

CASE NO. 26-40316

United States Court of Appeals
for the
Fifth Circuit

**UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT**

BLUE CROSS BLUE SHIELD OF TEXAS, A DIVISION OF HEALTH CARE
SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY,

Plaintiff-Appellant,

v.

HALOMD, LLC, et al.,

Defendants-Appellees.

On Appeal from the United States District Court for the Eastern District of
Texas, No. 5:25-cv-00132, Honorable Robert W. Schroeder III

**AMICUS CURIAE BRIEF BY THE AMERICAN BENEFITS COUNCIL,
THE ERISA INDUSTRY COMMITTEE, AND BUSINESS GROUP ON
HEALTH IN SUPPORT OF PLAINTIFF-APPELLANT AND
REVERSAL**

Lars C. Golumbic

Ryan C. Temme

Seth T. Perretta

Elizabeth Loh

GROOM LAW GROUP, CHARTERED

1701 Pennsylvania Ave., N.W.

Washington, D.C. 20006

Tel: (202) 867-0620

Fax: (202) 659-4503

CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that, in addition to the persons and entities identified in the certificate of interested persons filed by Plaintiff-Appellant, the following listed persons and entities have an interest in the outcome of this case. These representations are made so that the judges of this Court may evaluate possible disqualification or recusal.

Amici Curiae:

American Benefits Council
The ERISA Industry Committee
Business Group on Health

Attorneys for Amici Curiae:

Lars C. Golumbic
Ryan C. Temme
Seth T. Perretta
Elizabeth Loh
Groom Law Group, Chartered

Respectfully submitted,

s/ Lars C. Golumbic

Lars C. Golumbic
Ryan C. Temme (admission forthcoming)
Seth T. Perretta (admission forthcoming)
Elizabeth Loh (admission forthcoming)
GROOM LAW GROUP, CHARTERED
1701 Pennsylvania Ave., N.W.
Washington, D.C. 20006
Tel: (202) 867-0620
Fax: (202) 659-4503
lgolumbic@groom.com
rtemme@groom.com
sperretta@groom.com
eloh@groom.com

*Counsel for American Benefits Council,
ERISA Industry Committee
& Business Group on Health*

TABLE OF CONTENTS

CERTIFICATE OF INTERESTED PERSONS	i
TABLE OF AUTHORITIES.....	iv
INTEREST OF THE AMICI CURIAE.....	vi
INTRODUCTION.....	1
I. CONGRESS ENACTED THE NSA TO FIX A MARKET FAILURE, AND PURSUED TWO OBJECTIVES IN DOING SO: PROTECT PATIENTS AND REDUCE COSTS.....	3
II. THE IDR PROCESS HAS DEPARTED SHARPLY FROM ITS DESIGN.....	6
III. A SMALL NUMBER OF UNREGULATED INTERMEDIARIES DRIVE MOST OF THE VOLUME.....	13
IV. THE COSTS FALL ON EMPLOYER PLANS AND, THROUGH THEM, ON WORKING FAMILIES.....	15
CONCLUSION.....	17
CERTIFICATE OF COMPLIANCE.....	19
F.R.A.P. 29 DISCLOSURE.....	20
CERTIFICATE OF SERVICE.....	21

TABLE OF AUTHORITIES

Statutes

42 U.S.C. § 300gg-111(c)(5)(F)	7
42 U.S.C. § 300gg-132(b).....	3
Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020)	vi

Regulations

45 C.F.R. § 149.410(b)	3
45 C.F.R. § 149.440	3
45 C.F.R. § 149.510(b)(2)(iii)(A)(8)	8
45 C.F.R. § 149.510(c).....	9
45 C.F.R. § 149.510(c)(2).....	7
45 C.F.R. § 149.510(c)(2)(i)	9, 11
Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021)	14
Federal Independent Dispute Resolution Operations, 88 Fed. Reg. 75,744 (Nov. 3, 2023)	6
Federal Independent Dispute Resolution Operations, 91 Fed. Reg. 33,900 (June 4, 2026).....	9, 11

