

No. 26-40316

**IN THE 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, L.L.C.; ALLA LAROCHE; SCOTT LAROCHE,

Defendants – Appellees.

*On Appeal from the United States District Court
for the Eastern District of Texas
District Court No. 5:25-CV-132*

**BRIEF OF AMERICA’S HEALTH INSURANCE PLANS
AS AMICUS CURIAE IN SUPPORT OF APPELLANT**

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CERTIFICATE OF INTERESTED PERSONS

Blue Cross Blue Shield of Texas v. HaloMD, L.L.C., No. 26-40316

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

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Under Federal Rules of Appellate Procedure 26.1 and 29(a)(4)(A), America's Health Insurance Plans, Inc. states that it has no parent corporation and that no publicly held corporation owns 10% or more of its stock.

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STATEMENT OF INTEREST OF AMICUS CURIAE¹

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 healthcare 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 healthcare and health insurance systems work.

AHIP writes here to explain the broader consequences for the healthcare system if the district court's decision is upheld. The complaint alleges sweeping fraudulent manipulation of a dispute resolution system that Congress designed to be efficient, rarely used, and cost-saving for both taxpayers and healthcare consumers. The alleged fraud has caused Plaintiff-Appellant health plan to pay tens of millions of dollars in unwarranted fees and costs, ROA.739 (district court opinion)—a burden that will ultimately be borne by healthcare consumers. Yet the district court's

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. All parties have consented to the filing of the brief. *See* Fed. R. App. P. 29(a)(2), (4).

decision effectively forecloses any remedy for redressing or deterring fraud and abuse designed to obtain windfall payments on ineligible claims.

As Blue Cross Blue Shield of Texas argues, the No Surprises Act does not eliminate judicial redress for violations of other federal or state laws designed to remedy the type of widespread, systemic fraud alleged here. *See* Opening Br. 23-55. Piecemeal, decision-by-decision review of an Independent Dispute Resolution (IDR) entity's selection of one of two payment offers through the Act's vacatur provision does not address Defendants' alleged scheme to flood the system with ineligible claims and is wholly incapable of remedying many of the harms caused by a deluge of fraudulent claims. In addition, discovering and presenting allegations of fraud within the IDR process is often impossible because, *inter alia*, entities intentionally exploiting the IDR system can (and do) group their filings into waves and misdirect required IDR notices to avoid detection of their wholesale submission of ineligible disputes. *See* ROA.739 (describing allegations regarding "delay and dump tactics"). The fact that a plan manages to identify isolated disputes as ineligible during the IDR process does not indicate that process can remedy the kind of widespread fraud scheme alleged here.

Cutting off any meaningful anti-fraud remedies leads to grave consequences. Most healthcare providers are playing by the rules. They appear to have approached the Act in good faith and have been fairly compensated. But a handful of entities are

exploiting the system to obtain windfall profits on ineligible claims. The dispute resolution process lacks safeguards to protect against this fraud and abuse. Costs have ballooned, contravening Congress's design to rein them in. If this abuse can continue unchecked, the result will be spiraling healthcare costs for everyone.

INTRODUCTION AND SUMMARY OF ARGUMENT

AHIP's members strive to reach agreements with healthcare 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 out-of-network providers would send excessive surprise bills to patients to pressure patients' health plans to pay the providers' above-market, unilaterally set billed charges. This dynamic was particularly strong for private-equity-backed provider staffing companies in specialties where patients could not choose providers in advance, like for emergency care and providers typically chosen by in-network hospitals without patient input, such as anesthesiology, radiology, and neuromonitoring.

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 healthcare 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 IDR process to resolve them. In IDR, the parties submit confidential offers to the IDR entity. The IDR entity must select one of the two offers in a black-box process governed by short statutory deadlines. Congress selected this “baseball-style” format of final-offer arbitration to incentivize parties to submit reasonable offers and 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.

A handful of provider staffing firms and other entities that generate revenue from filing IDR disputes—many of them backed by private equity firms—have taken a different approach. They have adopted IDR exploitation as a business strategy. These entities, some of which were created with the objective of leveraging IDR to obtain excessive payments, are manipulating the system by knowingly

submitting huge numbers of ineligible claims. This strategy often works. As a spokesperson for the Centers for Medicare and Medicaid Services (CMS) recently acknowledged, “the system is being gamed.” 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>.

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 part of the alleged fraudulent scheme involves misdirecting disputes and filing them in same-day waves, health plans are hampered from meaningfully detecting—much less responding to—this 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. By effectively allowing these entities to abuse the system at scale without having to answer for their misconduct, the district court’s decision is devastating. It not only harms health plans. It also raises costs for American

families and reduces healthcare affordability. And it creates perverse incentives that will encourage even more fraud, waste, and abuse.

