

Nos. 26-2269, 26-2279, 26-2280, 26-2401, 26-2736 consolidated

**IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT**

SpecialtyCare, Inc.; Remote Neuromonitoring Physicians, PC; Sentient
Physicians, PC,

Plaintiffs-Appellants,

v.

Health Care Service Corporation, doing business as Blue Cross Blue
Shield of New Mexico,

Defendant-Appellee.

(caption continued on inside pages)

On Appeal from the United States District Court
for the Northern District of Illinois

OPENING BRIEF FOR PLAINTIFFS-APPELLANTS

Steven M. Shepard
Max I. Straus
Casen B. Ross
SUSMAN GODFREY LLP
One Manhattan West
50th Floor
New York, NY 10001
212.336.8330
sshepard@susmangodfrey.com

Joshua D. Arters
Kevin T. Elkins
Savannah L. Kolodziej
Rachel M. Roberson
Olivia D. Winnett
POL SINELLI PC
501 Commerce Street
Suite 1300
Nashville, TN 37203-6252
615.252.3923
jarters@polsinelli.com

SpecialtyCare, Inc.; Remote Neuromonitoring Physicians, PC; Sentient
Physicians, PC,

Plaintiffs-Appellants,

v.

Health Care Service Corporation, doing business as Blue Cross Blue
Shield of Illinois,

Defendant-Appellee.

SpecialtyCare, Inc.; Remote Neuromonitoring Physicians, PC; Sentient
Physicians, PC,

Plaintiffs-Appellants,

v.

Health Care Service Corporation, doing business as Blue Cross Blue
Shield of Texas,

Defendant-Appellee.

PHI Health, LLC,

Plaintiff-Appellant,

v.

Health Care Service Corporation, doing business as Blue Cross Blue
Shield of Texas,

Defendant-Appellee.

PHI Health, LLC,

Plaintiff-Appellant,

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Shield,

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APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 26-2269, 26-2279, 26-2280

Short Caption: SpecialtyCare, Inc., et al v. Health Care Service Corporation

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

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N/A
- (4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:
N/A
- (5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:
N/A

Attorney's Signature: /s/ Joshua D. Arters

Date: 9/9/26

Attorney's Printed Name: Joshua D. Arters

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d).

Yes

☒

No

☐

Address: 501 Commerce St., Ste. 1300

Nashville, Tennessee 37203

Phone Number: 615.252.3923

Fax Number: 423.800.5699

E-Mail Address: jarters@polsinelli.com

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N/A

Attorney's Signature: /s/ Kevin T. Elkins

Date: 9/9/26

Attorney's Printed Name: Kevin T. Elkins

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d).

Yes

☐

No

☒

Address: 501 Commerce St., Ste. 1300

Nashville, Tennessee 37203

Phone Number: 615.949.5919

Fax Number: 423.800.5699

E-Mail Address: kelkins@polsinelli.com

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- (5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:
N/A

Attorney's Signature: /s/ Savannah L. Kolodziej Date: 9/9/26

Attorney's Printed Name: Savannah L. Kolodziej

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). Yes ☐ No ☒

Address: 501 Commerce St., Ste. 1300
Nashville, Tennessee 37203

Phone Number: 615.949.5911 Fax Number: 423.800.5699

E-Mail Address: skolodziej@polsinelli.com

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Attorney's Signature: /s/ Rachel M. RobersonDate: 9/9/26Attorney's Printed Name: Rachel M. RobersonPlease indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d).

Yes

☐

No

☒Address: 501 Commerce St., Ste. 1300Nashville, Tennessee 37203Phone Number: 615.252.3987Fax Number: 423.800.5699E-Mail Address: rroberson@polsinelli.com

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N/A
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N/A

Attorney's Signature: /s/ Olivia D. Winnett

Date: 9/9/26

Attorney's Printed Name: Olivia D. Winnett

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d).

Yes

☐

No

☒

Address: 501 Commerce St., Ste. 1300

Nashville, Tennessee 37203

Phone Number: 615.949.5945

Fax Number: 423.800.5699

E-Mail Address: owinnett@polsinelli.com

TABLE OF CONTENTS

	Page
INTRODUCTION	1
STATEMENT OF JURISDICTION.....	4
STATEMENT OF THE ISSUES.....	5
STATEMENT OF THE CASE	6
A. The No Surprises Act Requires Health Insurers to Pay Out-of-Network Providers	6
B. Congress Established IDR as a Form of Arbitration	10
C. Millions of IDR Awards Are Issued Annually—and Providers Win the Vast Majority of Them	11
D. The NSA Did Not Grant Federal Agencies Authority to Enforce Payment.....	12
E. Many Insurers (Including Defendant) Refuse to Pay IDR Determinations—Especially After the Fifth Circuit’s Decision in <i>Guardian Flight</i>	16
F. Factual Background and Prior Proceedings	18
1. Case No. 26-2401 (PHI)	18
2. Case No. 26-2736 (PHI)	20
3. Case Nos. 26-2269, 26-2279 and 26-2280 (SpecialtyCare).....	22
SUMMARY OF ARGUMENT	24
STANDARD OF REVIEW.....	27
ARGUMENT	27
I. The No Surprises Act Provides Plaintiffs a Private Cause of Action	27