Legislative Materials

166 Cong. Rec. H7301-02, H7305 (Dec. 21, 2020)	5
H.R. Rep. No. 116-615 (2020).....	5

Other Authorities

Anna Wilde Mathews & Tom McGinty, <i>Medical Billing Arbitration Paid Out \$15 Billion to Providers in Surprise Bill Disputes</i> , Wall St. J. (July 22, 2026).....	7
AHIP, <i>New AHIP/BCBSA Survey Finds Providers are Flooding IDR System with Ineligible Disputes</i> (Oct. 2025).....	9

Benjamin Ukert & Aliza S. Gordon, <i>Arbitration Outcomes for Out-of-Network Medical Bills Under the No Surprises Act</i> (2025)	12
CBO, <i>Estimate for Divisions O Through FF, H.R. 133, Consolidated Appropriations Act, 2021</i> (Jan. 14, 2021)	4
CMS, <i>Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties</i> (June 2025)	10
CMS, <i>Federal IDR Supplemental Tables for 2025 Q1</i>	13
CMS, <i>Federal IDR Supplemental Tables for 2025 Q2</i>	13
CMS, <i>Federal IDR Supplemental Tables for 2025 Q3</i>	15
CMS, <i>Federal IDR Supplemental Tables for 2025 Q4</i>	15
CMS, <i>Independent Dispute Resolution Reports</i> (July 22, 2026)	7
CMS, <i>Supplemental Background on Federal Independent Dispute Resolution Public Use Files, July 1, 2025-December 31, 2025</i>	7, 9, 12, 15
HaloMD, https://halomd.com/ (last visited Sept. 25, 2026)	13
HHS, Office of the Assistant Secretary for Planning and Evaluation, <i>Evidence on Surprise Billing: Protecting Consumers with the No Surprises Act</i> , Issue Brief No. HP-2021-24 (Nov. 22, 2021)	4
Jack Hoadley & Kennah Watts, <i>Spending on IDR Process Pushes No Surprises Act Costs to More than \$22.4 Billion Over Just Four Years</i> , Health Affs. Forefront (Aug. 26, 2026)	6, 7, 13, 15
Jack Hoadley & Kennah Watts, <i>The Substantial Costs of the No Surprises Act Arbitration Process</i> , Ctr. on Health Ins. Reforms (Sept. 24, 2025)	12, 14
Olena Mazurenko et al., <i>The Impact of Narrow and Tiered Networks on Costs, Access, Quality, and Patient Steering: A Systematic Review</i> , 79 Med. Care Rsch. & Rev. (2022)	16
Zack Cooper, Fiona Scott Morton & Nathan Shekita, <i>Surprise! Out-of-Network Billing for Emergency Care in the United States</i> , 128 J. Pol. Econ. 3626 (2020)	4

INTEREST OF THE AMICI CURIAE

The American Benefits Council (“Council”) is a national non-profit organization dedicated to protecting and fostering privately sponsored employee benefit plans. Its approximately 440 members are primarily large, multistate employers that provide employee benefits to active and retired workers and their families. The Council’s membership also includes organizations that provide employee-benefit services to employers of all sizes. The Council regularly participates as *amicus curiae* in cases affecting employee benefits.

The ERISA Industry Committee (“ERIC”) is a national non-profit business trade association representing approximately 100 of the nation’s largest employers in their capacity as sponsors of employee benefit plans for their workers, retirees, and families. ERIC member companies are leaders in every sector of the economy. ERIC is the voice of large employer plan sponsors on public policies that affect their ability to provide benefits to millions of active workers, retired persons, and their families nationwide. ERIC frequently participates as *amicus curiae* in cases that have the potential for far-reaching effects on employee benefit plan design or administration.

Business Group on Health (“The Business Group”) is the leading non-profit organization representing employers’ perspectives on optimizing workforce strategy through innovative health, benefits, and well-being solutions and on health

policy issues. The Business Group keeps its membership informed of leading-edge thinking and action on health care cost and delivery, financing, affordability and experience with the health care system. The Business Group's over 455 members include 74 Fortune 100 companies as well as large public sector employers, who collectively provide health and well-being programs for more than 60 million individuals in 200 countries. The Business Group regularly participates as *amicus curiae* in cases impacting employer health and welfare plans.