ARGUMENT

I. The No Surprises Act Aims to Remedy Market Dysfunction Where Patients Cannot Choose Providers.

For most medical services, payments are set in advance by negotiation of rates between health plans and healthcare providers. Health plans work with providers to offer networks that provide Americans access to affordable, high-quality care. *See* AHIP, Center for Pol’y & Research, *Charges Billed by Out-of-Network Providers: Implications for Affordability*, at 3 (Sep. 2015), <https://tinyurl.com/2ehamzza>. Such networks benefit patients, employers and other health plan sponsors, and the entire healthcare system. They reduce costs, promote access to care, and provide high-quality choices for enrollees. *See* AHIP, *Issues: Provider Networks*, <https://tinyurl.com/2p94p4xz>. The resulting contracts typically limit the provider to the agreed payment from the plan and prohibit surprise bills to patients. *See* 86 Fed. Reg. 36872, 36874 (July 13, 2021). Out-of-network providers, in contrast, often charge higher rates. *Id.* Before the Act, these providers sometimes sent patients surprise bills for any part of their billed charges not paid by the patient’s health plan. *Id.*

Providers are more likely to be out-of-network when patients are unable to choose a provider in advance, such as for emergency care or for ancillary hospital-

based services (where the hospital assigns providers without patient direction, including anesthesiologists, radiologists, and pathologists). *See* 86 Fed. Reg. 55980, 56046 (Oct. 7, 2021); Gary Claxton et al., *An analysis of out-of-network claims in large employer health plans*, Peterson-KFF: Health System Tracker (Aug. 13, 2018), <https://tinyurl.com/3fp5psf9>. One of the reasons out-of-network bills can surprise patients is that choosing an in-network hospital does not guarantee in-network healthcare. *See* Zack Cooper et al., *Surprise! Out-of-Network Billing for Emergency Care in the United States*, 128 J. Pol. Econ. 3626, 3627 (2020). For example, approximately two-thirds of hospitals outsource the staffing of their emergency departments to provider staffing companies. *Id.* at 3631. Two national private-equity-owned provider staffing firms account for about a third of such outsourced staffing. *Id.* Doctors with provider staffing firms are employees or independent contractors; they do not collect the payments for their services—the firms do. *See* Erin Fuse Brown et al., *Private Equity Investment As A Divining Rod For Market Failure: Policy Responses To Harmful Physician Practice Acquisitions*, at 6, 26 (2021), <https://tinyurl.com/57kf5j9z>.

Before the No Surprises Act, out-of-network providers secured higher payments from health plans by leveraging their ability to surprise bill patients. *See* 86 Fed. Reg. at 36874. Studies have shown that providers in specialties that were able to send surprise bills charged (and obtained) “notably higher amounts, relative

to Medicare rates, than other specialties.” Loren Adler et al., *Provider charges relative to Medicare rates, 2012-2017*, Brookings (Dec. 5, 2019), <https://tinyurl.com/h8n663cc> (finding mean charges of 4 to 6.7 times Medicare rates for radiology, anesthesiology, and emergency care, compared to 2.6 times Medicare rates for non-surprise-billing specialties); Zack Cooper et al., *Out-Of-Network Billing and Negotiated Payments for Hospital-Based Physicians*, 39 Health Affairs 24, 26 (2020), <https://tinyurl.com/bddeyrfj> (finding in-network rates of 343% and 367% of Medicare rates for pathologists and anesthesiologists compared to 164% of Medicare rates for orthopedists). One study of a national provider staffing firm found that when it “enters into a new contract to manage a hospital’s [emergency department] services, it immediately exits insurer networks, ... and seeks to collect charges (which it doubles relative to the charges billed by the prior physician group in that hospital).” Cooper, *Surprise!*, *supra*, at 3629.

The No Surprises Act takes two key steps to protect patients from these unpredictable and out-of-control out-of-network costs. First, unless state law provides otherwise, the Act sets patients’ cost-sharing based on the Qualifying Payment Amount (QPA), which is generally the health plan’s median in-network contract rate for the same service in the same area.² Providers can bill a patient’s health plan, but they are barred from balance billing patients for the rest of their

² 42 U.S.C. § 300gg-111(a)(1)(C)(iii), (a)(3)(E), (H), (b)(1)(B).

charges.³ Second, the Act establishes negotiation and dispute resolution procedures to resolve disputes between providers and health plans about out-of-network payment amounts.

II. 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's dispute resolution process encourages prompt, voluntary resolution of out-of-network payment disputes. To begin, the plan makes an initial payment.⁴ Either the plan or the provider can then start a 30-day open negotiation period.⁵ If negotiations fail, then either party may initiate IDR within 4 days.⁶

IDR procedures are limited to foster efficiency. Each party must submit an offer within 10 days after an IDR entity is selected.⁷ Neither party sees or responds to the other party's offer.⁸ The IDR entity must select one of the two offers within 30 days; it cannot set any other payment amount.⁹ These limited "baseball-style"

³ *Id.* §§ 300gg-131, 300gg-132, 300gg-135.