A.	The NSA’s Right of Action is Narrow and Targeted	28
B.	The Text of the No Surprises Act Demonstrates Congress’s Intent to Create a Private Cause of Action.....	29
1.	Congress Mandated that Insurers “Shall Pay.”	29
2.	By Making IDR Determinations “Binding,” Congress Evinced Its Intent for Judicial Enforcement.	33
C.	The Structure of the No Surprises Act Also Proves Congress’s Intent to Create a Private Cause of Action.....	37
1.	Congress Abolished Providers’ Right to Obtain Payment from Patients.....	37
2.	Congress Did Not Create an Alternative Enforcement Mechanism.	39
D.	The NSA’s Prohibition on “Judicial Review” Does Not Entail a Prohibition on Judicial <i>Enforcement</i>	45
II.	Plaintiffs Have a Cause of Action under the Federal Arbitration Act	47
A.	The NSA’s IDR Process is an Arbitration, and IDR Determinations are Arbitration Awards.....	48
1.	IDR Determinations are Arbitration Awards.....	48
2.	By Declaring IDR Determinations “Binding,” Congress Intended Them to be Confirmable under the FAA.....	50
B.	Defendant Agreed to Arbitrate.....	51
1.	PHI Plausibly Pleaded a Written Agreement to Arbitrate.....	52

2.	Defendant’s Participation in Arbitration Constitutes an Implied Agreement to Arbitrate and Waives any Objection to Confirmation.....	53
III.	Plaintiffs Have a Cause of Action under the Illinois Uniform Arbitration Act	56
IV.	Plaintiffs Have a Cause of Action under ERISA	57
A.	Claims for the Nonpayment of Benefits Due Pursuant to IDR Determinations Fall Within ERISA’s “Zone of Interest”	59
1.	Because Every ERISA Plan Incorporates NSA Requirements, Withholding the Amount Due under the IDR Denies Benefits Due under the Terms of the Plan.....	60
2.	Underpayment of IDR Awards also Breaches Express Terms of the Plan Documents.....	63
3.	Section 502(a)(3) Expressly Authorizes Suits for Breaches of ERISA, Irrespective of Plan Terms.....	64
B.	The NSA’s Balance Billing Prohibition Does Not Remove Plaintiffs’ Claims from ERISA’s “Zone of Interest”	65
C.	The District Court Erred in Dismissing PHI’s ERISA Claims Based on an Alleged Failure to Plead that PHI is a Beneficiary	70
V.	The District Courts Erred in Dismissing Plaintiffs’ State- Law Claims	70
A.	The District Court Erred in Dismissing PHI’s Claims under the ICFA.....	70

B. In Nos. 26-2269, 26-2279, and 26-2280, SpecialtyCare’s State-Law Claims Should Be Reinstated on Remand.....	72
CONCLUSION	73
CERTIFICATE OF COMPLIANCE	74
CERTIFICATE OF SERVICE.....	75
SEVENTH CIRCUIT RULE 30(d) Statement	75
SEVENTH CIRCUIT RULE 30(a) Short Appendix	

TABLE OF AUTHORITIES

	Page(s)
Cases	
<i>Aetna Health Inc. v. Davila</i> , 542 U.S. 200 (2004)	59, 61, 63
<i>Agag v. Cigna Health & Life Ins. Co.</i> , 2026 WL 1021213 (D. Conn. Apr. 15, 2026)	41
<i>AGCO Corp. v. Anglin</i> , 216 F.3d 589 (7th Cir. 2000)	54
<i>Alexander v. Sandoval</i> , 532 U.S. 275 (2001)	<i>passim</i>
<i>Am. Zurich Ins. Co. v. Sun Holdings, Inc.</i> , 103 F.4th 475 (7th Cir. 2024)	28
<i>Avery v. State Farm Mut. Auto. Ins. Co.</i> , 835 N.E.2d 801 (Ill. 2005)	26, 71
<i>Blue Cross Blue Shield of Massachusetts, Inc. v. BCS Ins. Co.</i> , 671 F.3d 635 (7th Cir. 2011)	48
<i>Bowen v. Massachusetts</i> , 487 U.S. 879 (1988)	30
<i>Bowsher v. Merck & Co.</i> , 460 U.S. 824 (1983)	43
<i>Brown v. BlueCross BlueShield of Tennessee, Inc.</i> , 827 F.3d 543 (6th Cir. 2016)	62
<i>Bullard v. Bell</i> , 4 F. Cas. 624 (C.C.D.N.H. 1817)	30, 31
<i>Cent. Labs.’ Pension Fund v. Heinz</i> , 541 U.S. 739 (2004)	61