Taken together, *Amici's* members sponsor or administer the health coverage of a substantial share of all Americans who receive benefits through an employer. Those plans are the parties that pay awards issued under the independent dispute resolution ("IDR") process created by the No Surprises Act ("NSA"),¹ that pay the administrative and IDR entity fees the process generates, and that must staff and fund the work of reviewing each dispute filed against them. *Amici* therefore have a direct and substantial interest in whether the IDR process operates as Congress designed it.

The district court dismissed this action for want of subject-matter jurisdiction, holding that the NSA's bar on judicial review, Texas Senate Bill 1264, and the collateral attack doctrine together foreclose BCBSTX's claims against a non-party intermediary alleged to have obtained thousands of awards through false

¹ Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020).

eligibility attestations. A ruling of that kind, if it stands, leaves plans and employers with no other avenue for challenging conduct of this sort. Amici write to lay out, from the vantage point of the plans and employers who ultimately pay for it, what that means in practice.

In accordance with Federal Rule of Appellate Procedure 29(a)(2), Amici Curiae the American Benefits Council, the ERISA Industry Committee, and the Business Group on Health submit this brief without a motion for leave to file because all parties in this action have consented to its filing.

INTRODUCTION

This appeal's significance extends well beyond the parties before the Court. The district court read the NSA's narrow bar on judicial review, together with Texas Senate Bill 1264 and the collateral attack doctrine, to foreclose all judicial recourse for claims that a non-party intermediary obtained thousands of IDR awards through false eligibility attestations. On that reading, the bad-faith conduct BCBSTX alleges is simply beyond any court's reach. Employer-sponsored group health plans, and the employees and families who depend on them, are the ones who feel that most directly: they absorb the cost of every fraudulently obtained award through higher costs of coverage, reduced benefits, or both. Meanwhile, the NSA has become, contrary to the statutory structure and purpose of the NSA, a fertile ground for fraudulent and wasteful abuses that Congress could not have intended, and that serve no purpose other than creating windfalls for entities like the defendants in this case.

That exposure is not abstract. Plans must pay whatever amount the IDR entity selects, must pay the relevant fees associated with the IDR itself, and must absorb the cost of disputing and objecting to awards that are improperly decided by the IDR entity. In the district court's view, these costs and the burden these costs place on employers and working families should be borne without regard to whether the behavior complies with long-established legal and social norms around

misrepresentation and fraud. In addition to subverting the clear intent of Congress that out-of-network payment rates be reasonable, the conduct BCBSTX challenges has a truly negative impact on employers and their employees. Dollars expended in fraudulently obtained IDR awards or in defending against clearly ineligible awards do not purchase additional care or improve the quality of care that patients receive. Rather, abuse of the IDR process has become a business model for certain entities, and a cost of offering coverage, that employers and employees absorb through higher premiums, higher employee contributions, reductions in benefits, or a combination of the three.

This appeal matters deeply to *Amici's* members. The volume of ineligible filings is large, the federal enforcement response has been limited, and the only step available to a plan within the existing process is a written eligibility objection filed on a three-business-day clock which is decided by an entity that is paid nothing if it agrees with the challenge. If a plan that raises an objection and loses is also, by virtue of having participated, foreclosed from any judicial forum in which to address deliberate misuse of the process by a non-party, then the practical answer to large-scale abuse of the IDR system is that there is none. Because IDR entities have overwhelmingly, and regardless of merit, selected provider offers in IDR, the incentives for fraud, misrepresentation, and abuse have become overwhelming. *Amici* describe below why Congress enacted the NSA, what

Congress expected the IDR process to do, how it has departed from that design, and what employer plans and participants bear as a result.²

I. CONGRESS ENACTED THE NSA TO FIX A MARKET FAILURE, AND PURSUED TWO OVERARCHING OBJECTIVES IN DOING SO: PROTECT PATIENTS AND REDUCE COSTS.