⁴ *Id.* § 300gg-111(a)(1)(C)(iv)(I), (b)(1)(C).

⁵ *Id.* § 300gg-111(c)(1)(A).

⁶ *Id.* § 300gg-111(c)(1)(B).

⁷ *Id.* § 300gg-111(c)(5)(B).

⁸ *Id.*; see also CMS, *Federal [IDR] Process Guidance for Disputing Parties*, at 18-19 (Dec. 2023), <https://tinyurl.com/mr2xvdrk> (Disputing Party Guidance).

⁹ 42 U.S.C. § 300gg-111(c)(5)(A)(i).

procedures are intended to encourage reasonable offers, foster settlement, and minimize administrative costs.¹⁰

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 twenty 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 2 (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.* at 3. Collectively, about 94% of claims subject to the Act were resolved voluntarily in 2024. *See 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 healthcare 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. at 56056-57. Any additional administrative costs were projected to be offset by premium reductions, on the expectation that out-of-network payments would move

¹⁰ *See Tex. Med. Ass’n v. U.S. Dep’t Health & Hum. Servs.*, 110 F.4th 762, 768 n.8 (5th Cir. 2024); 42 U.S.C. § 300gg-111(c)(3)(A).

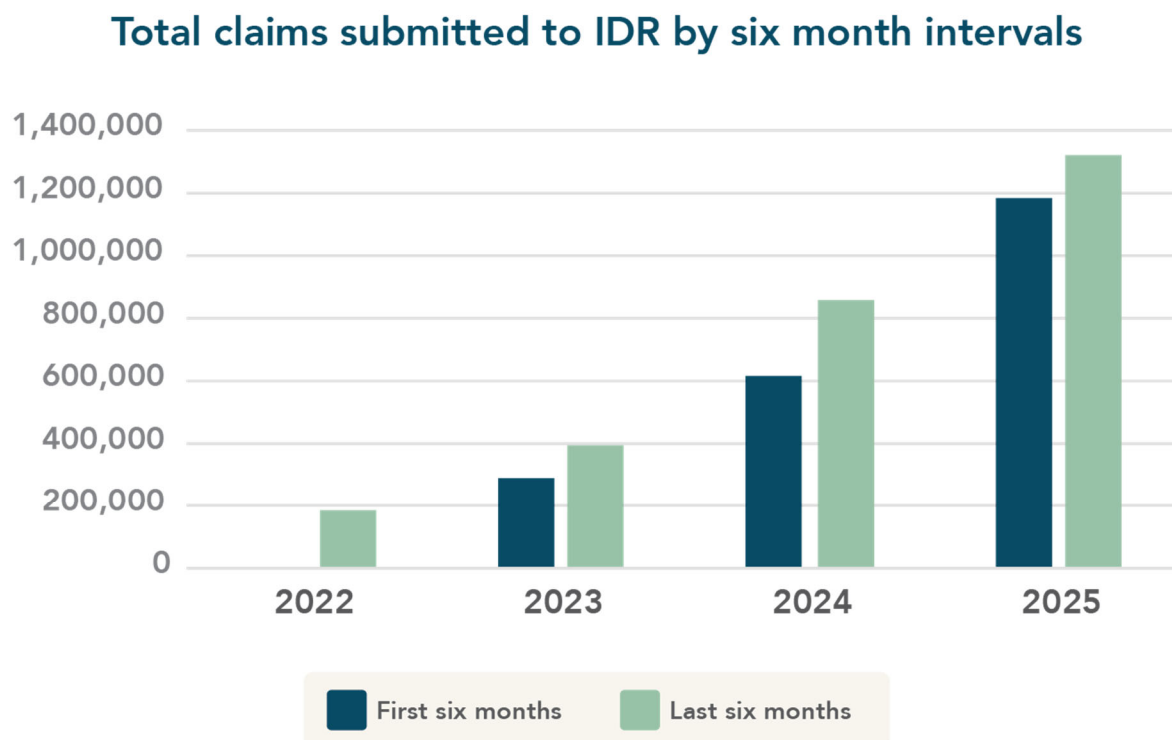
closer to negotiated rates. *See* Cong. Budget Off., *Estimate for Divisions O Through FF, H.R. 133*, at 2-3 (Jan. 14, 2021), <https://tinyurl.com/3eec2a4n>. At the time, this projection made sense because the Act was designed to rein in the pre-Act practice of extorting above-market payments from health plans by leveraging the threat to surprise bill their beneficiaries. *See* 86 Fed. Reg. at 36874. 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 staffing firms and emergent intermediaries that generate revenue from filing IDR disputes.

III. Abuse of the IDR Process Is Generating Billions in Unwarranted Costs.

A. A Few Entities Engaged in Concentrated Exploitation of the IDR System Have Flooded the System with Ineligible Disputes.

