health plan administered by Anthem. Anthem denied reimbursement for the service because it was not separately payable from a service that had already been billed and paid. No QPA applied to this claim because the NSA and IDR were inapplicable.

204. Even though neither iNeurology nor HaloMD initiated open negotiations for this service, on January 22, 2024, HaloMD, using the email address nsa@halomd.com, on behalf of and in coordination with iNeurology, initiated IDR and falsely attested to IDR eligibility.

205. Anthem submitted an objection to eligibility, which was also addressed to iNeurology at the 2915 W Bitters Address, asserting that "the non-participating provider/facility failed to engage in the 30-business day open negotiation period." Neither HaloMD nor iNeurology withdrew the dispute following Anthem's explicit notice of eligibility.

206. As a result of HaloMD and iNeurlogy's fraudulent attestations, Anthem was required to pay $7,309.58—***more than six times the billed amount*** of $1,275—along with $510.00 in unnecessary IDR-related fees, on a service for which no plan benefits were payable in the first place.

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F. Sound Physicians Emergency Medicine of Southern California

DISP-932222 (Incorrect Batching)

207. The IDR proceeding captioned DISP-932222 involved emergency services that SPEMSC rendered between September 20, 2023, and October 31, 2023. One service disputed in this proceeding was rendered to a member of a health plan insured and administered by Anthem. SPEMSC billed $1,761.00 in charges for the service.

208. Anthem approved payment for the service and sent its EOB to Sound Physicians at the address PO Box 748524, Los Angeles, California, 90074.

209. On November 30, 2023, SPEMSC, using the email address SoundFedIDR@SoundPhysicians.com, sent a notice of open negotiation, signed by Melissa Williams at Sound Physicians, to Anthem to initiate the federal IDR process. The notice of open negotiation attached a spreadsheet with dozens of claims that included the fully insured claim subject to DISP-932222. Anthem sent a response to SPEMSC offering additional payment to settle the dispute and inviting SPEMSC to submit additional information to support why it is entitled to greater reimbursement to continue discussions. SPEMSC did not respond to this correspondence.

210. On November 13, 2024, SPEMSC initiated a batched IDR using the email soundfedidr@soundphysicians.com. SPEMSC falsely attested that the services were qualified and within the scope of the federal IDR process despite the fact the dispute was ineligible for multiple reasons, including that SPEMSC inappropriately included 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.

211. Anthem responded to the IDR initiation to assert that IDR was not applicable to the dispute, stating in part: "Batched services include multiple Membership types," and providing a chart of all disputed services with the membership type attributable to each claim (*e.g.*, "ASO" and "Fully Insured".) SPEMSC did not withdraw the dispute. Nevertheless, as a result of SPEMSC's fraudulent attestation,

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Anthem was required to pay $1,761 for this specific unqualified service along with $900 in unnecessary IDR-related fees related to the improperly batched dispute.

DISP-1289721 (Ineligible Medicaid Claim; No Open Negotiation)

212. The IDR proceeding captioned DISP-1289721 involved emergency services that SPEMSC rendered on February 9, 2024, to a member of a Medicaid managed care plan administered by Anthem. Anthem paid the Medicaid rate of $44.60 for the service. No QPA applied to this claim because the NSA and IDR were inapplicable.

213. Neither SPEMSC, nor HaloMD acting on its behalf, initiated open negotiations for this service. Yet on October 23, 2024, HaloMD, using the email address soundnsa@halomd.com, on behalf of and in coordination with SPEMSC, initiated IDR and falsely attested to IDR eligibility.

214. Anthem submitted an objection to eligibility, asserting that the dispute was ineligible for IDR under the NSA because it involved a "Medicare/ Medicaid claim ineligible for NSA." Anthem also asserted: "The non-participating provider/facility failed to engage in the 30-business day open negotiation period, according to the NSA." This notice of ineligibility was sent to both HaloMD and SPEMSC, yet neither HaloMD nor SPEMSC withdrew the dispute. Nevertheless, as a result of HaloMD and SPEMSC's fraudulent attestations, Anthem was required to pay $1,880—which was more than SPEMSC billed for the service and more than 42 times the Medicaid rate—along with $915 in unnecessary IDR-related fees.

DISP-1568233 (Ineligible State Law Claim)

215. The IDR proceeding captioned DISP-1568233 involved emergency services that SPEMSC rendered on February 7, 2024, to a member of a fully insured health plan administered by Anthem. The member's plan is subject to state law and,

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therefore, California's Surprise Billing Laws—rather than the NSA—governed the reimbursement rate for services.

216. On June 5, 2024, even though SPEMSC and HaloMD knew that the claim was subject to state law, HaloMD, again acting on behalf of and in coordination with SPEMSC, sent a notice of open negotiation to Anthem to initiate the federal IDR process. HaloMD sent the open negotiation notice using the email address soundnsa@halomd.com with Eden.Dimayuga@halomd.com copied. The open negotiation notice offered $2,475 to resolve the dispute and was signed by Megan Rausch (HaloMD), noted to be the "Provider Representative," at the 2915 W Bitters Address.

217. On July 5, 2024, Anthem addressed its response to the notice of open negotiation to SPEMSC at the address for Sound Physician's headquarters (PO Box 748524), stating that the dispute did not qualify for IDR under the NSA. Neither HaloMD nor SPEMSC responded to Anthem's assertion of ineligibility.

218. On July 22, 2024, HaloMD, on behalf of and in coordination with SPEMSC, and using the email address soundnsa@halomd.com, falsely attested to IDR eligibility. Anthem submitted an objection to eligibility asserting that IDR was not applicable to the dispute because "a state surprise billing law applies." This notice of ineligibility was sent to both HaloMD and SPEMSC, yet neither HaloMD nor SPEMSC withdrew the dispute.

219. As a result of HaloMD and SPEMSC's fraudulent attestations, Anthem was required to pay $4,316.00, which was significantly more than HaloMD and SPEMSC had offered in open negotiations and after they had been informed that the services did not qualify for IDR. Anthem also paid $965 in unnecessary IDR-related fees.

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G. Sound Physicians Anesthesiology of California

DISP-803189 (No Open Negotiation)

220. The IDR proceeding captioned DISP-803189 involved anesthesia services that SPAC rendered on July 8, 2023, to a member of a health plan administered by Anthem.

221. Neither SPAC nor HaloMD acting on its behalf initiated open negotiations for this service. On September 25, 2024, SPAC, using the email address soundfedidr@soundphysicians.com, initiated IDR and falsely attested to IDR eligibility.

222. Anthem submitted an objection to eligibility, which was also addressed to SPAC at PO Box 741658, Los Angeles, California 90074, asserting: "The non-participating provider/facility failed to engage in the 30-business day open negotiation period, according to the NSA." SPAC did not withdraw the dispute following Anthem's explicit notice of eligibility.

223. As a result of SPAC's fraudulent attestations, Anthem was required to pay $1,565.50, which was greater than the $945.50 amount SPAC had billed for the same service in the original claim. Anthem also paid $445.00 in unnecessary IDR-related fees.

DISP-2639953 (No Open Negotiation; Ineligible State Law Claim)

224. The IDR proceeding captioned DISP-2639953 involved anesthesia services that SPAC rendered on November 21, 2024, to a member of a fully insured health plan administered by Anthem. As a fully insured plan, the member's plan is subject to state law, and therefore, California's Surprise Billing Laws—rather than the NSA—governed the reimbursement rate for services.

225. On January 8, 2025, HaloMD, on behalf of and in coordination with SPAC, sent a notice of open negotiation to Anthem. The open negotiation notice was signed by Megan Rausch, noted to be the "Provider Representative," at the 2915 W Bitters

Address and with the email address soundnsa@halomd.com. HaloMD requested $1,006.24 to resolve the dispute.

226. Anthem sent a response that was addressed to SPAC at PO Box 741658, Los Angeles, California 90074. The letter informed SPAC and HaloMD that the "[c]laim is not governed by the Federal No Surprises Act."

227. On January 9, 2025 Anthem sent a response to SPAC address to the Sound Physicians headquarters, asserting that the "Claim is not governed by the Federal No Surprises Act." SPAC did not respond to Anthem's assertion of ineligibility.

228. Even though the dispute clearly fell under state law and SPAC knew that the NSA did not apply, on February 25, 2025, HaloMD, on behalf of and in coordination with SPAC, using the email address soundnsa@halomd.com, initiated IDR and falsely attested to IDR eligibility.

229. Anthem submitted an objection to eligibility, which was also addressed to SPAC, asserting: "The claim(s) is ineligible for IDR under the NSA because a state surprise billing law applies." Again, neither HaloMD nor SPAC withdrew the dispute following Anthem's explicit notice of eligibility.

230. As a result of HaloMD and SPAC's fraudulent attestations, Anthem was required to pay $1,636.40 for the ineligible service, which was greater than the $1,016.40 amount SPAC had billed for the same service and greater than HaloMD's $1,006.24 offer to resolve the claim in open negotiations. Anthem also paid $503 in unnecessary IDR-related fees.

CLAIMS FOR RELIEF

COUNT I

VIOLATION OF RICO, 18 U.S.C. § 1962(c)

(Against All Defendants)

231. Anthem repeats and realleges the allegations in Paragraphs 1 through 230 in this Complaint as if fully set forth at length herein.

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232. Section 1962(c) makes it "unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity." 18 U.S.C. § 1962(c).

233. At all relevant times, Defendants have been "persons" under 18 U.S.C. § 1961(3) because they are capable of holding, and do hold, "a legal or beneficial interest in property."

234. Defendants together formed two distinct but similarly structured association-in-fact enterprises (the LaRoque Family and Sound Physicians Enterprises), as that term is defined in 18 U.S.C. § 1961(4), for the purposes of stealing and defrauding funds from Anthem through the fraudulent submission of ineligible and inflated disputes under the federal IDR process.

235. For several years, the LaRoque Family and Sound Physicians Enterprises have sought to illegally increase its profits by: (1) knowingly submitting false and fraudulent attestations of eligibility for services and disputes that they know are ineligible for the IDR process; (2) strategically initiating massive volumes of IDR disputes simultaneously against Anthem; and (3) improperly inflating payment offers that far exceed what the Provider Defendants could have received from patients or health plans in a competitive market and, in many case, are twice or more the Provider Defendants' billed charges.

236. At all relevant times, the LaRoque Family and Sound Physicians Enterprises each: (a) functioned as a continuing unit with an ascertainable structure separate and distinct from the pattern of racketeering activity; (b) shared a common purpose of furthering their illegal scheme and increasing their revenues and profits at the expense of Anthem; (c) had systematic linkage to each other through interpersonal and contractual relationships, financial ties, shared correspondence, and continuing coordination of activities; and (d) had sufficient longevity for the enterprise to pursue its purpose. Each member of the LaRoque Family and Sound Physicians Enterprises

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participated in the operation and management of the enterprises, including patterns of racketeering activity, and shared in the profits illicitly obtained due to the enterprises' fraudulent activity.

237. The LaRoque Family and Sound Physicians Enterprises are distinct from and have an existence beyond the pattern of racketeering that is described herein, namely by recruiting, employing, overseeing and coordinating many individuals who have been responsible for facilitating and performing a wide variety of administrative and ostensibly professional functions beyond the acts of wire fraud (*i.e.*, the submission of the ineligible and inflated disputes to Anthem through the IDR process), by creating and maintaining records, by negotiating and executing various agreements, and by maintaining the bookkeeping and accounting functions necessary to manage the receipt and distribution of the insurance proceeds.

238. Defendants carried out, or attempted to carry out, schemes to defraud Anthem by knowingly conducting or participating, directly or indirectly, in the conduct of the LaRoque Family and Sound Physicians Enterprises, as applicable, through a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1) that consisted of numerous and repeated violations of the federal wire fraud statute, which prohibits the use of any interstate wire facility for the purpose of executing a scheme to defraud, in violation of 18 U.S.C. § 1343.

239. Defendants committed, conspired to commit, and/or aided and abetted in the commission of at least two predicate acts of racketeering activity (*i.e.*, violations of U.S.C. § 1343) within the past ten years. The multiple acts of racketeering activity that the Defendants committed, or aided and abetted in the commission of, were related to each other and posed a threat of continued racketeering activity, and therefore constitute a "pattern of racketeering activity." The predicate acts, as applicable to each of the LaRoque Family and Sound Physicians Enterprises, also had the same or similar results, participants, victims, and methods. The predicate acts were related and not isolated events.

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240. Defendants violated 18 U.S.C. § 1343 by transmitting and/or receiving, or by causing to be transmitted and/or received, materials by interstate wire for the purpose of executing the unlawful scheme to defraud funds from Anthem by means of false pretenses, misrepresentations, promises and omissions. Specifically, the disputes Defendants submitted through the federal IDR process contained uniform misrepresentations that the disputes were eligible for that process and often contained inflated amounts. The predicate acts all had the purpose of substantially harming Anthem's business and property, while simultaneously generating substantial revenues for the members of the LaRoque Family and Sound Physicians Enterprises. The predicate acts were committed or caused to be committed by Defendants through their participation in the LaRoque Family and Sound Physicians Enterprises, as applicable, and in furtherance of their fraudulent schemes.

241. Defendants' predicate acts of racketeering—which began no later than January 2024 and have occurred continuously and systematically through the present day—committed by interstate wires, include: (a) submitting claims through the online IDR eligibility portal that were ineligible for the IDR process; (b) demanding outrageous payments far in excess of their charges, much less a commercially reasonable amount; (c) initiating over hundred disputes at the same time and in such a way as to make it difficult for Anthem to reasonably identify and object to all ineligible disputes; (d) engaging in the IDR process in bad faith; and (e) procuring payments on disputes that were ineligible for IDR and/or or grossly inflated. The fraudulent disputes submitted to Anthem that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the Sections titled "The LaRoque Family Enterprise" and "The Sound Physicians Enterprise," *supra*.

242. The members of the LaRoque Family and Sound Physicians Enterprises all shared a common purpose to enrich themselves at the expense of Anthem by fraudulently inducing and compelling Anthem to pay exorbitant amounts for services

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that were not eligible for the IDR process and causing Anthem to pay inflated amounts for eligible services far exceeding their billed charges.