Congress enacted the NSA to address a specific market failure. Ordinarily, a patient's ability to choose a doctor or hospital disciplines prices: providers who charge too much or stay out of network lose patients. That discipline does not exist for certain specialties, because the patient never gets to choose. The NSA itself recognizes this: both the NSA and its implementing regulations single out anesthesiology, radiology, pathology, neonatology, and the services of assistant surgeons, hospitalists, and intensivists as "ancillary services" for which a patient cannot even consent to waive protection, precisely because the patient has no opportunity to select the provider in the first place; air ambulance transport is treated the same way for the same reason.³ Because those providers keep their patient volume whether or not they are in a plan's network, they had little reason to negotiate reasonable in-network rates and, as one empirical study of emergency

²Amici's members are employers that sponsor group health plans, and their concern in this appeal is the federal IDR process. Amici take no position on the Texas-specific statutory questions presented.

³ 42 U.S.C. § 300gg-132(b); 45 C.F.R. § 149.410(b) (defining "ancillary services"); *id.* § 149.440 (air ambulance services).

physicians noted, every reason to use the threat of an out-of-network balance bill as leverage over the plan instead.⁴

Existing state protections against balance billing could not close that gap, because ERISA preemption placed self-insured employer plans, the coverage arrangement of most large employers, beyond their reach.⁵ Congress responded with two interlocking objectives.

The first objective is the one the statute is named for, and it has largely been achieved. Patients are now held harmless for the covered services within the NSA's scope; the dispute over the remaining balance is moved out of the examination room and into a process between the provider and the plan. *Amici* supported that protection and continue to support it.

The second objective was controlling costs. Congress did not just want to move the bill from the patient to someone else; it wanted the total bill to shrink. The Congressional Budget Office determined that the dispute resolution provisions would produce \$17 billion in budgetary savings and reduce premium rates by 0.5

⁴ Zack Cooper, Fiona Scott Morton & Nathan Shekita, *Surprise! Out-of-Network Billing for Emergency Care in the United States*, 128 J. Pol. Econ. 3626, 3627 (2020).

⁵ HHS, Office of the Assistant Secretary for Planning and Evaluation, *Evidence on Surprise Billing: Protecting Consumers with the No Surprises Act*, Issue Brief No. HP-2021-24 (Nov. 22, 2021).

to 1 percent.⁶ Those projected savings were not incidental. A central negotiator of the legislation explained on the House floor that they were what allowed Congress to fund other multi-year health priorities in the same package.⁷ The NSA's cost-reduction function was, in that sense, the consideration Congress received for the patient protections it enacted. Those costs savings were driven both by the expected rationalization of out-of-network payment rates consistent with market rates and the expected enhancement of provider networks, where high quality providers would be incentivized to enter into, or renew existing, network participation agreements that reflect the market value of the services they render.

The mechanism Congress chose to deliver those savings was tying IDR awards to the qualifying payment amount ("QPA"), the plan's median contracted rate for the item or service in the relevant market. The QPA is the only factor an IDR entity is *required* to consider; every other consideration in the statute is permissive. The House Report accompanying the legislation described the point of that design directly, praising "the opportunity to tether payment rates for surprise out-of-network bills directly to market-based prices, curbing cost growth relative to

⁶ CBO, *Estimate for Divisions O Through FF, H.R. 133, Consolidated Appropriations Act, 2021* (Jan. 14, 2021), https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf.

⁷ 166 Cong. Rec. H7301-02, H7305 (Dec. 21, 2020) (House floor debate on H.R. 133, the Consolidated Appropriations Act, 2021, as amended).

the status quo."⁸ Congress did not pick that number itself. It tied payment to a rate the market had already set through ordinary, arm's-length contracting between plans and providers.

II. THE IDR PROCESS HAS DEPARTED SHARPLY FROM ITS DESIGN.

The volume and fee data described below demonstrate that the screening step Congress built into the IDR process has no mechanism for distinguishing an honest eligibility mistake from a deliberate false attestation. That gap is the reason a claim alleging fraud needs a judicial forum: regulators and the IDR entities themselves are not positioned to detect deception in the materials submitted with an offer. Put differently, in virtually all other regulatory regimes, the courts serve as vital checks on the bad behavior of regulated entities. Contrary to that fundamental legal norm, Appellees here suggest that they can operate with impunity in the submission of claims that fail to meet the statutory requirements established by Congress regardless of whether their attestations are inaccurate, misleading, or obviously fraudulent.