<i>Cheli v. Taylorville Cmty. Sch. Dist.</i> , 986 F.3d 1035 (7th Cir. 2021).....	27
<i>Cheminova A/S v. Griffin LLC</i> , 182 F. Supp. 2d 68 (D.D.C. 2002).....	35, 36, 37
<i>Chicago Southshore & S. Bend R.R. v. N. Indiana Commuter Transp. Dist.</i> , 703 N.E.2d 7 (Ill. 1998).....	57
<i>Commonwealth Edison Co. v. Gulf Oil Corp.</i> , 541 F.2d 1263 (7th Cir. 1976).....	52, 53
<i>Comprehensive Acct. Corp. v. Rudell</i> , 760 F.2d 138 (7th Cir. 1985).....	54, 55
<i>ConFold Pac., Inc. v. Polaris Indus., Inc.</i> , 433 F.3d 952 (7th Cir. 2006).....	7
<i>Cosmetique, Inc. v. ValueClick, Inc.</i> , 753 F. Supp. 2d 716 (N.D. Ill. 2010).....	71
<i>Coy Chiropractic Health Ctr., Inc. v. Travelers Cas. & Sur. Co.</i> , 957 N.E.2d 1174 (Ill. Ct. App. 2011)	8
<i>DB Healthcare, LLC v. Blue Cross Blue Shield of Ariz., Inc.</i> , 852 F.3d 868 (9th Cir. 2017).....	62
<i>Druco Rest., Inc. v. Steak n Shake Enters., Inc.</i> , 2013 WL 5779646 (S.D. Ind. Oct. 9, 2013).....	49
<i>E. Coast Advanced Plastic Surgery, LLC v. Cigna Health & Life Ins. Co.</i> , Case No. 25-2204 (2d Cir.).....	16
<i>Elmar Hotel Mgmt., LLC v. Unite Here Loc. 1</i> , 182 F.4th 609 (7th Cir. 2026)	25, 54
<i>Federated Mut. Ins. Co. v. Coyle Mech. Supply Inc.</i> , 983 F.3d 307 (7th Cir. 2020).....	72

<i>Franco v. Chobani, LLC</i> , 184 F.4th 599 (7th Cir. 2026)	27
<i>FS Credit Opportunities Corp. v. Saba Capital Master Fund, Ltd.</i> , 146 S. Ct. 1546 (2026)	32
<i>Griffin v. TeamCare</i> , 909 F.3d 842 (7th Cir. 2018)	63
<i>Guardian Flight, LLC v. Health Care Serv. Corp.</i> , 140 F.4th 271 (5th Cir. 2025)	<i>passim</i>
<i>Guardian Flight LLC v. Aetna Life Ins. Co.</i> , 789 F. Supp. 3d 214 (D. Conn. 2025)	<i>passim</i>
<i>Halperin v. Richards</i> , 7 F.4th 534 (7th Cir. 2021)	15
<i>Harrison v. Envision Mgmt. Holding, Inc.</i> , 59 F.4th 1090 (10th Cir. 2023)	42
<i>Indiana Prot. & Advoc. Servs. v. Indiana Fam. & Soc. Servs.</i> <i>Admin.</i> , 603 F.3d 365 (7th Cir. 2010)	39, 44
<i>Int’l Union of Operating Eng’rs Loc. 649 v. Tyro Constr., Inc.</i> , 2026 WL 1833495 (C.D. Ill. June 25, 2026)	32, 48-49
<i>Int’l Union of Operating Eng’rs, Local 150 v. Ward</i> , 563 F.3d 276 (7th Cir. 2009)	27, 32
<i>Jackson v. Birmingham Bd. of Educ.</i> , 544 U.S. 167 (2005)	38
<i>Jacobs v. City of Chicago</i> , 215 F.3d 758 (7th Cir. 2000)	72
<i>Kennedy v. Connecticut Gen. Life Ins. Co.</i> , 924 F.2d 698 (7th Cir. 1991)	<i>passim</i>
<i>Key Tronic Corp. v. United States</i> , 511 U.S. 809 (1994)	30