1. IDR volume is very high and still growing, driven by ineligible claims.

IDR volume has increased more than seven-fold from the second half of 2022 to the end of 2025:



See generally CMS, *[IDR] Reports*, <https://tinyurl.com/5enjup2e>.¹¹

¹¹ See also CMS, *Supplemental Background on Federal [IDR] Public Use Files, July 1, 2025 – Dec. 31, 2025*, at 2 (July 22, 2026), <https://tinyurl.com/y8sa4zf7> (2025 Second Half IDR Report); CMS, *Supplemental Background on Federal [IDR] Public Use Files, July 1, 2024 – Dec. 31, 2024*, at 2 (May 28, 2025), <https://tinyurl.com/yrsassuu> (2024 IDR Report); CMS, *Supplemental Background on Federal [IDR] Public Use Files, July 1, 2023 – Dec. 31, 2023*, at 2 (June 13, 2024), <https://tinyurl.com/49vp3naz>; CMS, *Partial Report on the [IDR] Process: Oct. 1, 2022-Dec. 31, 2022*, at 7-8, <https://tinyurl.com/y5pywras>.

Disputes were up 16% in the latter half of 2025 over the first part of the year and are still climbing. 2025 Second Half IDR Report, *supra*, at 2. More than 2.5 million IDR disputes were initiated in 2025, which is more than 115 times the volume anticipated by the implementing agencies. *Id.*; 86 Fed. Reg. at 56056-57 & nn.187, 199. Filings in 2026 are on track to hit 3.6 million, *see CMS, Federal IDR bi-monthly reports* (July 31, 2026), <https://tinyurl.com/3rv425es>, and given “the dramatic increase in utilization of the Federal IDR process,” the government expects a further 30% increase from its reduction of the administrative fee. 91 Fed. Reg. 33900, 33969 n.128, 33971 n.142 (June 4, 2026).

This high volume is primarily driven by a handful of firms that have engaged in concentrated exploitation of the IDR system, largely by flooding the system 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*, Brookings, fig. 1 (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, intermediaries that provide no medical services but generate revenue from filing disputes, like Defendant HaloMD, had joined these firms among the top

initiators of IDR. 2025 Second Half IDR Report, *supra*, at 2. The top three initiating entities—HaloMD and two private-equity-backed provider staffing firms—generated 38% to 44% of all IDR disputes in 2025. *Id.*; CMS, *Supplemental Background on Federal [IDR] Public Use Files, Jan. 1, 2025 – June 30, 2025*, at 2 (Jan. 21, 2026), <https://tinyurl.com/yc35y54r>; U.S. Gov’t Accountability Off., *Private Health Insurance: Roll Out of [IDR] Process for Out-of-Network Claims Has Been Challenging*, at 43-44 (Dec. 2023), <https://tinyurl.com/58ks4aba> (identifying private-equity-backed firms).

The doctors themselves are often uninvolved in these claims—and may not receive the IDR award payments. Journalists interviewed “physicians who show up repeatedly” in the dispute files and found “they were salaried workers and uninvolved in the claims filed under their names.” Sarah Kliff & Margot Sanger-Katz, *Health Law Lets Doctors Cash In*, N.Y. Times, Apr. 26, 2026, at A1; *see also* Margot Sanger-Katz & Sarah Kliff, *\$22,000 Per Hour: Assistants Use a Legislative Loophole to Outearn Surgeons*, N.Y. Times, June 29, 2026, <https://tinyurl.com/y69bavhc> (describing how “surgical assistants at MPowerHealth” “are paid salaries for their work, and the company collects any arbitration awards”).

b. The disputes initiated by frequent filers are often ineligible for IDR. 91 Fed. Reg. at 33902 (“[I]nitiating parties are submitting a large number of ineligible

disputes, leading to ... a high volume of dispute submissions[.]”). Overall, about two-fifths of IDR disputes are ineligible for IDR because they are filed for services that do not qualify for IDR or are submissions that fail to comply with procedural requirements. *See* AHIP/BCBSA Survey, *supra*, at 4 (39%); 2025 Second Half IDR Report, *supra*, at 3 (40-42% challenged as ineligible in 2025); 2024 IDR Report, *supra*, at 3 (43-45% challenged as ineligible). That adds up to more than a million ineligible disputes per year based on the latest IDR volume data. Some of the fraudulent schemes involve even higher rates of ineligible claims; in one case, the health plan alleges a scheme where nearly 60% of the disputes that reached a payment determination were ineligible. Compl. ¶ 5, *Anthem Health Plans of Va., Inc. v. AGS Health, Inc.*, No. 7:25-cv-00804 (W.D. Va. Nov. 5, 2025), Dkt. No. 1.