The volume of disputes has gone far beyond what Congress or the Departments anticipated. The Departments projected roughly 22,000 disputes per

⁸ H.R. Rep. No. 116-615 (2020).

year.⁹ In 2025, initiating parties filed approximately 2.6 million—close to 120 times the projection.¹⁰ The trend has continued: CMS reported more than 2.1 million disputes in the first seven months of 2026 alone.¹¹ It is providers and their representatives who file the overwhelming majority of these disputes.¹² HaloMD, discussed in detail below, is one such filer. Researchers estimate the IDR process has now pushed the NSA's costs past \$22.4 billion in four years,¹³ and reporting on CMS data puts payments to providers through the process at roughly \$15 billion.¹⁴

The fee structure for IDR entities compounds that volume rather than checking it, and it incentivizes IDR entities to pay no attention to whether a given filing is a good-faith claim or a knowingly false one. The non-prevailing party pays the IDR entity fee,¹⁵ and, as discussed below, plans lose the substantial majority of

⁹ Federal Independent Dispute Resolution Operations, 88 Fed. Reg. 75,744 (Nov. 3, 2023).

¹⁰ Jack Hoadley & Kennah Watts, *Spending on IDR Process Pushes No Surprises Act Costs to More than \$22.4 Billion Over Just Four Years*, Health Affs. (Aug. 26, 2026), <https://tinyurl.com/2xyfmybz>.

¹¹ CMS, *Independent dispute resolution reports* (July 22, 2026), <https://tinyurl.com/5enjup2e>.

¹² CMS, *Supplemental Background on Federal Independent Dispute Resolution Public Use Files, July 1, 2025—December 31, 2025*, <https://www.cms.gov/priorities/innovation/data-and-reports/2026/federal-idr-supplemental-background-2025-q3-2025-q4>.

¹³ Hoadley & Watts, *supra* note 10.

¹⁴ Anna Wilde Mathews & Tom McGinty, *Medical Billing Arbitration Paid Out \$15 Billion to Providers in Surprise Bill Disputes*, Wall St. J. (July 22, 2026), <https://tinyurl.com/6zcf96ex>.

¹⁵ 42 U.S.C. § 300gg-111(c)(5)(F).

disputes. More consequential still, an IDR entity generally is paid only if it makes a payment determination: it is not paid for time spent evaluating eligibility, and it is not paid at all if it concludes that a dispute is ineligible.¹⁶ A mechanism designed as a last resort has become a routine, high-volume billing channel – a new business model for unscrupulous providers and their intermediaries. The result of this, as described in detail below, is an incentive structure that encourages the supposedly neutral arbiters that Congress intended to fail to differentiate between an honest mistake or a deliberate misrepresentation. IDR entities, absent the type of relief sought by BCBSTX, have no financial reason to tell the two apart. HaloMD’s model depends on that incentive. An IDR entity that is paid only if it finds a dispute eligible has no financial reason to sustain an objection, and a high-volume, contingency-fee filer that knows this can file without any threat of recourse, absent the courts preserving their long-standing role of determining whether challenged commercial behavior meets the strictures of the law.

The existing eligibility screening also does not sufficiently protect against abuses of the IDR process; even when plans identify eligibility issues, they are often ignored by IDR entities. This gap imposes both a financial cost on payers and creates a material recourse problem. The IDR process gives a responding plan the opportunity to object to eligibility, and plans use it. But the review that follows

¹⁶ *Id.*; 45 C.F.R. § 149.510(c)(2).

is built to move quickly, and fails to tell a good-faith eligibility mistake apart from a knowingly false attestation. Plans have three business days after a dispute is initiated to submit an eligibility objection and supporting documentation.¹⁷ The IDR entity, in turn, must decide eligibility no later than five business days after it is selected, based solely on the parties' written submissions; there is no discovery, no hearing, and no mechanism designed to detect a false attestation.¹⁸

The scale of what that review cannot sort out is visible in the data. Between April 15, 2022 and December 31, 2024, non-initiating parties challenged the eligibility of 976,721 disputes; certified IDR entities found 355,804 ineligible.¹⁹ In 2024, plans identified as much as 39% of disputes as ineligible, on grounds including that the claim was governed by state law rather than federal law, that it duplicated an earlier filing, that it involved an in-network provider, or that it had been paid by Medicare or Medicaid.²⁰ In the second half of 2025, non-initiating parties challenged 42% of disputes as ineligible, while IDR entities dismissed only

¹⁷ *Id.* § 149.510(b)(2)(iii)(A)(8).