243. Defendants aided and abetted others in the violations of the above laws, rendering them indictable as principals in the 18 U.S.C. § 1343 offenses.

244. The members of the LaRoque Family and Sound Physicians Enterprises have profited, and continue to profit, substantially from the fraudulent billing scheme, ultimately receiving several millions of dollars in illicitly obtained reimbursements and IDR-related fees. These payments, disbursed through interstate wire facilities, each constitute a separate violation of 18 U.S.C. § 1343.

245. The members of the LaRoque Family and Sound Physicians Enterprises knew their actions would cause harm to Anthem. Nevertheless, the members of the LaRoque Family and Sound Physicians Enterprises engaged in schemes of deception, that utilized the internet and wire transfers as part of their fraud, in order to steal funds from Anthem by means of false pretenses, misrepresentations and omissions.

246. The LaRoque Family and Sound Physicians Enterprises' fraudulent conduct and participation in the racketeering activity described herein has directly and proximately caused Anthem and its affiliated health plans to incur several millions of dollars in damages.

247. By reason of its injury, Anthem is entitled to compensatory, punitive, and treble damages, pre- and post-judgment interest, attorney's fees, costs incurred in bringing this action, and any other relief the Court deems just and proper.

COUNT II

VIOLATION OF RICO, 18 U.S.C. § 1962(d)

(Against All Defendants)

248. Anthem repeats and realleges the allegations in Paragraphs 1 through 230 contained in this Complaint as if fully set forth at length herein.

249. Section 1962(d) makes it unlawful for "any person to conspire to violate" Section 1962(c), among other provisions. 18 U.S.C. § 1962(d).

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250. The LaRoque Family and Sound Physicians Enterprises are each an association-in-fact "enterprise" as that term is defined in 18 U.S.C. § 1961(4), that engages in activities which affect interstate commerce.

251. Defendants are employed by and/or associated with the LaRoque Family and Sound Physicians Enterprises, as applicable.

252. The Defendants and the LaRoque Family and Sound Physicians Enterprises have knowingly agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of the LaRoque Family and Sound Physicians Enterprises' affairs, as applicable, through a pattern of racketeering activity consisting of repeated violations of the wire fraud statute, 18 U.S.C. § 1343, based upon the use of interstate wire facilities to execute the profit-making fraudulent billing schemes described herein. The fraudulent disputes submitted to Anthem that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the Sections titled "The LaRoque Family Enterprise" and "The Sound Physicians Enterprise," *supra*.

253. Defendants knew of, agreed to and acted in furtherance of the common overall objective (*i.e.*, to defraud Anthem and its affiliated health plans of money) by submitting or facilitating the submission of fraudulent ineligible and inflated disputes to Anthem through the IDR process.

254. The LaRoque Family and Sound Physicians Enterprises' fraudulent conduct and participation in the racketeering activity described herein has directly and proximately caused Anthem and its affiliated health plans to incur several millions of dollars in damages.

255. By reason of its injury, Anthem is entitled to compensatory, punitive, and treble damages, pre- and post-judgment interest, attorney's fees, costs incurred in bringing this action, and any other relief the Court deems just and proper.

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COUNT III

FRAUDULENT MISREPRESENTATION

(Against All Defendants)

256. Anthem repeats and realleges the allegations in Paragraphs 1 through 230 contained in this Complaint as if fully set forth at length herein.

257. The Provider Defendants, and the HaloMD Defendants on behalf of and in coordination with the Provider Defendants, knowingly and willfully executed the schemes described herein with the intent to defraud Anthem by (1) submitting knowingly false attestations of IDR eligibility to Anthem, the IDREs, and the Departments and (2) falsely representing to Anthem that the disputes were eligible for IDR prior to initiating the IDR process, all done with the intent to obtain money owned or controlled by Anthem and its affiliated health plans under the false pretense that the disputes were eligible for resolution through the IDR process.

258. For each of the IDRs initiated, the Provider Defendants, or the HaloMD Defendants on behalf of and in coordination with the Provider Defendants, submitted a completed version of the mandatory IDR notice of initiation to Anthem, the IDREs, and the Departments, which, in part, contained the following attestation:

> I, the undersigned initiating party (or representative of the initiating party), attests that to the best of my knowledge…the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) within the scope of the Federal IDR process.

259. Yet as discussed herein, thousands of the Provider Defendants' and the HaloMD Defendants' attestations were clearly false, as the underlying services were not qualified items or services, and in fact, the disputes were ineligible for resolution through the NSA's IDR process.

260. The Provider Defendants, or the HaloMD Defendants on behalf of and in coordination with the Provider Defendants, submitted the IDR notice of initiation in each such dispute with full knowledge of the falsity of this attestation. From the patient's insurance cards, the plain text of federal laws and regulations, CMS

publications and resources, the Provider Defendants' and/or the HaloMD Defendants' preparation of IDR initiation forms and notices, their participation in the IDR process, and the specific objections to eligibility that Anthem submitted to the Provider Defendants and to the HaloMD Defendants, among other sources, the Provider Defendants and the HaloMD Defendants knew that the services and disputes they were initiating were ineligible for the IDR process.

261. The Provider Defendants, and the HaloMD Defendants on behalf of and in coordination with the Provider Defendants, nevertheless submitted these false attestations and did so with the intent that Anthem and the IDRE rely on them. According to federal law, "the certified IDR entity selected must review the information submitted in the notice of IDR initiation"—including the Provider Defendants' and the HaloMD Defendants' false attestations of eligibility—"to determine whether the Federal IDR process applies." 45 C.F.R. § 149.510(c)(1)(v). Even if Anthem contested eligibility, the Provider Defendants and the HaloMD Defendants knew and expected their deliberate misrepresentations would force Anthem to reasonably and foreseeably rely on the misrepresentations because once the IDRE determines the dispute is eligible, Anthem has no choice but to proceed with the process, submit a final offer, and allow the dispute the continue to a payment determination; any other approach would result in a default award against Anthem in favor of the Provider Defendants and the HaloMD Defendants for whatever outrageous amount they included in their final offer.

262. As described above, these misrepresentations were submitted by corporate agents using corporate email addresses—including nsa@halomd.com, soundnsa@halomd.com, soundfedidr@soundphysicians.com, and medsurantarbitrationnsa@halomd.com—which, upon information and belief, was an attempt to conceal the identity of the individuals submitting the false attestations. As parties to IDR have no ability to engage in discovery—in fact, the parties submit final offers and supporting evidence in a blind process without the right or ability to see the other party's submission—the submission of false attestations achieved the

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concealment of the corporate actors filing the false attestations, save for DISP-2193991 where, on December 2, 2024, the HaloMD Defendant's employee "CJC" initiated IDR through the IDR portal using a false attestation of eligibility on behalf of and in coordination with N Express despite being on notice that the dispute was subject to California's State Surprise Billing Laws.

263. Between January 4, 2024, and April 30, 2025, the Provider Defendants, and HaloMD on behalf of and in coordination with the Provider Defendants, submitted thousands of false attestations, including, for example, the disputes specifically referenced above.

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

265. The Provider Defendants, and the HaloMD Defendants on behalf of and in coordination with the Provider Defendants, submitted the false attestations to receive a windfall for themselves, namely, IDR payment determinations in favor of the Provider Defendants and against Anthem regarding items or services that were ineligible for resolution through the IDR process.

266. At all times when submitting the false attestations and engaging in the relevant IDR disputes, the HaloMD Defendants were acting within the scope of HaloMD's agreements with the Provider Defendants to handle the IDR process for the Provider Defendants in connection with the identified disputes.

267. At all times when submitting the false attestations and engaging in the relevant IDR disputes, the HaloMD Defendants and the Provider Defendants were co-conspirators, each playing an integral role in carrying out the scheme, including providing funding, directing billing practices, and facilitating the submission of improper claims and IDR proceedings.

268. The Provider Defendants, and the HaloMD Defendants on behalf of and in coordination with the Provider Defendants, also fraudulently misrepresented to Anthem during the statutorily required open negotiations process that the disputes were eligible

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for IDR and involved qualified IDR items and services meeting the NSA and regulatory definitions of that term.

269. Anthem reasonably, foreseeably, and justifiably relied on the Provider Defendants and the HaloMD Defendants' misrepresentations during the open negotiations and IDR initiation process. As part of the fraudulent scheme described herein, Defendants' tactic to strategically flood the IDR process and overwhelm the system precluded Anthem from investigating each and every aspect of the tens of thousands of disputes they submitted within the 30-day open negotiations window or within three days of IDR initiation, intending that Anthem would rely on Defendants' false representations of eligibility. Additionally, in some cases (such as when the patient waived balance billing protections), Defendants are the only entities in possession of information critical to Anthem's ability to assess a claim for IDR eligibility, such as information pertaining to the provider, types of services rendered, and patient records. Thus, Defendants knew Anthem was often incapable of knowing the falsity of Defendants' misrepresentations. As a result, Anthem justifiably relied on Defendants' misrepresentations that the disputes were eligible for IDR and incurred significant monetary losses through incurring fees required by the NSA and in the form of IDR payment determinations finding against Anthem.

270. As a direct and proximate result of these misrepresentations by the Provider Defendants and the HaloMD Defendants on behalf of the Provider Defendants, Anthem and its affiliated plans have suffered substantial damages in the form of payment on IDR payment determinations that were ineligible for resolution through the NSA's IDR process.

COUNT IV

NEGLIGENT MISREPRESENTATION

(Against All Defendants)

271. Anthem repeats and realleges the allegations in Paragraphs 1 through 230 contained in this Complaint as if fully set forth at length herein.

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272. In submitting the false attestations of eligibility, the Provider Defendants, and HaloMD on behalf of and in coordination with the Provider Defendants, misrepresented material facts to Anthem, the IDREs, and the Departments regarding eligibility of the disputes to proceed to the IDR payment determination stage. From the patient's insurance cards, the plain text of federal laws and regulations, CMS publications and resources, the Provider Defendants' and the HaloMD Defendants' preparation of IDR initiation forms and notices, their participation in the IDR process, and the specific objections to eligibility that Anthem submitted to the Provider Defendants and to the HaloMD Defendants, among other sources, the Provider Defendants and the HaloMD Defendants had no reasonable grounds on which to believe and represent that the services and disputes they were initiating were ineligible for the IDR process.

273. As described above, these misrepresentations were submitted by corporate agents of the Provider Defendants and the HaloMD Defendants, using corporate email addresses—including nsa@halomd.com, soundnsa@halomd.com, soundfedidr@soundphysicians.com, and medsurantarbitrationnsa@halomd.com—which, upon information and belief, was an attempt to conceal the identity of the individuals submitting the false attestations. As parties to IDR have no ability to engage in discovery—in fact, the parties submit final offers and supporting evidence in a blind process without the right or ability to see the other party's submission—the submission of false attestations achieved the concealment of the corporate actors filing the false attestations, save for DISP-2193991 where, on December 2, 2024, the HaloMD Defendant's employee "CJC" initiated IDR through the IDR portal using a false attestation of eligibility on behalf of and in coordination with N Express despite being on notice that the dispute was subject to California's state specified law.

274. The Provider Defendants and the HaloMD Defendants owed a duty of reasonable care to Anthem, under which they were required to conduct reasonable investigations, ensure the eligibility of the services for which they were initiating the

IDR process, and guard against the submission of false attestations of eligibility leading IDREs to erroneously issue payment determinations in favor of the Provider Defendants and the HaloMD Defendants for items or services that were not eligible for the IDR process. The Provider Defendants and HaloMD Defendants owed Anthem a duty of care to submit accurate information to Anthem, the IDREs, and the Departments when they sought payment or additional payment on the medical claims underlying the IDR disputes. Specifically, in making the false representations to Anthem, the IDREs, and the Departments, the Provider Defendants and the HaloMD Defendants were acting in course of their business or profession and had a pecuniary interest in the underlying medical claims at issue. Moreover, the Provider Defendants and the HaloMD Defendants possessed superior knowledge of the facts underlying the services they (or their clients and co-conspirators in the case of the HaloMD Defendants) provide.

275. The Provider Defendants, and the HaloMD Defendants on behalf of and in coordination with the Provider Defendants, submitted these false attestations with the intent that Anthem and the IDRE rely on them. Even if Anthem contested eligibility, the Provider Defendants' and the HaloMD Defendants' deliberate misrepresentation to the IDRE, on which the IDRE relied, forced Anthem to rely on the misrepresentation because, once the IDRE determines the dispute is eligible, Anthem has no choice but to proceed with the process, submit a final offer, and allow the dispute the continue to a payment determination; any other approach would result in a default award against Anthem and in favor of the Provider Defendant for whatever outrageous amount the Provider Defendant, or HaloMD acting on its behalf, included as the final offer.

276. At all times when submitting the false attestations and engaging in the relevant IDR disputes, the HaloMD Defendants were acting within the scope of HaloMD's agreements with the Provider Defendants to handle the IDR process for the Provider Defendants in connection with the identified disputes.

277. At all times when submitting the false attestations and engaging in the relevant IDR disputes, the HaloMD Defendants and the Provider Defendants were co-

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conspirators, each playing an integral role in carrying out the scheme, including providing funding, directing billing practices, and facilitating the submission of improper claims and IDR proceedings.

278. The Provider Defendants and/or HaloMD on behalf of and in coordination with the Provider Defendants also falsely represented to Anthem during the statutorily required open negotiations process that the disputes were eligible for IDR and involved qualified IDR items and services meeting the NSA and regulatory definitions of that term when, in fact, they did not.

279. Anthem reasonably, foreseeably, and justifiably relied on the Provider Defendants and the HaloMD Defendants' misrepresentations during the open negotiations and IDR initiation process. As part of the fraudulent schemes described herein, Defendants' tactic was to flood the IDR process and overwhelm the system such that Anthem would be unable to investigate each and every aspect of the tens of thousands of disputes often submitted on the same day within the 30-day open negotiations window or within days after IDR initiation. Additionally, the HaloMD Defendants and the Provider Defendants are in some circumstances the only entities in possession of information critical to Anthem's ability to assess a claim for IDR eligibility, such as information pertaining to the provider, types of services rendered, and patient records. Thus, Defendants knew Anthem was often incapable of knowing the falsity of Defendants' misrepresentations. As a result, Anthem justifiably relied on the HaloMD Defendants' misrepresentations that the disputes were eligible for IDR and incurred significant monetary losses through incurring fees required by the NSA and in the form of IDR payment determinations finding against Anthem.