Because IDR was never intended to be a catch-all forum, there are many criteria that disqualify disputes from IDR. Only certain services are governed by the Act, the provider must be out-of-network, and the service must be covered by the health plan.¹² Some types of coverage (like Medicaid plans) are excluded.¹³ In addition, services subject to state surprise billing laws are not eligible for the federal IDR process.¹⁴ Parties must also adhere to precise statutory timeframes to invoke

¹² 42 U.S.C. § 300gg-111(a)(1), (b)(1).

¹³ *See id.*

¹⁴ *Id.* § 300gg-111(a)(3)(K).

IDR.¹⁵

Eligibility determinations are ministerial, not discretionary. If a dispute is ineligible, then the IDR entity is “statutorily prohibited from making [a] payment determination[.]” 91 Fed. Reg. at 33933. Determining eligibility requires no exercise of judgment; a dispute is either eligible or it is not. Plans communicate whether services meet the Act’s eligibility requirements when they issue an explanation of payments. *See* ROA.785-786, 789-790 (Compl. ¶¶ 102, 115-116). And the party initiating IDR will necessarily know whether it is initiating the dispute within the right timeframe. As the allegations illustrate here, there can be no question about eligibility when plans convey unambiguous disqualifiers up front, like Medicaid coverage or the applicability of a state surprise billing law. *See id.*

2. The IDR system is not equipped to self-correct for abuse and manipulation.

Congress did not assign IDR entities the task of determining dispute eligibility. 91 Fed. Reg. at 33942 (“[T]he statute does not contemplate an eligibility determination process[.]”).¹⁶ And it narrowed judicial review only for an IDR entity’s payment determination—*i.e.*, selection of one of two offers—not any assessments of dispute eligibility.¹⁷ As Blue Cross Blue Shield of Texas explains,

¹⁵ *Id.* § 300gg-111(c)(1)(B).

¹⁶ *See* 42 U.S.C. § 300gg-111(c)(5).

¹⁷ *See id.* § 300gg-111(c)(5)(A), (E).

that means Congress did not limit judicial review of a suit seeking to remedy a pattern of fraudulent submission of ineligible IDR disputes. Opening Br. 23-28. Nor could one-by-one review of IDR payment determinations—which are separate and distinct from any decision regarding eligibility—begin to remedy the harms caused by the fraudulent scheme here. Even if IDR entities screened out every ineligible claim—and they don’t—health plans (and ultimately consumers) must outlay substantial, unwarranted sums just to respond to the onslaught of fraudulent ineligible claims. Congress adopted the IDR system against the backdrop of laws, like the Racketeer Influenced and Corrupt Organizations Act, designed to deter and remedy abuse of it.¹⁸ It did not equip the system to self-police against the systemic fraud alleged here.

a. IDR entities have minimal incentives and limited capability to screen out ineligible claims. While IDR entities do screen out some ineligible disputes, responding to such disputes increases wasteful administrative costs even when the IDR entity ultimately finds them ineligible. *See* 2025 Second Half IDR Report, *supra*, at 3. Worse still, a huge number of ineligible disputes pass through and reach final payment determinations—15% of all disputes. AHIP/BCBSA Survey, *supra*, at 4. With 2026 IDR volume likely to be about 3.6 million disputes, that means several hundred thousand payment determinations are issued annually on disputes

¹⁸ *See* 18 U.S.C. § 1962(d).

that are in fact ineligible though the ineligibility is not identified by the IDR entities. This is a widespread problem. *See, e.g., Kliff & Sanger-Katz, supra*, at A1 (“Many claims that shouldn’t be eligible for arbitration ... move through the system anyway.”); AHIP, *Comment Letter on 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>. And there are no financial penalties for IDR entities for errors in eligibility determinations. CMS, *Federal [IDR] Technical Assistance for Certified IDR Entities and Disputing Parties*, at 1 (June 2025), <https://tinyurl.com/2ujrhaxu> (noting continued errors by IDR entities but specifying no financial penalties). Those fees have added up to a billion-dollar-plus industry on their own. Setting aside the profits reaped by intermediaries that generate revenue from filing disputes, IDR entities alone generated over one billion dollars in fees last year. Mathews & McGinty, *supra*.

IDR entities’ eligibility assessments are also hampered by an IDR process that lacks adversarial testing of submissions, especially if initiating parties sign false

attestations of eligibility criteria. *See* Opening Br. 8-10, 16-17. Under the regulations in place when this suit was filed, the IDR entity had only three days to make an eligibility determination, based on “review [of] the information submitted in the notice of IDR initiation.” 45 C.F.R. § 149.510(c)(1)(v) (2022). Parties could challenge eligibility and submit additional materials, but had only a few days to do so before the IDR entity made its decision. *Id.* § 149.510(c)(1)(iii) (2022); 91 Fed. Reg. at 33941-42; CMS, *Federal [IDR] Process: Guidance for Certified IDR Entities*, at 10-11 (2022), <https://tinyurl.com/m3zw648m>. This is precious little time to screen out false dates or other misstatements, especially if initiating parties deliberately group their filings into waves. *See* Opening Br. 15-16. If the IDR entity decided to proceed, it did not need to explain its reasoning. 45 C.F.R. § 149.510(c)(1)(v) (2022).