¹⁸ *Id.* § 149.510(c)(2)(i); *id.* § 149.510(c).

¹⁹ Federal Independent Dispute Resolution Operations, 91 Fed. Reg. 33,900, 33,902 (June 4, 2026).

²⁰ AHIP, *New AHIP/BCBSA Survey Finds Providers are Flooding IDR System with Ineligible Disputes* (Oct. 2025), https://ahiporg-production.s3.amazonaws.com/documents/202510_AHIP_IB_No_Surprises_Act_Survey51.pdf.

19%.²¹ Roughly 15% of all disputes reach a final award despite being ineligible.²²

The Departments themselves have acknowledged that initiating parties submit large numbers of ineligible disputes, and that the practice drives both the volume of filings and the delays in processing them.²³ These are industry-wide figures, not a HaloMD-specific count — but they make clear that a filer with HaloMD's incentives has overwhelming reason to exploit the system to its own benefit, and to the detriment of virtually every other stakeholder in the health care delivery system and in conflict with the well-considered views of Congress in adopting the reticulated scheme it did to ensure the validity of IDR determinations.

Moreover, there exists no meaningful channel for challenging the eligibility of these disputes after the fact. The Departments' published Technical Assistance permits parties to raise errors after a dispute closes and it does not address deception, but reopening runs through the same IDR entity whose fee is at stake, and a correction that reverses an eligibility finding requires that entity to refund a fee it has already collected and to spend uncompensated time reaching that

²¹ CMS, *Supplemental Background on the Federal IDR Public Use Files, July 1, 2025—December 31, 2025*, <https://www.cms.gov/priorities/innovation/data-and-reports/2026/federal-idr-supplemental-background-2025-q3-2025-q4>.

²² AHIP, *supra* note 20.

²³ 91 Fed. Reg. at 33,902.

conclusion.²⁴ *Amici's* members report long delays and, frequently, no response to requests for reopening. The Departments' June 2026 Final Rule is a potentially constructive step, but it operates prospectively, offers nothing as to disputes already resolved, addresses only some categories of ineligible submissions rather than all of them, and leaves the basic architecture intact: initiating parties still self-attest as to eligibility, and IDR entities still decide eligibility under the same fee incentives that compensate them only when they find the dispute eligible.²⁵ None of that addresses a false attestation once it has already produced an award.

That architecture creates a genuine bind for the plans on the receiving end of it. For a plan, each objection is a discrete expense incurred against the odds described above: identify the defect within three business days, document it, submit it, and then, in the substantial majority of cases, pay the IDR entity fee when the objection fails anyway. If a plan that raises the objection and loses is also foreclosed, by virtue of having participated in the process, from any judicial forum in which to address *deliberate* misuse of that process by a non-party, the plan is left worse off for having tried than if it had done nothing at all.

²⁴ CMS, *Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties* (June 2025), <https://www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf>.

²⁵ 91 Fed. Reg. 33,900; *see also* 45 C.F.R. § 149.510(c)(2)(i) (requiring IDR entities to consider eligibility information submitted by the non-initiating party, effective August 3, 2026).

Amici raise these points because the District Court’s order suggested that complaints of this kind are more appropriately addressed to policymakers rather than the courts. *Amici* have pursued and continue to pursue that route— in the drafting of the statute, in the implementing rulemakings, and in ongoing legislative efforts to repair the IDR process. But regulatory and legislative reform is prospective and directed at process design. It does not reach conduct that is alleged to be deliberate deception by an entity that is not a party to the proceedings it initiates, and it returns nothing to the plans and participants who have already paid for it.

Further, awards routinely exceed the QPA by multiples, not because these particular disputes carry any special merit, but because the same fee incentive described above is at work. Providers prevailed in 85% of IDR determinations in the second half of 2025,²⁶ and in approximately 85% of determinations the prevailing offer exceeded the QPA which Congress viewed as, at a minimum, the starting point for a reasonable payment for a given service.²⁷ The size of that excess is the more striking figure. Median federal IDR determinations equaled

²⁶ CMS, *supra* note 21.