280. As a direct and proximate result of the Provider Defendants' and the HaloMD Defendants' misrepresentations, and Anthem's reasonable reliance on the same, Anthem and its affiliated health plans have suffered substantial damages in the form of payment on IDR payment determinations that were ineligible for resolution through the NSA's IDR process.

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COUNT V

BUSINESS ACTS OR PRACTICES IN VIOLATION OF CAL. BUS. & PROF. CODE § 17200, *et seq.*

(Against All Defendants)

281. Anthem repeats and realleges the allegations in Paragraphs 1 through 230 contained in this Complaint as if fully set forth at length herein.

282. The Provider Defendants, and the HaloMD Defendants on behalf of and in coordination with the Provider Defendants, engaged in unlawful, unfair, and fraudulent business acts or practices by misrepresenting information to Anthem, the IDREs, and the Departments throughout the NSA dispute resolution process, including by submitting the false attestations of eligibility regarding the disputes. From January 4, 2024, to April 30, 2025, the Provider Defendants and/or the HaloMD Defendants on behalf of and in coordination with the Provider Defendants submitted thousands of ineligible disputes through the NSA dispute resolution process, including in the exemplar disputes identified above, in which they knowingly and willfully represented that the disputes were eligible through IDR when they knew they were not.

283. From the patient's insurance cards, the plain text of federal laws and regulations, CMS publications and resources, the Provider Defendants' and the HaloMD Defendants' preparation of IDR initiation forms and notices, their participation in the IDR process, and the specific objections to eligibility that Anthem submitted to the Provider Defendants and to the HaloMD Defendants, among other sources, the Provider Defendants and the HaloMD Defendants knew that the services and disputes they were initiating were ineligible for the IDR process.

284. The Provider Defendants and/or the HaloMD Defendants on behalf of the Provider Defendants, submitted these false attestations with the intent that Anthem and the IDRE rely on them.

285. The actions of the Provider Defendants, and the HaloMD Defendants on behalf of the Provider Defendants, violated the following statutes:

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- California Penal Code § 550, which makes it unlawful to knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim; conspire to or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact; or conspire to prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact, among other things.

- The Federal Health Care Fraud Statute, as set forth in 18 U.S.C. Section 1347, which prohibits individuals and entities from executing or attempting to execute a scheme to defraud a health care benefit program, whether or not it is a federal program.

286. In addition to being unlawful, the conduct by the Provider Defendants, and the HaloMD Defendants on behalf of the Provider Defendants, described herein, is immoral, unethical, oppressive, and unscrupulous. Moreover, through the significant financial harm this conduct causes to Anthem and its affiliated plans, it also disrupts the insurance market and causes significant downstream harm to consumers through the increased cost of health care services.

287. As a result of these unlawful, unfair, and fraudulent practices, Anthem and its affiliated health plans have suffered substantial damages.

COUNT VI

VACATUR OF NSA ARBITRATION AWARDS

(Against All Defendants)

288. Anthem repeats and realleges the allegations in Paragraphs 1 through 230 contained in this Complaint as if fully set forth at length herein.

289. Defendants improperly obtained arbitration awards under the NSA by misrepresenting that the services were qualified IDR items or services, warranting vacatur of such awards under 9 U.S.C. § 10(a) and 42 U.S.C. § 300gg-111(c)(5)(E).

290. The IDR payment determinations at issue were procured by undue means and misrepresentation.

291. For the IDR payment determinations at issue, 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.

292. Defendants continue to obtain awards by undue means and misrepresentation. Thus, the list of IDR payment determinations subject to vacatur is expected to increase during the pendency of the case.

COUNT VII

ERISA CLAIM FOR EQUITABLE RELIEF

(Against All Defendants)

293. Anthem repeats and realleges the allegations in Paragraphs 1 through 230 contained in this Complaint as if fully set forth at length herein.

294. Anthem provides claims administration services for certain health benefit plans governed by ERISA. Those health benefit plans and their employer sponsors delegate to Anthem discretionary authority to recover overpayments, including those resulting from fraud, waste, or abuse.

295. ERISA authorizes a fiduciary of a health plan to bring a civil action to "enjoin any act or practice which violates any provision of this subchapter or the terms of the plan" or "to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3).

296. Section 1185e of ERISA sets out the rights and obligations of plans and medical providers with respect to the IDR process, including that the IDR process does not apply in situations where there is a specified state law, where the provider is a

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participating provider, and where the provider has not initiated or engaged in open negotiations. 29 U.S.C. § 1185e.

297. Through the acts described herein, Defendants have caused and continue to cause the overpayment of funds on behalf of ERISA-governed benefit plans through conduct that violates Section 1185e of ERISA.

298. Defendants are continuing to engage in such improper conduct, including but not limited to failing to properly initiate or engage in open negotiations prior to initiating the IDR process, initiating IDR for services subject to California's specified state law, initiating IDR with respect to claims that Anthem denied and thus are exempt from the IDR process, and failing to comply with other NSA requirements such as the IDR batching rules or the cooling off period. This conduct causes ongoing harm to Anthem and the ERISA-governed benefit plans.

299. There is an actual case and controversy between Anthem and Defendants relating to the claims fraudulently submitted and arbitrated as part of the NSA's IDR process.

300. Anthem seeks an order enjoining Defendants from:

a. Initiating IDR without first properly initiating and engaging in open negotiations;

b. Initiating IDR for services subject to California's specified state law;

c. Initiating IDR for services that Anthem denied and thus are not eligible for IDR; and

d. Initiating IDR for services when Defendants failed to comply with other NSA requirements such as the deadline to initiate IDR following open negotiations.

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COUNT VIII

DECLARATORY AND INJUNCTIVE RELIEF

(Against All Defendants)

301. Anthem repeats and realleges the allegations in Paragraphs 1 through 230 contained in this Complaint as if fully set forth at length herein.

302. Anthem seeks a declaration that Defendants' conduct in submitting false attestations and initiating IDR for unqualified IDR items or services is unlawful. Anthem additionally seeks a declaration that IDR awards for such unqualified IDR items or services are not binding. It further seeks an injunction prohibiting Defendants from continuing to submit false attestations and initiate IDR for items or services that are not qualified for IDR, or from seeking to enforce non-binding awards entered on items and services not qualified for IDR.

303. With respect to health plans and claims governed by ERISA, this cause of action is alleged in the alternative to the previous cause of action, in the event that the Court determines that relief under Section 1132(a)(3) of ERISA is not available.

304. There is no adequate remedy at law to prevent the ongoing harm caused by Defendants' conduct.

PRAYER FOR RELIEF

WHEREFORE, Anthem respectfully requests that the Court:

a. Award compensatory, punitive, and treble damages;

b. Enter an injunction prohibiting Defendants from submitting unqualified IDR items and services to IDR and otherwise initiating improper arbitrations;

c. Vacate all improperly obtained NSA arbitration awards;

d. Order the return of funds wrongfully obtained by Defendants;

e. Award costs, attorney's fees, and interest;

f. Declare that IDR awards issued on unqualified IDR items or services are non-binding and are not payable on a go-forward basis;

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

JURY DEMAND

Anthem demands a trial by jury on all issues so triable.

DATED: July 7, 2025

By: /s/ *Amir Shlesinger*
Amir Shlesinger

REED SMITH LLP
A limited liability partnership formed in the State of Delaware

Name Martin J. Bishop, Jason T. Mayer (pro hac vice)
Address Crowell & Moring LLP, 300 N. LaSalle Drive, Suite 2500
City, State, Zip Chicago, IL 60654
Phone 312-321-4200
Fax 202-628-5116
E-Mail mbishop@crowell.com; jmayer@crowell.com

☐ FPD ☐ Appointed ☐ CJA ☐ Pro Per ☒ Retained

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE, et al., PLAINTIFF(S), v. HALOMD LLC, et al., DEFENDANT(S).	CASE NUMBER: 8:25-cv-01467-KES
	NOTICE OF APPEAL

NOTICE IS HEREBY GIVEN that Anthem Blue Cross Life and Health Insurance Company; and Blue Cross of California dba Anthem Blue Cross hereby appeals to
Name of Appellant
the United States Court of Appeals for the Ninth Circuit from:

Criminal Matter

☐ Conviction only [F.R.Cr.P. 32(j)(1)(A)]
☐ Conviction and Sentence
☐ Sentence Only (18 U.S.C. 3742)
☐ Pursuant to F.R.Cr.P. 32(j)(2)
☐ Interlocutory Appeals
☐ Sentence imposed:

☐ Bail status:

Civil Matter

☐ Order (specify):

☒ Judgment (specify): Docket No. 136

☐ Other (specify):

Imposed or Filed on April 9, 2026. Entered on the docket in this action on April 10, 2026.

A copy of said judgment or order is attached hereto.

April 13, 2026
Date

/s/ Jason Mayer
Signature
☐ Appellant/ProSe ☒ Counsel for Appellant ☐ Deputy Clerk

Note: The Notice of Appeal shall contain the names of all parties to the judgment or order and the names and addresses of the attorneys for each party. Also, if not electronically filed in a criminal case, the Clerk shall be furnished a sufficient number of copies of the Notice of Appeal to permit prompt compliance with the service requirements of FRAP 3(d).

JS-6

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

JUDGMENT

IT IS ADJUDGED that Plaintiffs' vacatur claims are DISMISSED WITH PREJUDICE. Plaintiffs' remaining claims are dismissed for lack of jurisdiction.

DATED: April 9, 2026

Karen E. Scott

Hon. Karen E. Scott
UNITED STATES DISTRICT JUDGE

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 6. Representation Statement

Instructions for this form: http://www.ca9.uscourts.gov/forms/form06instructions.pdf

Appellant(s) *(List **each** party filing the appeal, do not use "et al." or other abbreviations.)*

Name(s) of party/parties:

Anthem Blue Cross Life and Health Insurance Company; Blue Cross of California, doing business as Anthem Blue Cross

Name(s) of counsel (if any):

Emily T. Kuwahara - Crowell & Moring LLP

Address: 515 Flower St 41th floor, Los Angeles, CA 90071

Telephone number(s): 213-443-5556

Email(s): ekuwahara@crowell.com

Is counsel registered for Electronic Filing in the 9th Circuit? ◉ Yes ○ No

---

Appellee(s) *(List only the names of parties and counsel who will oppose you on appeal. List separately represented parties separately.)*

Name(s) of party/parties:

HaloMD LLC; Alla LaRoque; Scott LaRoque

Name(s) of counsel (if any):

Jonah D. Retzinger, April Chen Yang, Brock Joseph Seraphin, and Christopher D. Grigg

Address: 1 California Plaza 300 S. Grand Ave., Ste 4100 Los Angeles, CA 90071

Telephone number(s): 213-629-6000

Email(s): See attached

To list additional parties and/or counsel, use next page.

Feedback or questions about this form? Email us at forms@ca9.uscourts.gov

Continued list of parties and counsel: *(attach additional pages as necessary)*

Appellants

Name(s) of party/parties:

Anthem Blue Cross Life and Health Insurance Company; Blue Cross of California, doing business as Anthem Blue Cross

Name(s) of counsel (if any):

Martin J. Bishop

Address: 300 N. LaSalle Drive, Suite 2500, Chicago, IL 60654

Telephone number(s): 312-379-7614

Email(s): mbishop@crowell.com

Is counsel registered for Electronic Filing in the 9th Circuit? ◉ Yes ○ No

Appellees

Name(s) of party/parties:

Bruin Neurophysiology, P.C.; iNeurology, PC; N Express, PC; North American Neurological Associates, PC; MPOWERHealth Practice Management, LLC

Name(s) of counsel (if any):

B. Kurt Cooper, David M. DeVito, and James L. Poth

Address: 2727 N. Harwood St., Suite 500, Dallas TX 75201

Telephone number(s): 219-969-5163

Email(s): bkcooper@jonesday.com;ddevito@jonesday.com;jlpoth@jonesday.com

Name(s) of party/parties:

Sound Physicians Anesthesiology of California, P.C.; Sound Physicians Emergency Medicine of Southern California, P.C.

Name(s) of counsel (if any):

Connor S. Romm, Tala Toufanian Jayadevan, Erica Bentley Lang, Laura McLane, and Matthew L. Knowles

Address: 200 Clarendon Street Boston, MA 02116

Telephone number(s): 617-535-5977

Email(s): See attached

Feedback or questions about this form? Email us at forms@ca9.uscourts.gov

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 6. Representation Statement Continued

Appellee(s) *(List only the names of parties and counsel who will oppose you on appeal. List separately represented parties separately.)*

Email(s) for Counsel of HaloMD LLC, Alla LaRoque, and Scott LaRoque:
jretzinger@nixonpeabody.com, ayang@nixonpeabody.com, bseraphin@nixonpeabody.com, and cgrigg@nixonpeabody.com.

Email(s) for Counsel of Sound Physicians Anesthesiology of California, P.C.; Sound Physicians Emergency Medicine of Southern California, P.C.:
cromm@mwe.com, tjayadevan@mwe.com, elang@mcdermottlaw.com, lmclane@mwe.com, and mknowles@mwe.com.