<i>Lander Co. v. MMP Invs., Inc.</i> , 107 F.3d 476 (7th Cir. 1997).....	34, 35
<i>Larson v. United Healthcare Ins. Co.</i> , 723 F.3d 905 (7th Cir. 2013).....	69
<i>Lone Star OB/GYN Assocs. v. Aetna Health Inc.</i> , 579 F.3d 525 (5th Cir. 2009).....	62
<i>Maine Cmty. Health Options v. United States</i> , 590 U.S. 296 (2020).....	31, 38
<i>Marine Transit Corp. v. Dreyfus</i> , 284 U.S. 263 (1932).....	50
<i>May Dep’t Stores Co. v. Fed. Ins. Co.</i> , 305 F.3d 597 (7th Cir. 2002).....	58, 60, 61
<i>Midthun-Hensen v. Grp. Health Coop. of S. Cent. Wisconsin, Inc.</i> , 672 F. Supp. 3d 662 (W.D. Wis. 2023)	64
<i>Milwaukee Typographical Union No. 23 v. Newspapers, Inc.</i> , 639 F.2d 386 (7th Cir. 1981).....	<i>passim</i>
<i>Morrison v. YTB Int’l, Inc.</i> , 649 F.3d 533 (7th Cir. 2011).....	26, 71, 72
<i>New England PA, LLC, v. Cigna Health & Life Ins. Co.</i> , 2026 WL 2099041 (D. Conn. July 21, 2026)	32
<i>Northeast Plastic Surgery Ctr., LLC v. Cigna Health & Life Ins. Co.</i> , 2026 WL 2098146 (D. Conn. July 21, 2026)	33
<i>Ogden v. Saunders</i> , 25 U.S. 213 (1827).....	34
<i>PHI Health, LLC v. Optimum Choice, Inc.</i> , 826 F. Supp. 3d 654 (D. Md. 2026).....	<i>passim</i>
<i>Plumb v. Fluid Pump Serv., Inc.</i> , 124 F.3d 849 (7th Cir. 1997).....	60, 61

<i>Rice v. Off. of Servicemembers’ Grp. Life Ins.,</i> 260 F.3d 1240 (10th Cir. 2001)	37, 39
<i>Rodgers-Rouzier v. Am. Queen Steamboat Operating Co., LLC,</i> 104 F.4th 978 (7th Cir. 2024)	57
<i>Ross v. Blake,</i> 578 U.S. 632 (2016)	68
<i>Savory v. Cannon,</i> 947 F.3d 409 (7th Cir. 2020)	34
<i>Sekhhar v. United States,</i> 570 U.S. 729 (2013)	34
<i>Shareef Jandali Plastic Surgery LLC v. Cigna Health and Life</i> <i>Ins. Co.,</i> 2026 WL 2098149 (D. Conn. July 21, 2026)	33, 35, 45
<i>Skycom Corp. v. Telstar Corp.,</i> 813 F.2d 810 (7th Cir. 1987)	34
<i>Slaney v. The Int’l Amateur Athletic Fed’n,</i> 244 F.3d 580 (7th Cir. 2001)	54, 55
<i>Smith v. City of Jackson,</i> 544 U.S. 228 (2005)	50
<i>SpecialtyCare Inc., et al v. Aetna Inc.,</i> Case No. 26-1114 (3d Cir.)	16
<i>SpecialtyCare, Inc., et al. v. Kaiser Found. Health Plan, Inc.,</i> Case No. 26-4722 (9th Cir.)	16
<i>SpecialtyCare, Inc. v. CareFirst of Maryland, Inc.,</i> 2026 WL 1656946 (D. Md. June 9, 2026)	33
<i>Spray Drift Task Force v. Burlington Bio-Med. Corp.,</i> 429 F. Supp. 2d 49 (D.D.C. 2006)	51
<i>Thomas v. Union Carbide Agr. Prod. Co.,</i> 473 U.S. 568 (1985)	46, 50

<i>Tolle v. Carroll Touch, Inc.</i> , 977 F.2d 1129 (7th Cir. 1992).....	69
<i>United States v. Castleman</i> , 572 U.S. 157 (2014).....	38
<i>United States v. Farmer</i> , 543 F.3d 363 (7th Cir. 2008).....	34
<i>UNUM Life Ins. Co. of Am. v. Ward</i> , 526 U.S. 358 (1999).....	60, 61
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996).....	69-70

Statutes

7 U.S.C. § 136a(c)(1)(F)	35, 50, 51
26 U.S.C. § 4980D.....	14, 15
26 U.S.C. § 9816.....	6
26 U.S.C. § 9817.....	6
28 U.S.C. § 1291.....	5
28 U.S.C. § 1331.....	4
28 U.S.C. § 1367(a)	4
28 U.S.C. § 1367(c)(3)	70
29 U.S.C. § 1002(8)	58, 65, 66, 67
29 U.S.C. § 1054(g)	61
29 U.S.C. § 1104(a)(1)(D).....	60
29 U.S.C. § 1132.....	57
29 U.S.C. § 1132(a)(1)(B).....	59, 63, 65