²⁷ *Id.*

372% of the QPA in 2023²⁸ and 445% in 2024.²⁹ In disputes initiated by HaloMD, the median award was 934% of the QPA.³⁰ That figure is more than double the general median, reflecting the predictable effect of the same broken incentive on a filer built to exploit it at scale. The pattern holds across categories: for items and services under \$100, the median prevailing offer was 591% of the QPA in the first half of 2025, and for neurology and neuromuscular procedures — 52,641 claims in the second quarter of 2025 alone — the median prevailing offer reached 2,862% of the QPA.³¹

III. A SMALL NUMBER OF UNREGULATED INTERMEDIARIES DRIVE MOST OF THE VOLUME.

The publicly available information makes clear that these problems are highly concentrated. In 2025, three organizations accounted for more than three-fourths of all resolved dispute lines—the unit in which CMS’s public use files report claims, since a single dispute can bundle multiple services filed in batches.

²⁸ Benjamin Ukert & Aliza S. Gordon, *Arbitration Outcomes for Out-of-Network Medical Bills Under the No Surprises Act* (2025), <https://pmc.ncbi.nlm.nih.gov/articles/PMC12698988/>.

²⁹ Jack Hoadley & Kennah Watts, *The Substantial Costs of the No Surprises Act Arbitration Process*, Ctr. on Health Ins. Reforms (Sept. 24, 2025), <https://chir.georgetown.edu/the-substantial-costs-of-the-no-surprises-act-arbitration-process/>.

³⁰ Hoadley & Watts, *supra* note 29.

³¹ CMS, *Federal IDR Supplemental Tables for 2025 Q1*, <https://tinyurl.com/35e4kvb9>; CMS, *Federal IDR Supplemental Tables for 2025 Q2*, <https://tinyurl.com/ye9ymuuj>.

Radiology Partners, a national radiology practice group, filed 30%; HaloMD filed 27%; and TeamHealth, a multispecialty provider group filed 20%.³² HaloMD works for contingency fees and advertises awards of approximately five times the QPA.³³

Clinicians are licensed by the states and subject to federal fraud, waste, and abuse rules. Insurers are extensively regulated at the state and federal levels. Even the plans on the other side of these disputes answer to ERISA and the Affordable Care Act for how they administer benefits. HaloMD, however, occupies a unique regulatory position. It is a billing intermediary that is not a party to the disputes it files, is not licensed as a health care provider, and faces no comparable federal or state regime governing how it conducts itself. The concentration of filings in a handful of an intermediary like HaloMD is not an incidental feature of the current system; it is what a screening process with no real teeth and a payment benchmark that rewards volume will predictably produce. Nothing about that regulatory gap, however, licenses conduct that amounts to civil fraud, and the absence of a regulator elsewhere in the system is a reason for courts to remain open to claims of that kind, not a reason to close them.

³² Hoadley & Watts, *supra* note 10 (Radiology Partners, HaloMD, and TeamHealth together accounted for more than three-fourths of all resolved dispute lines in 2025).

³³ See HaloMD, <https://halomd.com/> (last visited Sept. 25, 2026).

IV. THE COSTS FALL ON EMPLOYER PLANS AND, THROUGH THEM, ON WORKING FAMILIES.

The first category of cost is administrative. A material share of it traces directly to identifying and challenging filings like the ones alleged here. Federal agencies estimated that a party's internal cost to prepare and submit IDR materials would be \$857 per dispute.³⁴ That figure is the baseline cost of the process working as designed; it does not include what a plan spends specifically to catch a false attestation. Applying that figure across the relevant period, researchers put internal administrative costs at approximately \$1.9 billion between 2022 and 2024.³⁵ Fees paid into the process itself are now of comparable magnitude: in the second half of 2025, administrative fees and IDR entity fees totaled \$932,712,931 across 1,372,563 initiated disputes, or roughly \$680 per dispute.³⁶ Neither figure captures the cost of the infrastructure plans have built specifically to detect and challenge ineligible filings of the kind HaloMD is alleged to have submitted, including vendor support, dedicated review staff, and specialized teams. Those costs are absorbed through higher premium contributions, higher deductibles, or reduced benefits, and none of them buys a participant any medical care. The second

³⁴ Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021).