ACCO,APPEAL,CLOSED,CONMAG,MJDAP

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA (Southern Division - Santa Ana)
CIVIL DOCKET FOR CASE #: 8:25-cv-01467-KES

Anthem Blue Cross Life and Health Insurance Company et al v. HaloMD LLC et al
Assigned to: Magistrate Judge Karen E. Scott
Case in other court: 9th CCA, 26-02355
Cause: 18:1962 Racketeering (RICO) Act

Date Filed: 07/07/2025
Date Terminated: 04/09/2026
Jury Demand: Plaintiff
Nature of Suit: 470 Racketeer/Corrupt Organization
Jurisdiction: Federal Question

Plaintiff

Anthem Blue Cross Life and Health Insurance Company

represented by **Amir Shlesinger**
Crowell and Moring LLP
515 South Flower Street, 41st Floor
Los Angeles, CA 90071
213-622-4750
Fax: 213-622-2690
Email: AShlesinger@crowell.com
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Jed Wulfekotte
Crowell and Moring LLP
1001 Pennsylvania Avenue, NW
Washington, DC 20004
202-624-2505
Email: jwulfekotte@crowell.com
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Lily C. Geyer
Crowell and Moring, LLP
1001 Pennsylvania Avenue, NW
Washington, DC 20004
202-624-2740
Fax: 202-628-5116
Email: lgeyer@crowell.com
LEAD ATTORNEY
PRO HAC VICE
ATTORNEY TO BE NOTICED

Alexandra M Lucas
Crowell and Moring LLP
455 CityFront Plaza, Suite 3600
Chicago, IL 60611
651-503-8877

Email: alucas@crowell.com
PRO HAC VICE
ATTORNEY TO BE NOTICED

Jason T. Mayer
Crowell and Moring LLP
300 N LaSalle, Suite 2500
Chicago, IL 60655
312-379-7618
Email: jmayer@crowell.com
PRO HAC VICE
ATTORNEY TO BE NOTICED

Jennie Wang VonCannon
Crowell and Moring LLP
515 South Flower Street, 41th Floor
Los Angeles, CA 90071
213-622-4750
Fax: 213-622-2690
Email: jvoncannon@crowell.com
ATTORNEY TO BE NOTICED

Joanna M Fuller
Crowell and Moring LLP
3 Park Plaza, 20th Floor
Irvine, CA 92614-8505
949-263-8400
Fax: 949-263-8414
Email: jfuller@crowell.com
ATTORNEY TO BE NOTICED

Joshua M. Robbins
Crowell and Moring LLP
3 Park Plaza, 20th Floor
Irvine, CA 99614
949-798-1325
Fax: 949-263-8414
Email: jrobbins@crowell.com
ATTORNEY TO BE NOTICED

Mark E Bini
Reed Smith LLP
599 Lexington Avenue, 22nd Floor
New York, NY 10022
212-521-5400
Fax: 212-521-5450
Email: mbini@reedsmith.com
TERMINATED: 08/19/2025
PRO HAC VICE

Martin J. Bishop
Crowell and Moring LLP
300 N. LaSalle Street, Suite 2500
Chicago, IL 60654

312-379-7614
Fax: 213-622-2690
Email: mbishop@crowell.com
PRO HAC VICE
ATTORNEY TO BE NOTICED

Plaintiff

Blue Cross of California
doing business as
Anthem Blue Cross

represented by **Amir Shlesinger**
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Jed Wulfekotte
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Lily C. Geyer
(See above for address)
LEAD ATTORNEY
PRO HAC VICE
ATTORNEY TO BE NOTICED

Alexandra M Lucas
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Jason T. Mayer
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Jennie Wang VonCannon
(See above for address)
ATTORNEY TO BE NOTICED

Joanna M Fuller
(See above for address)
ATTORNEY TO BE NOTICED

Joshua M. Robbins
(See above for address)
ATTORNEY TO BE NOTICED

Mark E Bini
(See above for address)
TERMINATED: 08/19/2025
PRO HAC VICE

Martin J. Bishop
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

V.

Movant

American Benefits Council represented by **Jessamyn Elizabeth Vedro**
Troutman Pepper Locke LLP
350 South Grand Avenue, Suite 3400
Los Angeles, CA 90071
213-928-9800
Fax: 213-928-9850
Email: jessamyn.vedro@troutman.com
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Elizabeth J. Loh
Groom Law Group, Chartered
1701 Pennsylvania Ave. NW, Suite 1200
Washington, DC 20006
202-861-9378
Fax: 202-659-4503
Email: ELoh@groom.com
PRO HAC VICE
ATTORNEY TO BE NOTICED

Ryan C. Temme
Groom Law Group, Chartered
1701 Pennsylvania Ave. NW, Suite 1200
Washington, DC 20006
202-861-6659
Fax: 202-659-4503
Email: rtemme@groom.com
PRO HAC VICE
ATTORNEY TO BE NOTICED

Seth T. Perretta
Groom Law Group, Chartered
1701 Pennsylvania Ave. NW, Suite 1200
Washington, DC 20006
202-861-6335
Fax: 202-659-4503
Email: sperretta@groom.com
PRO HAC VICE
ATTORNEY TO BE NOTICED

Movant

ERISA Industry Committee represented by **Jessamyn Elizabeth Vedro**
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Elizabeth J. Loh
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Ryan C. Temme
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Seth T. Perretta
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Movant

Business Group on Health represented by **Jessamyn Elizabeth Vedro**
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Elizabeth J. Loh
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Ryan C. Temme
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Seth T. Perretta
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

V.

Defendant

HaloMD LLC represented by **Jonah D. Retzinger**
Nixon Peabody LLP
One California Plaza
300 South Grand Avenue, Suite 4100
Los Angeles, CA 90071
213-629-6000
Fax: 213-629-6001
Email: jretzinger@nixonpeabody.com
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

April Chen Yang
Nixon Peabody LLP
300 South Grand Avenue, Suite 4100
Los Angeles, CA 90071
908-947-5296
Email: ayang@nixonpeabody.com
ATTORNEY TO BE NOTICED

Brock Joseph Seraphin
Nixon Peabody LLP
300 South Grand Avenue, Suite 4100
Los Angeles, CA 90071
213-629-6000
Fax: 213-629-6001
Email: bseraphin@nixonpeabody.com
ATTORNEY TO BE NOTICED

Christopher D Grigg
Nixon Peabody LLP
One California Plaza
300 South Grand Avenue, Suite 4100
Los Angeles, CA 90071
213-629-6134
Email: cgrigg@nixonpeabody.com
ATTORNEY TO BE NOTICED

Gregory Jones
Polsinelli
2049 Century Park East, Suite 2900
Los Angeles, CA 90067
310-556-1801
Fax: 310-556-1802
Email: gjones@polsinelli.com
TERMINATED: 11/06/2025
ATTORNEY TO BE NOTICED

Noel Scott Cohen
Polsinelli LLP
2049 Century Park East Suite 2900
Los Angeles, CA 90067
310-556-1801
Fax: 310-556-1802
Email: ncohen@polsinelli.com
TERMINATED: 11/06/2025
ATTORNEY TO BE NOTICED

Defendant

Alla LaRoque represented by

Jonah D. Retzinger
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

April Chen Yang
(See above for address)
ATTORNEY TO BE NOTICED

Brock Joseph Seraphin
(See above for address)
ATTORNEY TO BE NOTICED

Christopher D Grigg

(See above for address)
ATTORNEY TO BE NOTICED

Gregory Jones
(See above for address)
TERMINATED: 11/06/2025
ATTORNEY TO BE NOTICED

Noel Scott Cohen
(See above for address)
TERMINATED: 11/06/2025
ATTORNEY TO BE NOTICED

Defendant

Bruin Neurophysiology, P.C.

represented by **B. Kurt Copper**
Jones Day
2727 North Harwood St., Suite 500
Dallas, TX 75201
219-969-5163
Fax: 514-969-5100
Email: bkcopper@jonesday.com
LEAD ATTORNEY
PRO HAC VICE
ATTORNEY TO BE NOTICED

David M. DeVito
Jones Day
555 California Street, 26th Floor
San Francisco, CA 94104
415-626-3939
Fax: 415-875-5700
Email: ddevito@jonesday.com
ATTORNEY TO BE NOTICED

James L Poth
Jones Day
3161 Michelson Drive, Suite 800
Irvine, CA 92612
949-851-3939
Fax: 949-553-7539
Email: jlpoth@jonesday.com
ATTORNEY TO BE NOTICED

Defendant

iNeurology, PC

represented by **B. Kurt Copper**
(See above for address)
LEAD ATTORNEY
PRO HAC VICE
ATTORNEY TO BE NOTICED

David M. DeVito
(See above for address)
ATTORNEY TO BE NOTICED

James L Poth
(See above for address)
ATTORNEY TO BE NOTICED

Defendant

Los Angeles Neurological Associates, PC
TERMINATED: 10/17/2025

Defendant

N Express, PC

represented by **B. Kurt Copper**
(See above for address)
LEAD ATTORNEY
PRO HAC VICE
ATTORNEY TO BE NOTICED

David M. DeVito
(See above for address)
ATTORNEY TO BE NOTICED

James L Poth
(See above for address)
ATTORNEY TO BE NOTICED

Defendant

North American Neurological Associates, PC

represented by **B. Kurt Copper**
(See above for address)
LEAD ATTORNEY
PRO HAC VICE
ATTORNEY TO BE NOTICED

David M. DeVito
(See above for address)
ATTORNEY TO BE NOTICED

James L Poth
(See above for address)
ATTORNEY TO BE NOTICED

Defendant

Sound Physicians Anesthesiology of California, P.C.

represented by **Connor S. Romm**
McDermott Will and Schulte LLP
200 Clarendon Street
Boston, MA 02116
617-535-5977
Fax: 617-535-3800
Email: cromm@mwe.com
LEAD ATTORNEY
PRO HAC VICE
ATTORNEY TO BE NOTICED

Tala Toufanian Jayadevan
McDermott Will and Schulte
2049 Century Park East, Suite 3200

Los Angeles, CA 90067
310-277-4110
Fax: 310-277-4730
Email: Tjayadevan@mwe.com
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Erica Bentley Lang
McDermott Will and Schulte LLP
2049 Century Park East, Suite 3200
Los Angeles, CA 90067-3206
310-277-4110
Fax: 310-277-4730
Email: Elang@mcdermottlaw.com
ATTORNEY TO BE NOTICED

Laura McLane
McDermott Will and Schulte LLP
200 Clarendon Street
Boston, MA 02116
617-535-4410
Email: lmclane@mwe.com
PRO HAC VICE
ATTORNEY TO BE NOTICED

Matthew L. Knowles
McDermott Will and Schulte LLP
200 Clarendon Street
Boston, MA 02116
617-535-3885
Email: mknowles@mwe.com
PRO HAC VICE
ATTORNEY TO BE NOTICED

Megan O. Corrigan
McDermott Will and Schulte LLP
200 Clarendon Street, Floor 58
Boston, MA 02130
617-535-3919
Email: mcorrigan@mwe.com
TERMINATED: 10/30/2025
PRO HAC VICE

Defendant

Sound Physicians Emergency Medicine of Southern California, P.C.

represented by

Connor S. Romm
(See above for address)
LEAD ATTORNEY
PRO HAC VICE
ATTORNEY TO BE NOTICED

Tala Toufanian Jayadevan
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Erica Bentley Lang
(See above for address)
ATTORNEY TO BE NOTICED

Laura McLane
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Matthew L. Knowles
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Megan O. Corrigan
(See above for address)
TERMINATED: 10/30/2025
PRO HAC VICE

Defendant

Scott LaRoque represented by **Jonah D. Retzinger**
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

April Chen Yang
(See above for address)
ATTORNEY TO BE NOTICED

Brock Joseph Seraphin
(See above for address)
ATTORNEY TO BE NOTICED

Christopher D Grigg
(See above for address)
ATTORNEY TO BE NOTICED

Defendant

MPOWERHealth Practice Management, LLC represented by **B. Kurt Copper**
(See above for address)
LEAD ATTORNEY
PRO HAC VICE
ATTORNEY TO BE NOTICED

David M. DeVito
(See above for address)
ATTORNEY TO BE NOTICED

James L Poth
(See above for address)
ATTORNEY TO BE NOTICED

Amicus

California Medical Association represented by **Eric David Chan**
Athene Law, LLP
10866 Washington Boulevard, Suite 142
Culver City, CA 90232
310-913-4013
Fax: 844-619-8022
Email: eric@athenelaw.com
ATTORNEY TO BE NOTICED

Long Xuan Do
Athene Law LLP
5432 Geary Boulevard No 200
San Francisco, CA 94121
415-686-7531
Fax: 844-619-8022
Email: long@athenelaw.com
ATTORNEY TO BE NOTICED

Amicus

America's Health Insurance Plans, Inc. represented by **Hyland Hunt**
Deutsch Hunt PLLC
300 New Jersey Avenue NW Suite 300
Washington, DC 20001
202-868-6915
Fax: 202-609-8420
Email: hhunt@deutschhunt.com
LEAD ATTORNEY
PRO HAC VICE
ATTORNEY TO BE NOTICED

Eli Alan Alcaraz
Spertus, Josephs and Minnick LLP
617 West 7th Street, Suite 200
Los Angeles, CA 90017
213-205-6520
Fax: 213-205-6521
Email: ealcaraz@spertuslaw.com
ATTORNEY TO BE NOTICED

Date Filed	#	Docket Text
07/07/2025	1	COMPLAINT Receipt No: ACACDC-40044564 - Fee: $405, filed by Plaintiffs Blue Cross of California d/b/a Anthem Blue Cross, Anthem Blue Cross Life and Health Insurance Company. (Attorney Amir Shlesinger added to party Anthem Blue Cross Life and Health Insurance Company(pty:pla), Attorney Amir Shlesinger added to party Blue Cross of California d/b/a Anthem Blue Cross(pty:pla))(Shlesinger, Amir) (Entered: 07/07/2025)
07/07/2025	2	CIVIL COVER SHEET filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California d/b/a Anthem Blue Cross. (Shlesinger, Amir) (Entered: 07/07/2025)
07/07/2025	3	CORPORATE DISCLOSURE STATEMENT *PLAINTIFFS' CERTIFICATION OF INTERESTED PARTIES/RULE 7.1 CORPORATE DISCLOSURE* filed by Plaintiffs

		Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California d/b/a Anthem Blue Cross identifying Elevance Health, Inc., f/k/a Anthem, Inc as Corporate Parent. (Shlesinger, Amir) (Entered: 07/07/2025)
07/10/2025	4	NOTICE OF ASSIGNMENT to a U.S. Magistrate Judge and Declination of Consent. This case has been randomly assigned to Magistrate Judge Karen E. Scott. (ghap) (Entered: 07/10/2025)
07/10/2025	5	NOTICE OF PRO HAC VICE APPLICATION DUE for Non-Resident Attorney Mark E Bini on behalf of Plaintiffs. A document recently filed in this case lists you as an out-of-state attorney of record. However, the Court has not been able to locate any record that you are admitted to the Bar of this Court, and you have not filed an application to appear Pro Hac Vice in this case. Accordingly, within 5 business days of the date of this notice, you must either (1) have your local counsel file an application to appear Pro Hac Vice (Form G-64) and pay the applicable fee, or (2) complete the next section of this form and return it to the court at cacd_attyadm@cacd.uscourts.gov. You have been removed as counsel of record from the docket in this case, and you will not be added back to the docket until your Pro Hac Vice status has been resolved. (ghap) (Entered: 07/10/2025)
07/10/2025	6	NOTICE OF PRO HAC VICE APPLICATION DUE for Non-Resident Attorney Martin J Bishop on behalf of Plaintiffs. A document recently filed in this case lists you as an out-of-state attorney of record. However, the Court has not been able to locate any record that you are admitted to the Bar of this Court, and you have not filed an application to appear Pro Hac Vice in this case. Accordingly, within 5 business days of the date of this notice, you must either (1) have your local counsel file an application to appear Pro Hac Vice (Form G-64) and pay the applicable fee, or (2) complete the next section of this form and return it to the court at cacd_attyadm@cacd.uscourts.gov. You have been removed as counsel of record from the docket in this case, and you will not be added back to the docket until your Pro Hac Vice status has been resolved. (ghap) (Entered: 07/10/2025)
07/10/2025	7	NOTICE OF PRO HAC VICE APPLICATION DUE for Non-Resident Attorney Alexandra M Lucas on behalf of Plaintiffs. A document recently filed in this case lists you as an out-of-state attorney of record. However, the Court has not been able to locate any record that you are admitted to the Bar of this Court, and you have not filed an application to appear Pro Hac Vice in this case. Accordingly, within 5 business days of the date of this notice, you must either (1) have your local counsel file an application to appear Pro Hac Vice (Form G-64) and pay the applicable fee, or (2) complete the next section of this form and return it to the court at cacd_attyadm@cacd.uscourts.gov. You have been removed as counsel of record from the docket in this case, and you will not be added back to the docket until your Pro Hac Vice status has been resolved. (ghap) (Entered: 07/10/2025)
07/10/2025	8	NOTICE OF PRO HAC VICE APPLICATION DUE for Non-Resident Attorney Jason T Mayer on behalf of Plaintiffs. A document recently filed in this case lists you as an out-of-state attorney of record. However, the Court has not been able to locate any record that you are admitted to the Bar of this Court, and you have not filed an application to appear Pro Hac Vice in this case. Accordingly, within 5 business days of the date of this notice, you must either (1) have your local counsel file an application to appear Pro Hac Vice (Form G-64) and pay the applicable fee, or (2) complete the next section of this form and return it to the court at cacd_attyadm@cacd.uscourts.gov. You have been removed as counsel of record from the docket in this case, and you will not be added back to the docket until your Pro Hac Vice status has been resolved. (ghap) (Entered: 07/10/2025)
07/15/2025	9	APPLICATION of Non-Resident Attorney Jason T. Mayer to Appear Pro Hac Vice on behalf of Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California (Pro Hac Vice Fee - $500 Fee Paid, Receipt No. ACACDC-40095487) filed

		by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (Attachments: # 1 Proposed Order Proposed Order) (Shlesinger, Amir) (Entered: 07/15/2025)
07/15/2025	10	APPLICATION of Non-Resident Attorney Mark E. Bini to Appear Pro Hac Vice on behalf of Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California (Pro Hac Vice Fee - $500 Fee Paid, Receipt No. ACACDC-40095519) filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (Attachments: # 1 Proposed Order Proposed Order) (Shlesinger, Amir) (Entered: 07/15/2025)
07/15/2025	11	APPLICATION of Non-Resident Attorney Alexandra M. Lucas to Appear Pro Hac Vice on behalf of Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California (Pro Hac Vice Fee - $500 Fee Paid, Receipt No. ACACDC-40095889) filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (Attachments: # 1 Proposed Order Proposed Order) (Shlesinger, Amir) (Entered: 07/15/2025)
07/15/2025	12	APPLICATION of Non-Resident Attorney Martin J. Bishop to Appear Pro Hac Vice on behalf of Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California (Pro Hac Vice Fee - $500 Fee Paid, Receipt No. ACACDC-40101096) filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (Attachments: # 1 Proposed Order Proposed Order) (Shlesinger, Amir) (Entered: 07/15/2025)
07/17/2025	13	ORDER by Magistrate Judge Karen E. Scott: Granting 9 Non-Resident Attorney Jason T. Mayer APPLICATION to Appear Pro Hac Vice on behalf of Plaintiff(s) Anthem Blue Cross Life and Health Insurance Company; Blue Cross of California dba Anthem Blue Cross, designating Amir Shlesinger as local counsel. (es) (Entered: 07/18/2025)
07/17/2025	14	ORDER by Magistrate Judge Karen E. Scott: Granting 10 Non-Resident Attorney Mark E. Bini APPLICATION to Appear Pro Hac Vice on behalf of Plaintiff(s) Anthem Blue Cross Life and Health Insurance Company; Blue Cross of California dba Anthem Blue Cross, designating Amir Shlesinger as local counsel. (es) (Entered: 07/18/2025)
07/17/2025	15	ORDER by Magistrate Judge Karen E. Scott: Granting 11 Non-Resident Attorney Alexandra M. Lucas APPLICATION to Appear Pro Hac Vice on behalf of Plaintiff(s) Anthem Blue Cross Life and Health Insurance Company; Blue Cross of California dba Anthem Blue Cross, designating Amir Shlesinger as local counsel. (es) (Entered: 07/18/2025)
07/17/2025	16	ORDER by Magistrate Judge Karen E. Scott: Granting 12 Non-Resident Attorney Martin J. Bishop APPLICATION to Appear Pro Hac Vice on behalf of Plaintiff(s) Anthem Blue Cross Life and Health Insurance Company; Blue Cross of California dba Anthem Blue Cross, designating Amir Shlesinger as local counsel. (es) (Entered: 07/18/2025)
08/15/2025	17	WAIVER OF SERVICE Returned Executed filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company. upon HaloMD LLC waiver sent by Plaintiff on 8/4/2025, answer due 10/3/2025. Waiver of Service signed by Gregory Jones. (Shlesinger, Amir) (Entered: 08/15/2025)
08/15/2025	18	WAIVER OF SERVICE Returned Executed filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company. upon Alla LaRoque waiver sent by Plaintiff on 8/4/2025, answer due 10/3/2025. Waiver of Service signed by Gregory Jones. (Shlesinger, Amir) (Entered: 08/15/2025)
08/15/2025	19	NOTICE OF MOTION AND MOTION of Mark E. Bini to Withdraw as Attorney filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of

		California. (Bini, Mark) (Entered: 08/15/2025)
08/18/2025	20	NOTICE of Appearance filed by attorney Gregory Jones on behalf of Defendants HaloMD LLC, Alla LaRoque (Attorney Gregory Jones added to party HaloMD LLC(pty:dft), Attorney Gregory Jones added to party Alla LaRoque(pty:dft))(Jones, Gregory) (Entered: 08/18/2025)
08/18/2025	21	CONSENT TO PROCEED before Magistrate Judge, in accordance with Title 28 Section 636(c) and F.R.CIV.P 73(b), (Jones, Gregory) (Entered: 08/18/2025)
08/19/2025	22	WAIVER OF SERVICE Returned Executed filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company. upon Sound Physicians Emergency Medicine of Southern California, P.C. waiver sent by Plaintiff on 7/21/2025, answer due 9/19/2025. Waiver of Service signed by Matthew Knowles. (Shlesinger, Amir) (Entered: 08/19/2025)
08/19/2025	23	WAIVER OF SERVICE Returned Executed filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company. upon Sound Physicians Anesthesiology of California, P.C. waiver sent by Plaintiff on 7/21/2025, answer due 9/19/2025. Waiver of Service signed by Matthew Knowles. (Shlesinger, Amir) (Entered: 08/19/2025)
08/19/2025	24	NOTICE TO FILER OF DEFICIENCIES in Electronic Filed Document RE: NOTICE OF MOTION AND MOTION of Mark E. Bini to Withdraw as Attorney 19 . The following error(s) was found: Incorrect event selected. Correct event to be used is: Notice of Appearance or Withdrawal of Counsel (G-123). Please re-file the document using the correct event. (jdo) (Entered: 08/19/2025)
08/19/2025	25	Notice of Appearance or Withdrawal of Counsel: for attorney Mark E Bini counsel for Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. Mark E. Bini is no longer counsel of record for the aforementioned party in this case for the reason indicated in the G-123 Notice. Filed by Outgoing Counsel for Plaintiffs. (Bini, Mark) (Entered: 08/19/2025)
08/20/2025	26	(TEXT ONLY) ORDER by Magistrate Judge Karen E. Scott. By 8/27/25, Plaintiff shall file a declaration stating when Plaintiff served the Notice of Assignment to a U.S. Magistrate Judge and Declination of Consent form (Dkt. 4) on each Defendant for whom a proof of service or waiver of service has been filed. Future proof of service forms/declarations should state when the other Defendants were served with the declination of consent form. The Court needs this information to determine when each Defendant's deadline to decline consent expires. THERE IS NO PDF DOCUMENT ASSOCIATED WITH THIS ENTRY. (jdo) TEXT ONLY ENTRY (Entered: 08/20/2025)
08/20/2025	27	NOTICE of Change of Attorney Business or Contact Information: for attorney Jason Theodore Mayer counsel for Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. Changing Address and Firm Name to Crowell & Moring LLP, 455 N. Cityfront Plaza Drive, Suite 3600, Chicago IL 60611. Changing E-mail and Fax Number to jmayer@crowell.com, (312) 321-4299. Filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (Attorney Jason Theodore Mayer added to party Anthem Blue Cross Life and Health Insurance Company(pty:pla))(Mayer, Jason) (Entered: 08/20/2025)
08/22/2025	28	NOTICE of Change of Attorney Business or Contact Information: for attorney Martin J Bishop counsel for Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. Changing Address and Firm Name to Crowell & Moring LLP, 455 N. Cityfront Plaza Drive, Suite 3600, Chicago IL 60611. Changing E-mail and Fax Number to mbishop@crowell.com, (312) 321-4299. Filed by Plaintiffs Anthem Blue

		Cross Life and Health Insurance Company, Blue Cross of California. (Bishop, Martin) (Entered: 08/22/2025)
08/27/2025	29	WAIVER OF SERVICE Returned Executed filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company. upon Bruin Neurophysiology, P.C. waiver sent by Plaintiff on 7/30/2025, answer due 9/29/2025. Waiver of Service signed by James Poth. (Shlesinger, Amir) (Entered: 08/27/2025)
08/27/2025	30	WAIVER OF SERVICE Returned Executed filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company. upon iNeurology, PC waiver sent by Plaintiff on 7/30/2025, answer due 9/29/2025. Waiver of Service signed by James Poth. (Shlesinger, Amir) (Entered: 08/27/2025)
08/27/2025	31	WAIVER OF SERVICE Returned Executed filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company. upon Los Angeles Neurological Associates, PC waiver sent by Plaintiff on 7/30/2025, answer due 9/29/2025. Waiver of Service signed by James Poth. (Shlesinger, Amir) (Entered: 08/27/2025)
08/27/2025	32	WAIVER OF SERVICE Returned Executed filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company. upon N Express, PC waiver sent by Plaintiff on 7/30/2025, answer due 9/29/2025. Waiver of Service signed by James Poth. (Shlesinger, Amir) (Entered: 08/27/2025)
08/27/2025	33	WAIVER OF SERVICE Returned Executed filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company. upon North American Neurological Associates, PC waiver sent by Plaintiff on 7/30/2025, answer due 9/29/2025. Waiver of Service signed by James Poth. (Shlesinger, Amir) (Entered: 08/27/2025)
08/27/2025	34	CERTIFICATE OF SERVICE filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California, re Waiver of Service Executed, 31 , Waiver of Service Executed, 22 , Waiver of Service Executed, 33 , Waiver of Service Executed, 23 , Waiver of Service Executed, 30 , Waiver of Service Executed, 29 , Waiver of Service Executed, 32 *Certification of by Counsel for Plaintiffs - Notice of Assignment to a U.S. Magistrate Judge and Declination of Consent Form* served on August 20, 2025. (Shlesinger, Amir) (Entered: 08/27/2025)
08/27/2025	35	DECLARATION of Amir Shlesinger re Text Only Scheduling Notice,, 26 *Declaration of Amir Shlesinger* filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (Shlesinger, Amir) (Entered: 08/27/2025)
09/09/2025	36	CORPORATE DISCLOSURE STATEMENT filed by Defendants HaloMD LLC, Alla LaRoque (Jones, Gregory) (Entered: 09/09/2025)
09/11/2025	37	The period to decline consent to a magistrate judge has expired. No timely declination of consent has been received by the Court. Each party is deemed to have knowingly and voluntarily consented to proceed before a Magistrate Judge for all purposes pursuant to the Local Rules. The case shall now proceed before a Magistrate Judge for all purposes. THERE IS NO PDF DOCUMENT ASSOCIATED WITH THIS ENTRY. (jdo) TEXT ONLY ENTRY (Entered: 09/11/2025)
09/18/2025	38	NOTICE of Appearance filed by attorney Tala Toufanian Jayadevan on behalf of Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C. (Attorney Tala Toufanian Jayadevan added to party Sound Physicians Anesthesiology of California, P.C.(pty:dft), Attorney Tala Toufanian Jayadevan added to party Sound Physicians Emergency Medicine of Southern California, P.C.(pty:dft))(Jayadevan, Tala) (Entered: 09/18/2025)