Recent amendments are little help. They give IDR entities two additional days and expressly provide for submissions from both parties (on their own initiative or at the request of the IDR entity). But submissions are still subject to little adversarial testing and IDR entities do not have to explain their decisions. 91 Fed. Reg. at 33942-43.

The “large number of ineligible disputes” undermines the effectiveness of the procedures for handling them. *See id.* at 33902, 33942. The government decided not to require IDR entities to explain their eligibility decisions because ineligible

disputes “drain[] resources needed to efficiently operate the Federal IDR process” and the volume of disputes leaves IDR entities with no time to explain their eligibility determinations. *Id.* at 33942.

b. The district court noted that plans were able to make some eligibility objections during the IDR process. ROA.742. But the court failed to account for how crucial elements of the alleged fraudulent scheme—including grouping filings in waves and often failing to provide the required notices to the plan—make it impossible to identify and present the fraudulent scheme at the IDR stage. *See* ROA.807-808 (Compl. ¶¶ 199-206). Plans often lack notice of an IDR proceeding altogether 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 Second Half IDR Report, *supra*, at 4—reflects fundamental loopholes in the process that can be exploited by fraud and abuse.¹⁹

3. This concentrated exploitation undermines the speedy, accurate determination of a limited subset of disputes as authorized by Congress.

The extraordinarily high IDR volume, including rampant ineligible claims,

¹⁹ New rules were recently finalized to require the exchange of additional information during open negotiation and when IDR is initiated. 91 Fed. Reg. at 33927. Such rules can help reduce good-faith miscommunication, but they cannot guard against knowing misdirection.

has bogged down the system. Ineligible claims “slow processing of disputes” for everybody. 91 Fed. Reg. at 33902. What’s more, dispute resolution is prone to error. In 2025, the implementing agencies recognized that continued clerical, jurisdictional, and procedural errors by IDR entities undermined the program’s integrity. CMS, *Technical Assistance*, *supra*. The agencies therefore created a process for reopening erroneous IDR determinations. *Id.* 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 Generates Billions of Dollars of Wasteful Costs.

The negative consequences from abuse of the IDR system are immense already, and will only grow if the district court’s decision is affirmed, foreclosing any meaningful remedy. IDR is very costly, in terms of both administrative costs and extraordinarily high IDR determinations (often for claims that were never eligible for IDR to begin with).

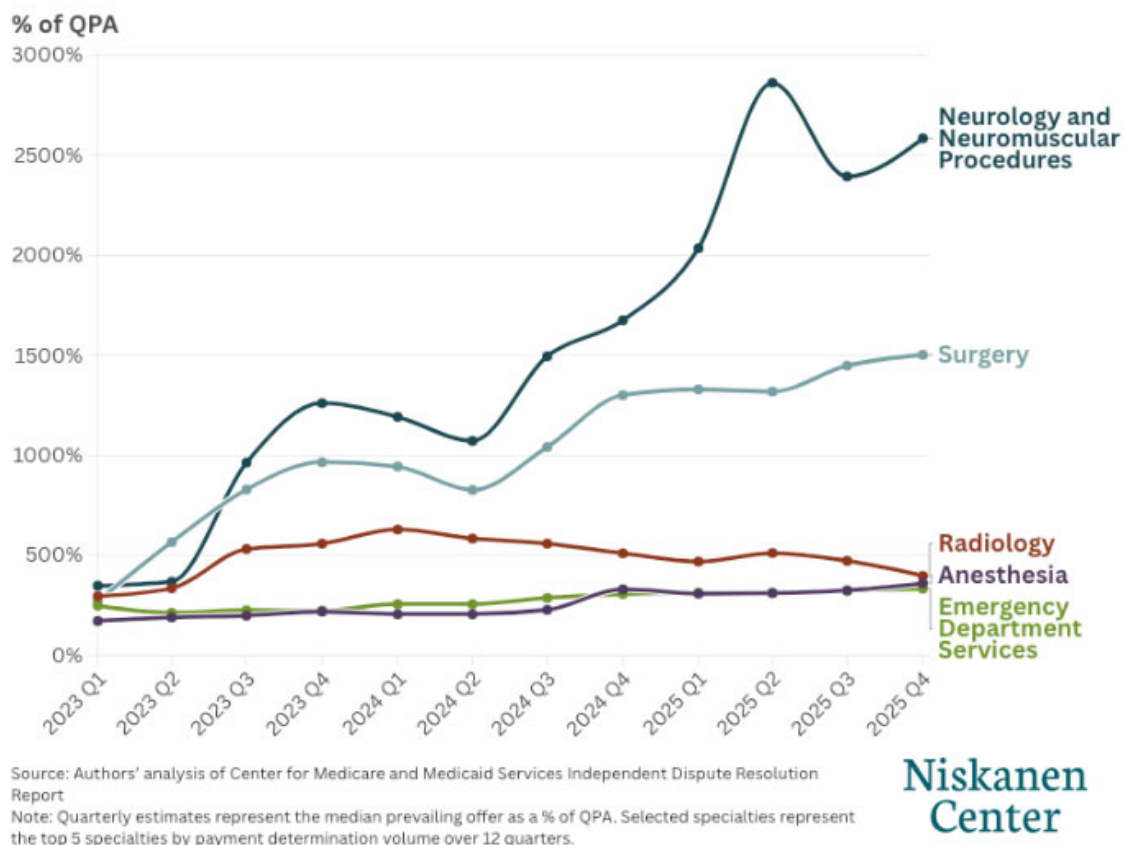
Both parties must pay an administrative fee and the losing party must pay IDR fees that can reach nearly \$1,200 or more for a batched claim with many items, amounting to nearly \$1.3 billion in fees last year. 88 Fed. Reg. 88494, 88523 (Dec. 21, 2023); Mathews & McGinty, *supra*. There are also considerable IDR-related staffing and technology expenses which are increased by the need to rapidly sort through a torrent of ineligible claims. Using just the agencies’ 2021 per-dispute