29 U.S.C. § 1132(a)(3).....	58, 64, 65, 69
29 U.S.C. § 1132(a)(5).....	15
29 U.S.C. § 1185e.....	6, 64
29 U.S.C. § 1185e(a)(1).....	7
29 U.S.C. § 1185e(a)(2).....	13
29 U.S.C. § 1185e(a)(3)(K).....	9
29 U.S.C. § 1185e(c)(4)(A)	12, 36
29 U.S.C. § 1185e(c)(4)(F)(i)	10
29 U.S.C. § 1185e(c)(5)(E)	<i>passim</i>
29 U.S.C. § 1185f	6, 62
29 U.S.C. § 1185f(a)(2).....	8
29 U.S.C. § 1185f(a)(3).....	<i>passim</i>
29 U.S.C. § 1185f(b)(5)(A).....	2, 9, 28, 49
29 U.S.C. § 1185f(b)(5)(C)(i)(I)	13
29 U.S.C. § 1185f(b)(6).....	9, 24, 30
39 U.S.C. § 1207(2)	50
42 U.S.C. § 300gg-22	14
42 U.S.C. § 300gg-22(a)(2).....	14
42 U.S.C. § 300gg-22(b)(1).....	40
42 U.S.C. § 300gg-22(b)(2).....	14
42 U.S.C. § 300gg-111(a)(1).....	24
42 U.S.C. § 300gg-111(a)(2)(A).....	13

42 U.S.C. § 300gg-111(a)(2)(B).....	13
42 U.S.C. § 300gg-131(a)	8
42 U.S.C. § 300gg-132(a)	8
42 U.S.C. § 300gg-135	<i>passim</i>
42 U.S.C. § 18062(b)(1).....	31
Illinois Uniform Arbitration Act, 710 Ill. Comp. Stat. Ann. 5	<i>passim</i>
710 Ill. Comp. Stat. Ann. 5/11	56
710 Ill. Comp. Stat. Ann. 5/16	56
Rules	
Fed. R. App. P. 4(a)(1)(A)	4
Fed. R. App. P. 12(b)(6)	63
Fed. R. App. P. 30(a) and (b)	75
Fed. R. Civ. P. 69(a).....	29
Regulations	
26 C.F.R. § 54.9816-1T <i>et seq.</i>	14
29 C.F.R. § 2590.716-1 <i>et seq.</i>	14
29 C.F.R. § 2590.716-8(c)(5)(vi).....	49
45 C.F.R. § 149.10 <i>et seq.</i>	14
91 Fed. Reg. 3,665 (Jan. 28, 2026)	41
91 Fed. Reg. 33,900 (June 4, 2026)	12

Other Authorities

Amicus Brief of the United States, <i>Guardian Flight, LLC et al. v. Health Care Service Corp.</i> , No. 24-10561, 2024 WL 4451970 (5th Cir. Oct. 4, 2024)	42
Black’s Law Dictionary (12th ed. 2024).....	46
H.R. Rep. No. 116-615 (Dec. 2, 2020).....	34, 38
Private Health Insurance—Roll Out of Independent Dispute Resolution Process for Out-of-Network Claims Has Been Challenging (Dec. 2023), https://www.gao.gov/assets/d24106335.pdf	43
Restatement (Third) of Restitution and Unjust Enrichment § 20 (2011)	7
U.S. Dep’ts of Health & Human Servs., the Treasury, and Labor, Supplemental Background on Federal Independent Dispute Resolution Public Use Files January 1, 2025 – June 30, 2025, https://www.cms.gov/files/document/federal-idr-supplemental-background-2025-q1-2025-q2.pdf	11
U.S. Dep’ts of Health & Human Servs., the Treasury, and Labor, 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	11

INTRODUCTION

Plaintiffs PHI Health, LLC (“PHI”) and SpecialtyCare Inc., Remote Neuromonitoring Physicians, PC, and Sentient Physicians, PC (collectively, “SpecialtyCare”) treated patients who were covered by group health plans or insurance policies administered or issued by Defendant Health Care Service Corporation. The No Surprises Act mandates that Defendant “shall” pay Plaintiffs for that treatment, in amounts determined by “binding” arbitration awards, no later than 30 days after those awards issue. Arbitration awards issued in Plaintiffs’ favor. Defendant refused to pay. Defendant then asserted that no court could make it do so. The district courts agreed and dismissed Plaintiffs’ complaints. This Court should reverse those judgments and remand for further proceedings.