09/18/2025	39	NOTICE of Interested Parties filed by Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C., (Jayadevan, Tala) (Entered: 09/18/2025)
09/18/2025	40	Joint STIPULATION Extending Time to Answer the complaint as to All Defendants, re Complaint (Attorney Civil Case Opening), 1 filed by Defendants Sound Physicians Emergency Medicine of Southern California, P.C., Sound Physicians Anesthesiology of California, P.C..(Jayadevan, Tala) (Entered: 09/18/2025)
09/25/2025	41	APPLICATION of Non-Resident Attorney Megan O. Corrigan to Appear Pro Hac Vice on behalf of Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C. (Pro Hac Vice Fee - $500 Fee Paid, Receipt No. ACACDC-40573461) filed by Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C.. (Attachments: # 1 Certificate of Good Standing, # 2 Proposed Order) (Jayadevan, Tala) (Entered: 09/25/2025)
09/25/2025	42	APPLICATION of Non-Resident Attorney Matthew L. Knowles to Appear Pro Hac Vice on behalf of Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C. (Pro Hac Vice Fee - $500 Fee Paid, Receipt No. ACACDC-40573523) filed by Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C.. (Attachments: # 1 Certificate of Good Standing, # 2 Proposed Order) (Jayadevan, Tala) (Entered: 09/25/2025)
09/25/2025	43	APPLICATION of Non-Resident Attorney Laura McLane to Appear Pro Hac Vice on behalf of Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C. (Pro Hac Vice Fee - $500 Fee Paid, Receipt No. ACACDC-40573560) filed by Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C.. (Attachments: # 1 Certificate of Good Standing, # 2 Proposed Order) (Jayadevan, Tala) (Entered: 09/25/2025)
09/26/2025	44	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott granting 41 Non-Resident Attorney Megan O. Corrigan APPLICATION to Appear Pro Hac Vice on behalf of Defendant Sound Physicians Emergency Medicine of Southern California, P.C.; and Sound Physicians Anesthesiology of California, P.C., designating Tala Toufanian Jayadevan as local counsel. (san) (Entered: 09/29/2025)
09/26/2025	45	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott granting 42 Non-Resident Attorney Matthew L. Knowles APPLICATION to Appear Pro Hac Vice on behalf of Defendant Sound Physicians Emergency Medicine of Southern California, P.C.; and Sound Physicians Anesthesiology of California, P.C., designating Tala Toufanian Jayadevan as local counsel. (san) (Entered: 09/29/2025)
09/26/2025	46	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott granting 43 Non-Resident Attorney Laura McLane APPLICATION to Appear Pro Hac Vice on behalf of Defendant Sound Physicians Emergency Medicine of Southern California, P.C.; and Sound Physicians Anesthesiology of California, P.C., designating Tala Toufanian Jayadevan as local counsel. (san) (Entered: 09/29/2025)
10/07/2025	47	STIPULATION for Extension of Time to File Responses filed by Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C.. (Attachments: # 1 of Tala Jayadevan in Support of Stipulation

		to Extend or Stay Response Deadlines Due to Forthcoming Amended Complaint, # 2 Proposed Order Extending Response Deadlines Due to Forthcoming Amended Complaint)(Jayadevan, Tala) (Entered: 10/07/2025)
10/08/2025	48	ORDER EXTENDING RESPONSE DEADLINES DUE TO FORTHCOMING AMENDED COMPLAINT by Magistrate Judge Karen E. Scott, re Stipulation for Extension of Time to File, 47 . The Court GRANTS the Stipulation and ORDERS the Defendants' October 10, 2025 deadline to respond to the Complaint is stayed. Plaintiffs may amend the Complaint on or before October 17, 2025. [SEE DOCUMENT FOR FURTHER DETAILS] (sh) (Entered: 10/09/2025)
10/17/2025	49	NOTICE OF DISMISSAL filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company pursuant to FRCP 41a(1) *Notice of Voluntary Dismissal Without Prejudice pursuant to Fed. R. Civ. P. 41(a)(1)(A)(i)* as to Los Angeles Neurological Associates, PC. (Mayer, Jason) (Entered: 10/17/2025)
10/17/2025	50	First AMENDED COMPLAINT against Defendants Bruin Neurophysiology, P.C., HaloMD LLC, Alla LaRoque, N Express, PC, North American Neurological Associates, PC, Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C., iNeurology, PC, Scott LaRoque, MPOWERHealth Practice Management, LLC amending Complaint (Attorney Civil Case Opening), 1 , filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company(Mayer, Jason) (Entered: 10/17/2025)
10/30/2025	51	Notice of Appearance or Withdrawal of Counsel: for attorney Megan O. Corrigan counsel for Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C.. Megan Corrigan is no longer counsel of record for the aforementioned party in this case for the reason indicated in the G-123 Notice. Filed by Defendant Sound Physicians. (Corrigan, Megan) (Entered: 10/30/2025)
11/03/2025	52	(Attorney Jonah D. Retzinger added to party HaloMD LLC(pty:dft), Attorney Jonah D. Retzinger added to party Alla LaRoque(pty:dft), Attorney Jonah D. Retzinger added to party Scott LaRoque(pty:dft))(Retzinger, Jonah) (Entered: 11/03/2025)
11/03/2025	53	EX PARTE APPLICATION for Extension of Time to File Response to Plaintiff's Amended Complaint filed by Defendants HaloMD LLC, Alla LaRoque, Scott LaRoque. (Attachments: # 1 Declaration of Jonah Retzinger, # 2 Proposed Order) (Retzinger, Jonah) (Entered: 11/03/2025)
11/03/2025	54	(Attorney Christopher D Grigg added to party HaloMD LLC(pty:dft), Attorney Christopher D Grigg added to party Alla LaRoque(pty:dft), Attorney Christopher D Grigg added to party Scott LaRoque(pty:dft))(Grigg, Christopher) (Entered: 11/03/2025)
11/03/2025	55	(Attorney Brock Joseph Seraphin added to party HaloMD LLC(pty:dft), Attorney Brock Joseph Seraphin added to party Alla LaRoque(pty:dft), Attorney Brock Joseph Seraphin added to party Scott LaRoque(pty:dft))(Seraphin, Brock) (Entered: 11/03/2025)
11/04/2025	56	WAIVER OF SERVICE Returned Executed filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company. upon Scott LaRoque waiver sent by Plaintiff on 10/27/2025, answer due 12/26/2025. Waiver of Service signed by Jonah D. Retzinger. (Shlesinger, Amir) (Entered: 11/04/2025)
11/04/2025	57	ORDER RE DEFENDANTS' UNOPPOSED EX PARTE APPLICATION FOR ORDER EXTENDING FILING DEADLINES by Magistrate Judge Karen E. Scott: granting 53 EX PARTE APPLICATION for Extension of Time to File. Defendants' deadline to file an answer, motion, or otherwise respond to Plaintiff's Amended Complaint is December 12, 2025. (SEE DOCUMENT FOR DETAILS) (sh) (Entered: 11/05/2025)

11/05/2025	58	WAIVER OF SERVICE Returned Executed filed by Plaintiffs Blue Cross of California, Anthem Blue Cross Life and Health Insurance Company. upon MPOWERHealth Practice Management, LLC waiver sent by Plaintiff on 10/30/2025, answer due 12/29/2025. Waiver of Service signed by James L. Poth. (Shlesinger, Amir) (Entered: 11/05/2025)
11/05/2025	59	First REQUEST TO SUBSTITUTE ATTORNEY Jonah D. Retzinger in place of attorney Gregory Jones and Noel Scott Cohen , First REQUEST to Substitute attorney Jonah D. Retzinger in place of attorney Gregory Jones and Noel Scott Cohen filed by Defendant HaloMD LLC. (Attachments: # 1 Proposed Order on Request for Approval of Substitution of Attorney) (Retzinger, Jonah) (Entered: 11/05/2025)
11/05/2025	60	First REQUEST TO SUBSTITUTE ATTORNEY Jonah D. Retzinger in place of attorney Gregory Jones and Noel Scott Cohen filed by Defendant Alla LaRoque. (Attachments: # 1 Proposed Order ON REQUEST FOR APPROVAL OF SUBSTITUTION OR WITHDRAWAL OF ATTORNEY) (Retzinger, Jonah) (Entered: 11/05/2025)
11/06/2025	61	ORDER ON REQUEST FOR APPROVAL OF SUBSTITUTION OR WITHDRAWAL OF ATTORNEY 59 by Magistrate Judge Karen E. Scott. The Court hereby orders that the request of Defendant HaloMD, LLC to substitute Jonah D. Retzinger as attorney of record instead of Gregory Jones and Noel Scott Cohen is hereby GRANTED. (SEE DOCUMENT FOR DETAILS) (sh) (Entered: 11/07/2025)
11/06/2025	62	ORDER ON REQUEST FOR APPROVAL OF SUBSTITUTION OR WITHDRAWAL OF ATTORNEY 60 by Magistrate Judge Karen E. Scott. The Court hereby orders that the request of Defendant Alla LaRoque to substitute Jonah D. Retzinger as attorney of record instead of Gregory Jones and Noel Scott Cohen is hereby GRANTED. (SEE DOCUMENT FOR DETAILS) (sh) (Entered: 11/07/2025)
11/14/2025	63	Notice of Appearance or Withdrawal of Counsel: for attorney April Chen Yang counsel for Defendants HaloMD LLC, Alla LaRoque, Scott LaRoque. Adding April C. Yang as counsel of record for HaloMD, LLC, Alla LaRoque and Scott LaRoque for the reason indicated in the G-123 Notice. Filed by Defendants HaloMD, LLC, Alla LaRoque and Scott LaRoque. (Attorney April Chen Yang added to party HaloMD LLC(pty:dft), Attorney April Chen Yang added to party Alla LaRoque(pty:dft), Attorney April Chen Yang added to party Scott LaRoque(pty:dft))(Yang, April) (Entered: 11/14/2025)
11/26/2025	64	APPLICATION of Non-Resident Attorney Connor S. Romm to Appear Pro Hac Vice on behalf of Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C. (Pro Hac Vice Fee - $450 Fee Paid, Receipt No. ACACDC-40988832) filed by defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C.. (Attachments: # 1 Certificate of Good Standing, # 2 Proposed Order) (Jayadevan, Tala) (Entered: 11/26/2025)
12/01/2025	65	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott: granting 64 Non-Resident Attorney Connor S. Romm APPLICATION to Appear Pro Hac Vice on behalf of Defendant Sound Physicians Anesthesiology of California, P.C., designating Tala Toufanian Jayadevan as local counsel. (sh) (Entered: 12/02/2025)
12/09/2025	66	Notice of Appearance or Withdrawal of Counsel: for attorney James L Poth counsel for Defendants Bruin Neurophysiology, P.C., MPOWERHealth Practice Management, LLC, N Express, PC, North American Neurological Associates, PC, iNeurology, PC. Adding James L. Poth as counsel of record for MPowerHealth Practice Management, LLC; North American Neurological Associates, PC; N Express, PC; iNeurology, PC and Bruin Neurophysiology, P.C. for the reason indicated in the G-123 Notice. Filed by Defendants MPowerHealth Practice Management, LLC; North American Neurological Associates,

		PC; N Express, PC; iNeurology, PC and Bruin Neurophysiology, P.C.. (Attorney James L Poth added to party Bruin Neurophysiology, P.C.(pty:dft), Attorney James L Poth added to party MPOWERHealth Practice Management, LLC(pty:dft), Attorney James L Poth added to party N Express, PC(pty:dft), Attorney James L Poth added to party North American Neurological Associates, PC(pty:dft), Attorney James L Poth added to party iNeurology, PC(pty:dft))(Poth, James) (Entered: 12/09/2025)
12/10/2025	67	APPLICATION of Non-Resident Attorney B. Kurt Copper to Appear Pro Hac Vice on behalf of Defendants Bruin Neurophysiology, P.C., MPOWERHealth Practice Management, LLC, N Express, PC, North American Neurological Associates, PC, iNeurology, PC (Pro Hac Vice Fee - $450 Fee Paid, Receipt No. ACACDC-41074732) filed by Defendants Bruin Neurophysiology, P.C., MPOWERHealth Practice Management, LLC, N Express, PC, North American Neurological Associates, PC, iNeurology, PC. (Attachments: # 1 Proposed Order Re B. Kurt Copper Pro Hac Vice) (Poth, James) (Entered: 12/10/2025)
12/11/2025	70	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott: granting 67 Non-Resident Attorney B. Kurt Copper APPLICATION to Appear Pro Hac Vice on behalf of Defendants MPowerHealth Practice Management, LLC; North American Neurological Associates, PC; N Express, PC; iNeurology, PC; Bruin Neurophysiology, PC, designating James L Poth as local counsel. (sh) (Entered: 12/12/2025)
12/12/2025	68	NOTICE OF MOTION AND MOTION to Strike Pursuant to Cal. Civ. Proc. Code § 425.16 filed by defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C.. Motion set for hearing on 3/10/2026 at 10:00 AM before Magistrate Judge Karen E. Scott. (Attachments: # 1 Memorandum, # 2 Declaration of Matthew L. Knowles, # 3 Proposed Order) (Jayadevan, Tala) (Entered: 12/12/2025)
12/12/2025	69	NOTICE OF MOTION AND MOTION to Dismiss Case filed by defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C.. Motion set for hearing on 3/10/2026 at 10:00 AM before Magistrate Judge Karen E. Scott. (Attachments: # 1 Memorandum, # 2 Declaration of Matthew L. Knowles, # 3 Proposed Order) (Jayadevan, Tala) (Entered: 12/12/2025)
12/12/2025	71	NOTICE of Interested Parties filed by Defendants Bruin Neurophysiology, P.C., MPOWERHealth Practice Management, LLC, N Express, PC, North American Neurological Associates, PC, iNeurology, PC, identifying MPowerHealth Holdings, LLC; MPowerHealth Intermediate, LLC; LFF Holdings Group, LTD Co.; Scott LaRoque; Rock Capital Holdings, LLC; Robin Soffer, MD; Azadeh Farin, MD; Kushagra Verma, MD; John Aldridge, MD. (Poth, James) (Entered: 12/12/2025)
12/12/2025	72	NOTICE OF MOTION AND MOTION to Dismiss for Lack of Jurisdiction *Under Rule 12(b)(2)* filed by Defendants Bruin Neurophysiology, P.C., MPOWERHealth Practice Management, LLC, N Express, PC, North American Neurological Associates, PC, iNeurology, PC. Motion set for hearing on 3/10/2026 at 10:00 AM before Magistrate Judge Karen E. Scott. (Attachments: # 1 Memorandum of Points & Authorities In Support of Rule 12(b)(2), # 2 Proposed Order) (Poth, James) (Entered: 12/12/2025)
12/12/2025	73	NOTICE OF MOTION AND MOTION to Dismiss for Lack of Jurisdiction *Under 12(b)(6)* filed by Defendants Bruin Neurophysiology, P.C., MPOWERHealth Practice Management, LLC, N Express, PC, North American Neurological Associates, PC, iNeurology, PC. Motion set for hearing on 3/10/2026 at 10:00 AM before Magistrate Judge Karen E. Scott. (Attachments: # 1 Memorandum of Points & Authorities In Support of Rule 12(b)(6), # 2 Proposed Order) (Poth, James) (Entered: 12/12/2025)