estimate for such costs, which is a substantial understatement, administrative costs alone totaled more than \$6.8 billion over a four-year period (2022-2025) for all IDR parties. Jack Hoadley & Kennah Watts, *Spending On IDR Process Pushes No Surprises Act Costs To More Than \$22.4 Billion Over Just Four Years*, Health Affairs: Forefront (Aug. 26, 2026), <https://tinyurl.com/ycxjy8mj>. The costs can grow even higher if there is no remedy to deter parties from flooding the system with fraudulent disputes. Efforts to identify false statements require a significant investment of plan resources—costs that are ultimately borne by healthcare consumers.

On top of the administrative costs, concentrated exploitation of the IDR system has yielded payment determinations far exceeding market rates, sometimes exceeding even the highest amount any provider has ever attempted to bill for services. IDR entities have regularly awarded “extremely high prices for common medical procedures.” Kliff & Sanger-Katz, *supra*, at A1. Recall that one of the problems that persisted before the Act was payment rates for surprise-billing specialties that far exceeded the rates for specialties historically unable to balance bill. *See supra* Section I. The differential has only gotten worse. 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 (when rates for specialties historically unable to balance bill are typically

about one and a half times Medicare rates). Fiedler & Adler, *supra*; Cooper, *Out-Of-Network Billing, supra*, at 26. By 2024, mean IDR determinations for emergency care had increased to nearly five times Medicare rates. Loren Adler et al., *No Surprises Act arbitration databook*, Brookings, fig. 2 (Apr. 20, 2026), <https://tinyurl.com/2m62e6jb> (Brookings Study). For imaging services, mean IDR determinations were nearly eight times Medicare rates. *Id.*

Emergency care and imaging are not unique. Median IDR awards in 2025 for some other specialties had skyrocketed to 10 to 25 times median in-network rates:



Lawson Mansell & Caitlin Rowley Gallamore, *New data, same problem: No*

Surprises Act arbitration abuse persists, Niskanen Ctr., fig. 3 (July 30, 2026), <https://tinyurl.com/ytycnujt>. One contributing factor to IDR awards for surgical services that are about 1500% of in-network rates is likely awards for surgical assistant services that are up to twenty-five times the surgeon's rate. See Sanger-Katz & Kliff, *supra*. To give a few other examples, a neurosurgery firm was awarded \$330,000 for a diagnostic procedure to measure blood flow to the brain where the standard in-network rate is \$2,660. Kliff & Sanger-Katz, *supra*, at A1. A gynecology firm has “won fees 600 times higher than usual rates for placing intrauterine contraceptive devices.” *Id.*

The lure of such extraordinary payments has proved irresistible to the handful of firms exploiting IDR and filing ever-increasing waves of fraudulent ineligible disputes. “[T]he system is being gamed to get higher prices.” Mathews & McGinty, *supra*. Studies analyzing 2024 data on emergency care show that health plan payment offers match or exceed market rates: the median health plan IDR payment offer exceeded median in-network rates (131%) and was more than double what Medicare would pay for the same service (212%). Cong. Research Serv., *An Analysis of No Surprises Act (NSA) Independent Dispute Resolution (IDR) Emergency Service Outcomes Relative to In-Network Rates*, at 10 (Feb. 10, 2026), <https://tinyurl.com/3eadtc58> (in-network comparison); Brookings Study, *supra*, at fig. 3 (Medicare comparison). But the objective of IDR-exploiting firms is not

securing market-rate compensation for medical services. It is generating IDR awards that are often “hundreds of times higher than what they could negotiate with insurers directly or what they could have earned from patients before the law passed.” Kliff & Sanger-Katz, *supra*, at A1.