These appeals concern whether out-of-network healthcare providers have an enforceable right to compensation for their services. In the No Surprises Act (“NSA”), Congress prohibited those providers from billing patients. *E.g.*, 42 U.S.C. § 300gg-135. Instead, Congress mandated that insurers “shall ... pay” providers, 29 U.S.C. § 1185f(a)(3), an amount of money determined by a federally certified arbitrator in a process

known as Independent Dispute Resolution (“IDR”), *id.* § 1185f(b)(5)(A), and to do so within 30 days, *id.* § 1185f(b)(6). These appeals are actions to enforce that “shall ... pay” mandate, *i.e.*, to compel Defendant to pay the money that the NSA requires Defendant to pay.

The Court should reverse dismissal of Plaintiffs’ complaints for multiple independent reasons. First, the NSA gives Plaintiffs a private right of action. Both the text and structure of the NSA demonstrate that Congress intended to grant that right. Using language long held to imply a cause of action, Congress mandated that insurers “shall ... pay” to providers the amounts determined in IDR, *id.* § 1185f(a)(3), and Congress declared the arbitrators’ determinations to be “binding” on insurers, *id.* § 1185e(c)(5)(E)(i)(I). Congress provided no administrative alternative to judicial enforcement. If the district court’s judgments stand, then IDR determinations will not be “binding” at all. They will be voluntary. Providers will go out of business. That was manifestly *not* Congress’s intent.

Second, and in the alternative, Plaintiffs have a cause of action under the Federal Arbitration Act (“FAA”) and the Illinois Uniform Arbitration Act (“IUAA”). These acts require courts to confirm arbitral

awards. IDR satisfies the traditional hallmarks of arbitration; and courts have long recognized that “binding” arbitration creates a right to confirm awards under Section 9 of the FAA. *E.g., Milwaukee Typographical Union No. 23 v. Newspapers, Inc.*, 639 F.2d 386, 389–90 (7th Cir. 1981).

Third, Plaintiffs have pled viable causes of action under Section 502(a)(1)(B) and (a)(3) of the Employee Retirement Income Security Act of 1974 (“ERISA”). The district court erred in finding that enforcement of IDR determinations does not fall within ERISA’s “zone of interests.” The NSA amended ERISA to require every group health plan to comply with NSA requirements and made out-of-network providers statutory beneficiaries. *E.g.*, 29 U.S.C. § 1185f(a)(3).

Finally, the Court should reverse dismissal of Plaintiffs’ state-law claims. For Plaintiff PHI’s Illinois Consumer Fraud and Deceptive Business Practices Act (“ICFA”) claim, the district court improperly resolved factual questions at a motion to dismiss and construed allegations against PHI. The district court declined to exercise supplemental jurisdiction over SpecialtyCare’s state-law claims; that decision should be vacated.

STATEMENT OF JURISDICTION

Case No. 26-2401. PHI filed its original complaint in Illinois state court. Appx194–214. Defendant removed to federal court based on federal-question jurisdiction because PHI’s claims arise under the No Surprises Act. Appx188–89. PHI then amended its complaint, invoking the district court’s jurisdiction under 28 U.S.C. §§ 1331, 1367(a). Appx217. On June 23, 2026, the district court dismissed PHI’s claims. Appx249–69. On July 1, that court entered judgment. Appx270. PHI filed a timely notice of appeal the same day. Appx271; Fed. R. App. P. 4(a)(1)(A).

Case No. 26-2736. PHI’s complaint was filed in federal court based on federal-question jurisdiction under 28 U.S.C. § 1331. *See* Appx277. On August 5, 2026, the district court dismissed PHI’s claims, Appx363–80, and it entered final judgment on August 18, Appx381. PHI filed a timely notice of appeal the next day. Appx382.

Cases Nos. 26-2269, 26-2279, and 26-2280. SpecialtyCare filed these complaints in federal court based on federal-question jurisdiction under 28 U.S.C. § 1331, with supplemental jurisdiction over state-law claims, *id.* § 1367(a). *See* Appx55, Appx92, Appx133. On June 2, 2026, the

district court dismissed SpecialtyCare's claims in all three cases. Appx68–81, Appx109–22, Appx168–81. SpecialtyCare filed timely notices of appeal on June 12, 2026. Appx84, Appx125, Appx184.

This Court has jurisdiction over the consolidated appeals under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether the No Surprises Act gives Plaintiffs a cause of action to sue Defendant for failing to pay to them the amounts of money that the Act mandates Defendant “shall ... pay” pursuant to “binding” IDR determinations.

2. Whether, in the alternative, Plaintiffs have stated a claim, under the Federal Arbitration Act and the Illinois Uniform Arbitration Act, to confirm the IDR arbitrators' determinations.

3. Whether Plaintiffs have stated a denial-of-benefits claim under ERISA Section 502(a)(1)(B) for Defendant's failure to pay the amounts that the NSA requires Defendant to pay.