12/12/2025	74	Notice of Joinder to Special Motion to Strike filed by Defendants Bruin Neurophysiology, P.C., MPOWERHealth Practice Management, LLC, N Express, PC, North American Neurological Associates, PC, iNeurology, PC. (Poth, James) (Entered: 12/12/2025)
12/12/2025	75	DECLARATION of James L. Poth In Support Of NOTICE OF MOTION AND MOTION to Dismiss for Lack of Jurisdiction *Under 12(b)(6)* 73 , NOTICE OF MOTION AND MOTION to Dismiss for Lack of Jurisdiction *Under Rule 12(b)(2)* 72 *and NOTICE OF JOINDER TO SPECIAL MOTION TO STRIKE* filed by Defendants Bruin Neurophysiology, P.C., MPOWERHealth Practice Management, LLC, N Express, PC, North American Neurological Associates, PC, iNeurology, PC. (Poth, James) (Entered: 12/12/2025)
12/12/2025	76	NOTICE OF MOTION AND MOTION to Dismiss Amended Complaint filed by Defendant HaloMD LLC. Motion set for hearing on 3/10/2026 at 10:00 AM before Magistrate Judge Karen E. Scott. (Attachments: # 1 Memorandum, # 2 Request for Judicial Notice, # 3 Declaration of J. Retzinger, # 4 Exhibit A, # 5 Exhibit B, # 6 Exhibit C, # 7 Exhibit D, # 8 Exhibit E, # 9 Proposed Order) (Retzinger, Jonah) (Entered: 12/12/2025)
12/12/2025	77	NOTICE OF MOTION AND MOTION to Dismiss Amended Complaint filed by Defendants Alla LaRoque, Scott LaRoque. Motion set for hearing on 3/10/2026 at 10:00 AM before Magistrate Judge Karen E. Scott. (Attachments: # 1 Memorandum, # 2 Proposed Order) (Retzinger, Jonah) (Entered: 12/12/2025)
12/12/2025	78	NOTICE OF MOTION AND MOTION to Strike Amended Complaint/Petition,, 50 *Pursuant to Cal. Code Civ. Proc. 425.16* filed by Defendants HaloMD LLC, Alla LaRoque, Scott LaRoque. Motion set for hearing on 3/10/2026 at 10:00 AM before Magistrate Judge Karen E. Scott. (Attachments: # 1 Memorandum, # 2 Proposed Order) (Retzinger, Jonah) (Entered: 12/12/2025)
12/31/2025	79	Notice of Appearance or Withdrawal of Counsel: for attorney Long Xuan Do counsel for Amicus California Medical Association. Adding Long X. Do as counsel of record for One for the reason indicated in the G-123 Notice. Filed by Amicus California Medical Association. (Attorney Long Xuan Do added to party California Medical Association(pty:am))(Do, Long) (Entered: 12/31/2025)
12/31/2025	80	APPLICATION to File Amicus Brief filed by Amicus California Medical Association. Application set for hearing on 1/27/2026 at 10:00 AM before Magistrate Judge Karen E. Scott. (Attachments: # 1 Amicus Curiae Brief, # 2 Declaration, # 3 Proposed Order) (Do, Long) (Entered: 12/31/2025)
12/31/2025	81	CERTIFICATE of Interested Parties filed by Amicus California Medical Association, identifying None. (Do, Long) (Entered: 12/31/2025)
12/31/2025	82	Notice of Appearance or Withdrawal of Counsel: for attorney Eric David Chan counsel for Amicus California Medical Association. Adding Eric D. Chan as counsel of record for California Medical Association for the reason indicated in the G-123 Notice. Filed by Amicus California Medical Association. (Attorney Eric David Chan added to party California Medical Association(pty:am))(Chan, Eric) (Entered: 12/31/2025)
01/07/2026	83	MINUTES (IN CHAMBERS) Order GRANTING California Medical Association's Application to File Amicus Brief (Dkt. 80) by Magistrate Judge Karen E. Scott: granting 80 APPLICATION to File Amicus Brief. IT IS THEREFORE ORDERED that the California Medical Association's application (Dkt. 80) is granted. The Court will consider the brief attached to the application. (Dkt. 80-1.) (SEE DOCUMENT FOR DETAILS) (sh) (Entered: 01/08/2026)

01/20/2026	84	Notice of Appearance or Withdrawal of Counsel: for attorney Jennie Wang VonCannon counsel for Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. Adding Jennie Wang VonCannon as counsel of record for Anthem Blue Cross Life and Health Insurance Company; Blue Cross of California d/b/a Anthem Blue Cross for the reason indicated in the G-123 Notice. Filed by Plaintiffs Blue Cross of California d/b/a Anthem Blue Cross. (Attorney Jennie Wang VonCannon added to party Anthem Blue Cross Life and Health Insurance Company(pty:pla), Attorney Jennie Wang VonCannon added to party Blue Cross of California (pty:pla))(VonCannon, Jennie) (Entered: 01/20/2026)
01/20/2026	85	APPLICATION of Non-Resident Attorney Jed Wulfekotte to Appear Pro Hac Vice on behalf of Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California (Pro Hac Vice Fee - $450 Fee Paid, Receipt No. ACACDC-41312819) filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (Attachments: # 1 Proposed Order) (Shlesinger, Amir) (Entered: 01/20/2026)
01/21/2026	86	NOTICE of Appearance filed by attorney Joshua M. Robbins on behalf of Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California (Attorney Joshua M. Robbins added to party Anthem Blue Cross Life and Health Insurance Company(pty:pla), Attorney Joshua M. Robbins added to party Blue Cross of California (pty:pla))(Robbins, Joshua) (Entered: 01/21/2026)
01/21/2026	88	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott: granting 85 Non-Resident Attorney Jed Wulfekotte APPLICATION to Appear Pro Hac Vice on behalf of Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California doing business as Anthem Blue Cross, designating Amir Shlesinger as local counsel. (sh) (Entered: 01/22/2026)
01/22/2026	87	APPLICATION of Non-Resident Attorney Lily C. Geyer to Appear Pro Hac Vice on behalf of Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California (PHV fee of $450 paid.) filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (Attachments: # 1 Certificate of Good Standing, # 2 Proposed Order) (VonCannon, Jennie) (Entered: 01/22/2026)
01/26/2026	89	STIPULATION to Exceed Page Limitation as to STIPULATION TO FILE CONSOLIDATED BRIEF IN OPPOSITION TO MOTIONS TO DISMISS UP TO 23,000 WORDS AND CONSOLIDATED OPPOSITION TO MOTIONS TO STRIKE UP TO 11,000 WORDS filed by Defendants Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (Attachments: # 1 Declaration, # 2 Proposed Order) (Shlesinger, Amir) Modified on 1/27/2026 (kh). (Entered: 01/26/2026)
01/27/2026	90	ORDER GRANTING STIPULATION TO FILE CONSOLIDATED BRIEF IN OPPOSITION TO MOTIONS TO DISMISS UP TO 23,000 WORDS AND CONSOLIDATED OPPOSITION TO MOTIONS TO STRIKE UP TO 11,000 WORDS 89 by Magistrate Judge Karen E. Scott: The Court GRANTS the Stipulation. **See Order for details** (kh) (Entered: 01/27/2026)
01/28/2026	91	ORDER ON APPLICATION OF NON- RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott: denying 87 Non-Resident Attorney Lily C. Geyer APPLICATION to Appear Pro Hac Vice on behalf of Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California doing business as Anthem Blue Cross. Terming Attorney Lily C. Geyer. (sh) (Entered: 01/29/2026)
01/30/2026	92	MEMORANDUM in Opposition to NOTICE OF MOTION AND MOTION to Strike Pursuant to Cal. Civ. Proc. Code § 425.16 68 , NOTICE OF MOTION AND MOTION to

		Strike Amended Complaint/Petition,, 50 *Pursuant to Cal. Code Civ. Proc. 425.16* 78 *Plaintiff Anthem's Memorandum of Law in Opposition to Defendants' Special Motions to Strike* filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (Shlesinger, Amir) (Entered: 01/30/2026)
01/30/2026	93	MEMORANDUM in Opposition to NOTICE OF MOTION AND MOTION to Dismiss for Lack of Jurisdiction *Under 12(b)(6)* 73 , NOTICE OF MOTION AND MOTION to Dismiss Case 69 , NOTICE OF MOTION AND MOTION to Dismiss Amended Complaint 77 , NOTICE OF MOTION AND MOTION to Dismiss Amended Complaint 76 , NOTICE OF MOTION AND MOTION to Dismiss for Lack of Jurisdiction *Under Rule 12(b)(2)* 72 *Plaintiffs' Memorandum of Law in Opposition to Defendants' Motions to Dismiss* filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (Shlesinger, Amir) (Entered: 01/30/2026)
02/02/2026	94	APPLICATION of Non-Resident Attorney Lily C. Geyer to Appear Pro Hac Vice on behalf of Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California (PHV fee of $450 paid.) filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (Attachments: # 1 Certificate of Good Standing, # 2 Proposed Order) (VonCannon, Jennie) (Entered: 02/02/2026)
02/02/2026	95	NOTICE of Appearance filed by attorney Joanna M Fuller on behalf of Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California (Attorney Joanna M Fuller added to party Anthem Blue Cross Life and Health Insurance Company(pty:pla), Attorney Joanna M Fuller added to party Blue Cross of California (pty:pla))(Fuller, Joanna) (Entered: 02/02/2026)
02/03/2026	96	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott: granting 94 Non-Resident Attorney Lily C. Geyer APPLICATION to Appear Pro Hac Vice on behalf of Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California doing business as Anthem Blue Cross, designating Jennie Wang VonCannon as local counsel. (sh) (Entered: 02/04/2026)
02/05/2026	97	Notice of Appearance or Withdrawal of Counsel: for attorney Eli Alan Alcaraz counsel for Amicus America's Health Insurance Plans, Inc.. Adding Eli A. Alcaraz as counsel of record for America's Health Insurance Plans, Inc. for the reason indicated in the G-123 Notice. Filed by Amicus America's Health Insurance Plans, Inc.. (Attorney Eli Alan Alcaraz added to party America's Health Insurance Plans, Inc.(pty:am))(Alcaraz, Eli) (Entered: 02/05/2026)
02/05/2026	98	APPLICATION of Non-Resident Attorney Hyland Hunt to Appear Pro Hac Vice on behalf of Amicus America's Health Insurance Plans, Inc. (Pro Hac Vice Fee - $450 Fee Paid, Receipt No. ACACDC-41443654) filed by Amicus America's Health Insurance Plans, Inc.. (Attachments: # 1 Proposed Order) (Alcaraz, Eli) (Entered: 02/05/2026)
02/06/2026	99	APPLICATION to File Amicus Brief filed by Amicus America's Health Insurance Plans, Inc.. (Attachments: # 1 Declaration of E. Alcaraz, # 2 Proposed Order, # 3 Exhibit A - Amicus Curiae Brief) (Alcaraz, Eli) (Entered: 02/06/2026)
02/06/2026	100	CERTIFICATE of Interested Parties filed by Amicus America's Health Insurance Plans, Inc., identifying None. (Alcaraz, Eli) (Entered: 02/06/2026)
02/06/2026	101	NOTICE OF MOTION AND MOTION for Leave to file AMICUS CURIAE BRIEF BY THE AMERICAN BENEFITS COUNCIL, THE ERISA INDUSTRY COMMITTEE, & THE BUSINESS GROUP ON HEALTH IN OPPOSITION TO DEFENDANTS MOTIONS TO DISMISS AND SPECIAL MOTION TO STRIKE American Benefits Council, ERISA Industry Committee, Business Group on Health. (Attachments: # 1 Exhibit, # 2 Certificate of Compliance, # 3 Proposed Order) (Attorney Jessamyn