The result is tremendously costly for the healthcare system. One analysis indicated that excess payments generated by IDR from 2023 through 2025—*i.e.*, payments exceeding in-network rates—amounted to \$15.6 billion. Hoadley & Watts, *supra*. In 2025, total IDR payments were “more than six times” estimated in-network rates for the same services. *See* Mathews & McGinty, *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.*, ROA.805-807 (Compl. ¶¶ 188-197). A scheme to use ineligibility fraud 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. Merely considering billed charges—never mind amounts *above* billed charges—can drive up costs and result in higher premiums. 86 Fed. Reg. at 56060. So it is unsurprising that Congress barred IDR

entities from considering billed charges.²⁰ Systemic abuse that allows provider-staffing firms to secure payments above already excessive billed amounts turns the system on its head.

C. If Left Unchecked, Abusive IDR Practices Will Proliferate and Imperil Healthcare Affordability for Patients and Healthcare Consumers.

If the door is left open for firms to abuse the IDR system, the negative consequences will only amplify, impairing healthcare affordability for all Americans. With a total cost of about \$13.6 billion in 2025 (counting payments exceeding in-network rates and IDR entity fees), Mathews & McGinty, *supra*, 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 two billion dollars annually in unwarranted costs and payments to providers for ineligible claims. And even where IDR entities do identify claims as ineligible, plans are saddled with the administrative costs of reviewing and responding to torrents of ineligible claims.

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. As noted above,

²⁰ 42 U.S.C. § 300gg-111(c)(5)(D).

the Congressional Budget Office projected that the No Surprises Act would reduce premiums. *See supra* p. 11. But—as the Office’s analysts drily put it—“[e]merging evidence suggests that the law might not have the effects that CBO anticipated.” Jessica Hale et al., *A Call for New Research on the No Surprises Act*, Cong. Budget Off.: Blog (June 15, 2026), <https://tinyurl.com/54r6b5w6>.

Reviewing the situation now, IDR-related evidence “suggests that the law could cause premiums to increase.” *Id.* This is both because the “number of IDR cases has far exceeded projections,” and because “awarded payments are often much higher than anticipated” and “much larger than the typical prices for health care services.” *Id.* Some health plans have already been forced to increase premiums to cover inflated out-of-network costs. Kliff & Sanger-Katz, *supra*, at A1. A national survey of employers identified No Surprises-related costs as one of the top three recent developments driving the expected 8%-plus increase in health benefit costs in 2027—the largest increase in more than two decades. Beth Umland & Sunit Patel, *Survey: Health benefit costs expected to jump 8.2% in 2027, the biggest increase since 2003*, Mercer (Aug. 31, 2026), <https://tinyurl.com/3d8paj8f>. New York State, for example, has identified hundreds of millions of dollars in additional out-of-network payments “stemming from [IDR] abuse” as the “primary contributor” to a nearly 10% premium increase this year for just one of its health plans for employees and retirees. *FY 2027 New York State Executive Budget: Public Protection &*

General Government Article VII Legislation—Memorandum in Support, at 26, <https://tinyurl.com/54fp97pz>.

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.²¹ And when the ill-gotten gains are pocketed by private equity provider staffing firms and third-party intermediaries, the “money does not always end up with the doctors” who provided the care. Kliff & Sanger-Katz, *supra*, at A1.

By making fraudulent IDR practices effectively immune from liability, the district court’s decision drives increased costs and reduces healthcare affordability for everyone. If a handful of provider staffing firms and intermediaries can adopt schemes to sneak large numbers of 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, the more likely that the system is further overwhelmed, and that even more ineligible or fraudulent claims pass through. The IDR system cannot police the kind of fraud alleged here. Nor can vacatur of individual payment determinations remedy the costs to plans (and ultimately, to consumers) of responding to an onslaught of ineligible claims. The prospect of liability for fraud is

²¹ See, e.g., 42 U.S.C. § 300gg-18(b).

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.

CONCLUSION

The judgment of the district court should be reversed.

September 25, 2026

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CERTIFICATE OF COMPLIANCE

The foregoing brief is in 14-point Times New Roman proportional font and contains 6,143 words, and thus complies with the type-volume limitation set forth in Rule 29(a)(5) and Circuit Rule 29.3.

s/Hyland Hunt
Hyland Hunt

September 25, 2026

CERTIFICATE OF SERVICE

I hereby certify that, on September 25, 2026, I served the foregoing brief upon all counsel of record by filing a copy of the document with the Clerk through the Court's electronic docketing system.

s/Hyland Hunt
Hyland Hunt