4. Whether PHI has stated a claim for injunctive relief under ERISA Section 502(a)(3) for Defendant's failure to pay those amounts.

5. Whether PHI stated a claim under the ICFA for Defendant’s failure to pay those amounts.

6. Whether the district court’s decision not to exercise supplemental jurisdiction over SpecialtyCare’s state-law claims should be vacated.

STATEMENT OF THE CASE

A. The No Surprises Act Requires Health Insurers to Pay Out-of-Network Providers

Congress enacted the No Surprises Act (“NSA”), as part of the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, div. BB, § 101 *et seq.*, 134 Stat. 1182, 2757. The NSA made largely parallel amendments to three statutes: ERISA (codified, *inter alia*, at 29 U.S.C. §§ 1185e, 1185f), the Public Health Service Act (42 U.S.C. §§ 300gg-111, 300gg-112), and the Internal Revenue Code of 1986 (26 U.S.C. §§ 9816, 9817). This brief cites the ERISA codification, except when the distinction is relevant.

Congress’s purpose, in the NSA, was to reform compensation for “out-of-network” healthcare providers of certain kinds of services—namely, emergency care; air ambulance transport; and care rendered by

an out-of-network provider at an in-network facility.¹ “Out-of-network” providers are those that do not have a contract with the patient’s insurer. Before the Act, group health plans and health insurance issuers (referred to in this brief collectively as “insurers” except when the distinction is relevant) routinely refused to pay “out-of-network” providers more than a small fraction of the providers’ invoices. Those payments were often below the providers’ costs. In response to these underpayments, out-of-network providers billed their patients for the invoices’ “balance,” *i.e.*, the portion the insurer had refused to pay. The providers could hold their patients liable through common-law or equitable claims, such as claims for breach of contract or restitution. *See* Restatement (Third) of Restitution and Unjust Enrichment § 20 (2011) (“The claim for emergency medical services rendered in the absence of contract is one of restitution’s paradigms.”); *ConFold Pac., Inc. v. Polaris Indus., Inc.*, 433 F.3d 952, 958 (7th Cir. 2006).

¹ To the extent that the NSA includes parallel provisions for each type of provider, *e.g.*, 29 U.S.C. § 1185e(a)(1) (emergency services), *id.* § 1185e(b)(1) (out-of-network providers at in-network facilities), *id.* § 1185f(a) (air ambulance providers), this brief cites the provision applicable to air ambulance providers, unless otherwise noted.

Patients were unhappy to receive these surprise “balance bills.” But the out-of-network providers had no other way to get paid for their work. Out-of-network providers generally could not sue their patients’ insurers for the balance owed under most states’ common law. *E.g.*, *Coy Chiropractic Health Ctr., Inc. v. Travelers Cas. & Sur. Co.*, 957 N.E.2d 1174, 1182 (Ill. Ct. App. 2011).

The No Surprises Act was intended to solve this problem. The Act reversed the common law rule: The provider now may *only* demand compensation from the insurer and may *not* bill the patient for the balance owed. Patients pay only the same “cost-sharing requirement”—*i.e.*, deductible, copayment, or coinsurance—that they would have owed had they received care from an *in-network* provider. 29 U.S.C. § 1185f(a)(2). Providers cannot hold patients liable for amounts exceeding this “cost sharing requirement.” 42 U.S.C. §§ 300gg-131(a), 300gg-132(a), 300gg-135.

In place of the *patient*, the NSA instead mandates that the *insurer* “shall . . . pay” the out-of-network provider an amount equal to an “out-of-network rate” minus the patient’s “cost-sharing” amount:

(3) the group health plan or health insurance issuer, respectively, shall—

....

(B) pay a total plan or coverage payment, in accordance with, if applicable, subsection (b)(6), directly to such provider ... equal to the amount by which the out-of-network rate ... exceeds the cost-sharing amount

29 U.S.C. § 1185f(a)(3); *see also* 29 U.S.C. § 1185e(a)(3)(K) (defining “out-of-network rate”).

The NSA mandates a *30-day deadline* by which the insurer “shall” make this payment to the provider:

(6) Timing of payment

The total plan or coverage payment required pursuant to subsection (a)(3), with respect to qualified IDR ... services for which a determination is made under paragraph (5)(A) ... shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.

Id. § 1185f(b)(6).

The “determination ... under paragraph (5)(A),” which triggers this payment deadline, is the determination of the *dollar amount* (the “out-of-network rate”) owed for the provider’s services. That determination is made in an “independent dispute resolution” (IDR) process by a “certified IDR entity.” *Id.* § 1185f(b)(5)(A).