		Elizabeth Vedro added to party American Benefits Council(pty:bkmov), Attorney Jessamyn Elizabeth Vedro added to party ERISA Industry Committee(pty:bkmov), Attorney Jessamyn Elizabeth Vedro added to party Business Group on Health(pty:bkmov)) (Vedro, Jessamyn) (Entered: 02/06/2026)
02/06/2026	102	NOTICE of Appearance filed by attorney Jessamyn Elizabeth Vedro on behalf of Movants American Benefits Council, Business Group on Health, ERISA Industry Committee (Vedro, Jessamyn) (Entered: 02/06/2026)
02/06/2026	103	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott: granting 98 Non-Resident Attorney Hyland Hunt APPLICATION to Appear Pro Hac Vice on behalf of Amicus America's Health Insurance Plans, Inc., designating Eli Alan Alcaraz as local counsel. (sh) (Entered: 02/10/2026)
02/09/2026	107	MINUTES (IN CHAMBERS) Order GRANTING Applications to File Amicus Brief (Dkt. 99 , 101) by Magistrate Judge Karen E. Scott: granting 99 APPLICATION to File Amicus Brief; granting 101 APPLICATION for Leave to File. IT IS THEREFORE ORDERED that the applications (Dkt. 99, 101) are granted. The Court will consider the briefs attached to the applications. (Dkt. 99, 101. (SEE DOCUMENT FOR FURTHER DETAILS) (sh) (Entered: 02/10/2026)
02/10/2026	104	APPLICATION of Non-Resident Attorney Ryan C. Temme to Appear Pro Hac Vice on behalf of Movants American Benefits Council, Business Group on Health, ERISA Industry Committee (Pro Hac Vice Fee - $450 Fee Paid, Receipt No. ACACDC-41470369) filed by Amicus Curiae American Benefits Council, Business Group on Health, ERISA Industry Committee. (Attachments: # 1 Proposed Order) (Vedro, Jessamyn) (Entered: 02/10/2026)
02/10/2026	105	APPLICATION of Non-Resident Attorney Seth T. Perretta to Appear Pro Hac Vice on behalf of Movants American Benefits Council, Business Group on Health, ERISA Industry Committee (Pro Hac Vice Fee - $450 Fee Paid, Receipt No. ACACDC-41470528) filed by Amicus Curiae American Benefits Council, Business Group on Health, ERISA Industry Committee. (Attachments: # 1 Proposed Order) (Vedro, Jessamyn) (Entered: 02/10/2026)
02/10/2026	106	APPLICATION of Non-Resident Attorney Elizabeth J. Loh to Appear Pro Hac Vice on behalf of Movants American Benefits Council, Business Group on Health, ERISA Industry Committee (Pro Hac Vice Fee - $450 Fee Paid, Receipt No. ACACDC-41470634) filed by Amicus Curiae American Benefits Council, Business Group on Health, ERISA Industry Committee. (Attachments: # 1 Proposed Order) (Vedro, Jessamyn) (Entered: 02/10/2026)
02/11/2026	108	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott: denying 104 Non-Resident Attorney Ryan C. Temme APPLICATION to Appear Pro Hac Vice on behalf of Movant American Benefits Council, Business Group on Health and The ERISA Industry Committee. Terming Attorney Ryan C. Temme. Applicant has not hand-signed the application. L.R. 5-4.3.4(a)(3). May refile. (sh) (Entered: 02/12/2026)
02/11/2026	109	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott: denying 105 Non-Resident Attorney Seth T. Perretta APPLICATION to Appear Pro Hac Vice on behalf of Movant American Benefits Council, Business Group on Health and The ERISA Industry Committee. Terming Attorney Seth T. Perretta. Applicant has not hand-signed the application. L.R. 5-4.3.4(a)(3). May refile. (sh) (Entered: 02/12/2026)

02/11/2026	110	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott: denying 106 Non-Resident Attorney Elizabeth J. Loh APPLICATION to Appear Pro Hac Vice on behalf of Movant American Benefits Council, Business Group on Health and The ERISA Industry Committee. Terming Attorney Elizabeth J. Loh. Applicant has not hand-signed the application. L.R. 5-4.3.4(a)(3). May refile. (sh) (Entered: 02/12/2026)
02/13/2026	111	APPLICATION of Non-Resident Attorney Ryan C. Temme to Appear Pro Hac Vice on behalf of Movants American Benefits Council, Business Group on Health, ERISA Industry Committee (Pro Hac Vice Fee - $450 Previously Paid on 2/10/2026, Receipt No. ACACDC-41470369) filed by Amicus Curiae American Benefits Council, Business Group on Health, ERISA Industry Committee. (Attachments: # 1 Proposed Order) (Vedro, Jessamyn) (Entered: 02/13/2026)
02/13/2026	112	APPLICATION of Non-Resident Attorney Seth T. Perretta to Appear Pro Hac Vice on behalf of Movants American Benefits Council, Business Group on Health, ERISA Industry Committee (Pro Hac Vice Fee - $450 Previously Paid on 2/10/2026, Receipt No. ACACDC-41470528) filed by Amicus Curiae American Benefits Council, Business Group on Health, ERISA Industry Committee. (Attachments: # 1 Proposed Order) (Vedro, Jessamyn) (Entered: 02/13/2026)
02/13/2026	113	APPLICATION of Non-Resident Attorney Elizabeth J. Loh to Appear Pro Hac Vice on behalf of Movants American Benefits Council, Business Group on Health, ERISA Industry Committee (Pro Hac Vice Fee - $450 Previously Paid on 2/10/2026, Receipt No. ACACDC-41470634) filed by Amicus Curiae American Benefits Council, Business Group on Health, ERISA Industry Committee. (Attachments: # 1 Proposed Order) (Vedro, Jessamyn) (Entered: 02/13/2026)
02/17/2026	114	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott: granting 113 Non-Resident Attorney Elizabeth J. Loh APPLICATION to Appear Pro Hac Vice on behalf of Movants American Benefits Council, Business Group on Health and The ERISA Industry Committee, designating Jessamyn E. Vedro as local counsel. (sh) (Entered: 02/18/2026)
02/17/2026	115	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott: granting 112 Non-Resident Attorney Seth T. Perretta APPLICATION to Appear Pro Hac Vice on behalf of Movants American Benefits Council, Business Group on Health and The ERISA Industry Committee, designating Jessamyn E. Vedro as local counsel. (sh) (Entered: 02/18/2026)
02/17/2026	116	ORDER ON APPLICATION OF NON-RESIDENT ATTORNEY TO APPEAR IN A SPECIFIC CASE PRO HAC VICE by Magistrate Judge Karen E. Scott: granting 111 Non-Resident Attorney Ryan C. Temme APPLICATION to Appear Pro Hac Vice on behalf of Movants American Benefits Council, Business Group on Health and The ERISA Industry Committee, designating Jessamyn E. Vedro as local counsel. (sh) (Entered: 02/18/2026)
02/24/2026	117	REPLY in Support of NOTICE OF MOTION AND MOTION to Dismiss Case 69 filed by Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C.. (Jayadevan, Tala) (Entered: 02/24/2026)
02/24/2026	118	REPLY in Support of NOTICE OF MOTION AND MOTION to Strike Pursuant to Cal. Civ. Proc. Code § 425.16 68 filed by Defendants Sound Physicians Anesthesiology of

		California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C.. (Jayadevan, Tala) (Entered: 02/24/2026)
02/24/2026	119	NOTICE of Appearance filed by attorney David M. DeVito on behalf of Defendants Bruin Neurophysiology, P.C., MPOWERHealth Practice Management, LLC, N Express, PC, North American Neurological Associates, PC, iNeurology, PC (Attorney David M. DeVito added to party Bruin Neurophysiology, P.C.(pty:dft), Attorney David M. DeVito added to party MPOWERHealth Practice Management, LLC(pty:dft), Attorney David M. DeVito added to party N Express, PC(pty:dft), Attorney David M. DeVito added to party North American Neurological Associates, PC(pty:dft), Attorney David M. DeVito added to party iNeurology, PC(pty:dft))(DeVito, David) (Entered: 02/24/2026)
02/24/2026	120	REPLY NOTICE OF MOTION AND MOTION to Dismiss Amended Complaint 76 filed by Defendant HaloMD LLC. (Retzinger, Jonah) (Entered: 02/24/2026)
02/24/2026	121	REPLY NOTICE OF MOTION AND MOTION to Dismiss Amended Complaint 77 filed by Defendants Alla LaRoque, Scott LaRoque. (Retzinger, Jonah) (Entered: 02/24/2026)
02/24/2026	122	REPLY NOTICE OF MOTION AND MOTION to Strike Amended Complaint/Petition,, 50 *Pursuant to Cal. Code Civ. Proc. 425.16* 78 filed by Defendants HaloMD LLC, Alla LaRoque, Scott LaRoque. (Retzinger, Jonah) (Entered: 02/24/2026)
02/24/2026	123	REPLY in support of NOTICE OF MOTION AND MOTION to Dismiss for Lack of Jurisdiction *Under Rule 12(b)(2)* 72 filed by Defendants Bruin Neurophysiology, P.C., MPOWERHealth Practice Management, LLC, N Express, PC, North American Neurological Associates, PC, iNeurology, PC. (Poth, James) (Entered: 02/24/2026)
02/24/2026	124	REPLY in support of NOTICE OF MOTION AND MOTION to Dismiss for Lack of Jurisdiction *Under 12(b)(6)* 73 filed by Defendants Bruin Neurophysiology, P.C., MPOWERHealth Practice Management, LLC, N Express, PC, North American Neurological Associates, PC, iNeurology, PC. (Poth, James) (Entered: 02/24/2026)
02/26/2026	125	Notice of Appearance or Withdrawal of Counsel: for attorney Erica Bentley Lang counsel for Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C.. Adding Erica Lang as counsel of record for California, P.C. and Defendant Sound Physicians Anesthesiology of California, P.C. for the reason indicated in the G-123 Notice. Filed by defendant Sound Physicians Emergency Medicine of Southern California, P.C. and Sound Physicians Anesthesiology of California, P.C.. (Attorney Erica Bentley Lang added to party Sound Physicians Anesthesiology of California, P.C.(pty:dft), Attorney Erica Bentley Lang added to party Sound Physicians Emergency Medicine of Southern California, P.C.(pty:dft))(Lang, Erica) (Entered: 02/26/2026)
02/27/2026	126	NOTICE OF ERRATA filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. correcting MEMORANDUM in Opposition to Motion,, 93 , MEMORANDUM in Opposition to Motion, 92 (Attachments: # 1 Exhibit 1 - MTS Amended Certificate of Compliance, # 2 Exhibit 2 - MTD Amended Certificate of Compliance)(Robbins, Joshua) (Entered: 02/27/2026)
03/10/2026	127	MINUTES OF MOTION HEARING held before Magistrate Judge Karen E. Scott re Motions 68 69 72 73 76 77 78 : Case is called. Court hears oral arguments. Court takes the motions under submission. Appearances for Plaintiff: Joshua Robbins; Jason Meyer. Appearances for Defendants: Jonah Retzinger; Christopher Grigg; Matthew Knowles; Erica Lang; B. Kurt Copper; David M. DeVito. Deputy Clerk: Jazmin Dorado. Time in court 01:50. Court Recorder: CourtSmart. THERE IS NO PDF DOCUMENT ASSOCIATED WITH THIS ENTRY. (jdo) (Entered: 03/10/2026)

03/10/2026	134	MINUTE ORDER (IN CHAMBERS) by Magistrate Judge Karen E. Scott: At the hearing on March 10, 2026, the parties submitted the attached presentation materials for the Court's consideration. (Attachments: # 1 Plaintiffs' Presentation Material, # 2 Defendants' Presentation Materials) (jdo) (Entered: 04/07/2026)
03/11/2026	128	TRANSCRIPT ORDER as to Defendants HaloMD LLC, Alla LaRoque, Scott LaRoque for Court Smart (CS). Court will contact April Yang at ayang@nixonpeabody.com with further instructions regarding this order. Transcript preparation will not begin until payment has been satisfied with the transcription company. (Yang, April) (Entered: 03/11/2026)
03/12/2026	129	TRANSCRIPT ORDER as to Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California for Court Smart (CS). Court will contact Jason Mayer at jmayer@crowell.com with further instructions regarding this order. Transcript preparation will not begin until payment has been satisfied with the transcription company. (Mayer, Jason) (Entered: 03/12/2026)
03/12/2026	130	TRANSCRIPT ORDER as to defendants Bruin Neurophysiology, P.C., MPOWERHealth Practice Management, LLC, N Express, PC, North American Neurological Associates, PC, iNeurology, PC for Court Smart (CS). Court will contact Norma Martinez at normamartinez@jonesday.com with further instructions regarding this order. Transcript preparation will not begin until payment has been satisfied with the transcription company. (DeVito, David) (Entered: 03/12/2026)
03/12/2026	131	TRANSCRIPT ORDER as to Defendants Sound Physicians Anesthesiology of California, P.C., Sound Physicians Emergency Medicine of Southern California, P.C. for Court Smart (CS). Court will contact Diksha Vadan at dvadan@mcdermottlaw.com with further instructions regarding this order. Transcript preparation will not begin until payment has been satisfied with the transcription company. (Jayadevan, Tala) (Entered: 03/12/2026)
03/16/2026	132	TRANSCRIPT for proceedings held on 3/10/2026 at 10:11am. Court Reporter/Electronic Court Recorder: EXCEPTIONAL REPORTING SERVICES, INC., phone number (361) 949-2988. Transcript may be viewed at the court public terminal or purchased through the Court Reporter/Electronic Court Recorder before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER. Notice of Intent to Redact due within 7 days of this date. Redaction Request due 4/6/2026. Redacted Transcript Deadline set for 4/16/2026. Release of Transcript Restriction set for 6/15/2026. (mg) (Entered: 03/16/2026)
03/16/2026	133	NOTICE OF FILING TRANSCRIPT filed for proceedings 3/10/2026 at 10:11am re Transcript 132 THERE IS NO PDF DOCUMENT ASSOCIATED WITH THIS ENTRY. (mg) TEXT ONLY ENTRY (Entered: 03/16/2026)
04/09/2026	135	MEMORANDUM OPINION AND ORDER by Magistrate Judge Karen E. Scott: finding as moot 68 MOTION ; granting 69 MOTION to Dismiss Case ; finding as moot 72 MOTION to Dismiss for Lack of Jurisdiction ; granting 73 MOTION to Dismiss for Lack of Jurisdiction ; granting 76 MOTION to Dismiss ; granting 77 MOTION to Dismiss ; finding as moot 78 MOTION. 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. (SEE DOCUMENT FOR DETAILS) (sh) (Entered: 04/10/2026)
04/09/2026	136	JUDGMENT by Magistrate Judge Karen E. Scott, IT IS ADJUDGED that Plaintiffs' vacatur claims are DISMISSED WITH PREJUDICE. Plaintiffs' remaining claims are dismissed for lack of jurisdiction. Related to: Order on Motion to Strike, Order on Motion

		to Dismiss Case, Order on Motion to Dismiss/Lack of Jurisdiction 135 (MD JS-6, Case Terminated). (sh) (Entered: 04/10/2026)
04/13/2026	137	NOTICE OF APPEAL to the 9th Circuit Court of Appeals filed by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. Appeal of Judgment, 136 . (Appeal Fee - $605 Fee Paid, Receipt No. ACACDC-41988620.) (Mayer, Jason) (Entered: 04/13/2026)
04/16/2026	138	NOTIFICATION from Ninth Circuit Court of Appeals of case number assigned and briefing schedule. Appeal Docket No. 26-2355 assigned to Notice of Appeal to 9th Circuit Court of Appeals, 137 as to plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California. (mat) (Entered: 04/17/2026)
04/27/2026	139	DESIGNATION of Record on Appeal by Plaintiffs Anthem Blue Cross Life and Health Insurance Company, Blue Cross of California re 137 (Mayer, Jason) (Entered: 04/27/2026)

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