³⁵ Hoadley & Watts, *supra* note 30.

³⁶ CMS, *supra* note 21; CMS, *Federal IDR Supplemental Tables for 2025 Q3*, <https://tinyurl.com/ymapy4tj>; CMS, *Federal IDR Supplemental Tables for 2025 Q4*, <https://tinyurl.com/2s4hsvv5>.

category is the awards themselves, and it is the fee incentive described above, not any special merit in these disputes, that produces high-dollar awards at this scale. Determinations that exceed the plan's median contracted rate by factors of four, nine, or more, as described above, must be paid in full, and the excess is a permanent transfer out of the plan's assets. Aggregated across millions of disputes, the sums are not marginal; researchers estimate that the IDR process has added total costs to the health care system above \$22.4 billion in four years.³⁷ For certain entities like HaloMD, regardless of whether they are compensated on a contingency basis, a process that lacks any judicial remedy for fraud amplifies the incentives for fraudulent or misleading behavior.

Beyond these dollar costs is a further consequence, one that is not a cost in the same sense but is just as much a departure from what the NSA was meant to accomplish. It is the slowest to materialize and the most difficult to reverse: when out-of-network payment consistently exceeds in-network payment by large multiples, the rational course for a provider in a high-demand specialty is to stay out of the network. Each departure narrows the network around which employer coverage is built. Participants then face higher cost sharing, fewer in-network options for the specialties in which shortages are already acute, longer waits, and

³⁷ Hoadley & Watts, *supra* note 10.

less coordinated care³⁸ A thin enough network also undercuts the NSA's core promise: it puts patients back in exactly the position the statute was meant to prevent, needing care from an out-of-network provider they never chose. A plan that spends more to keep providers in network is not avoiding this consequence; it is absorbing it earlier instead of later, with the costs ultimately passed on to participants as higher premiums.

CONCLUSION

The NSA's dispute resolution process was designed to protect patients and to restrain the cost of out-of-network care. It has accomplished the first goal; conduct like the fraudulent scheme alleged here undermines the second. Employer plans and their participants are the ones who pay for that scheme: in amounts spent defending against it and in awards obtained through it. *Amici* ask that the Court, in deciding the questions presented, consider what the IDR process has become and what it means for the millions of working families whose coverage absorbs its costs. For the reasons stated by Plaintiff-Appellant, the judgment should be reversed.

Dated: September 25, 2026

Respectfully submitted,

s/ Lars C. Golumbic
Lars C. Golumbic

³⁸ Olena Mazurenko et al., *The Impact of Narrow and Tiered Networks on Costs, Access, Quality, and Patient Steering: A Systematic Review*, 79 Med. Care Rsch. & Rev. (2022), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9817087/>.

Ryan C. Temme (admission
forthcoming)
Seth T. Perretta (admission
forthcoming)
Elizabeth Loh (admission forthcoming)
GROOM LAW GROUP, CHARTERED
1701 Pennsylvania Ave., N.W.
Washington, D.C. 20006
Tel: (202) 867-0620
Fax: (202) 659-4503
lgolumbic@groom.com
rtemme@groom.com
sperretta@groom.com
eloh@groom.com

*Counsel for American Benefits
Council, ERISA Industry Committee
& Business Group on Health*

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 4,391 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f). This brief also complies with the typeface requirements of Fed. R. App. P. 32(a)(5)(A) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman font size 14.

s/ Lars C. Golumbic
Lars C. Golumbic

F.R.A.P. 29 DISCLOSURE

Consistent with Federal Rule of Appellate Procedure, rule 29(a)(4)(E), the undersigned counsel for the American Benefits Council, Business Group on Health, and the ERISA Industry Committee represents that no party or party's counsel (i) authored this amicus brief in whole or in part; (ii) contributed money that was intended to fund preparing or submitting this brief; or (iii) contributed money that was intended to fund preparing or submitting the brief, other than the amicus curiae, its members, or its counsel.

s/ Lars C. Golumbic
Lars C. Golumbic

CERTIFICATE OF SERVICE

I certify that on September 25, 2026, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I further certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

s/ Lars C. Golumbic
Lars C. Golumbic