B. Congress Established IDR as a Form of Arbitration

The “certified IDR entity” is a neutral arbitrator. *Id.* § 1185e(c)(4)(A)(ii) (imposing impartiality requirements); *id.* § 1185e(c)(4)(F)(i) (same). These arbitrators are private companies. They are certified by the relevant Departments (Labor, Health and Human Services (“HHS”) and the Treasury), as having “sufficient medical, legal, and other expertise” to make these determinations. *Id.* § 1185e(c)(4)(A)(i). If the parties cannot agree on a certified IDR entity, the responsible agency appoints one. *Id.* § 1185e(c)(4)(F)(ii).

IDR is a “baseball-style” arbitration. Each party submits a written “offer” to the certified IDR entity for the “out-of-network rate” for the service in question. *Id.* § 1185f(b)(5)(B)(i). Each party may also submit information relevant to determining the out-of-network rate. *Id.* § 1185f(b)(5)(B)(ii). After considering that information and a set of statutory factors, the certified IDR entity selects one of the two offers as the “out-of-network rate.” *Id.* § 1185f(b)(5)(A), (C).

The NSA provides that the determination of the certified IDR entity “shall be binding upon the parties involved”:

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 [*i.e.*, Section 10(a)(1) to (4) of the Federal Arbitration Act (“FAA”)].

Id. § 1185e(c)(5)(E); *see also id.* § 1185f(b)(5)(D).

There is no provision for any administrative appeal of the certified IDR entity’s “binding” determination.

C. Millions of IDR Awards Are Issued Annually—and Providers Win the Vast Majority of Them

IDR entities have resolved millions of payment disputes in favor of providers. In 2025, parties initiated 2,559,375 IDRs.² Certified IDR entities issued determinations in 2,227,286 disputes during that period,

² U.S. DEPTS OF HEALTH & HUMAN SERVS., THE TREASURY, AND LABOR, Supplemental Background on Federal Independent Dispute Resolution Public Use Files January 1, 2025 – June 30, 2025 at 2, <https://www.cms.gov/files/document/federal-idr-supplemental-background-2025-q1-2025-q2.pdf>; U.S. DEPTS OF HEALTH & HUMAN SERVS., THE TREASURY, AND LABOR, Supplemental Background on Federal Independent Dispute Resolution Public Use Files July 1, 2025 – December 31, 2025 at 2, <https://www.cms.gov/priorities/innovation/data-and-reports/2026/federal-idr-supplemental-background-2025-q3-2025-q4>.

ruling in favor of providers 88% (in the first half of the year) and 85% (in the second half of the year) of the time.³ The agencies anticipate that this dispute volume will increase significantly. 91 Fed. Reg. 33,900, 33,971 (June 4, 2026).

The IDR process is generally the *only* mechanism for providers to secure fair compensation for services covered by the NSA.

D. The NSA Did Not Grant Federal Agencies Authority to Enforce Payment

Congress has not granted power to the agencies to enforce the NSA’s mandate that the insurer “shall ... pay” the “total plan or coverage payment ... directly to [the] provider.” 29 U.S.C. § 1185f(a)(3).

The absence of any enforcement authority is made more glaring because the NSA *did* grant *other* powers to the agencies. Congress directed the Secretaries of Labor, HHS, and Treasury to “establish” the IDR process, *id.* § 1185f(b)(2)(A), and the “process to certify” IDR entities, *id.* § 1185e(c)(4)(A). Congress also directed HHS to take specific actions regarding the “qualifying payment amount,” a figure considered by the

³ See page 4 of the reports cited in n.2.

certified IDR entity when selecting an “offer.”⁴ Congress directed HHS to conduct audits of insurers’ (but not ERISA group health plans’) calculations of the qualifying payment amounts. 42 U.S.C. § 300gg-111(a)(2)(A).⁵ Congress also charged HHS with establishing a process to receive complaints regarding insurers’ (but not ERISA group health plans’) calculations of the qualifying payment amounts. 42 U.S.C. § 300gg-111(a)(2)(B).⁶

The agencies’ regulations, implementing the NSA, hew to the Act’s limited grants of authority. The regulations do not provide for

⁴ 29 U.S.C. § 1185f(b)(5)(C)(i)(I). The qualifying payment amount also determines patients’ cost-sharing responsibility. *Id.* § 1185e(a)(1)(C)(iii), (b)(1)(B), (a)(3)(H)(ii).

⁵ Congress did not grant similar authority to the Department of Labor—the agency responsible for ERISA group health plans. 29 U.S.C. § 1185e(a)(2) omits the equivalent of 42 U.S.C. § 300gg-111(a)(2)(A)—instead replicating only 42 U.S.C. § 300gg-111(a)(2)(B). As a result, the mandate in 29 U.S.C. § 1185e(a)(2)(D) that the Secretary of Labor establish “a process to receive complaints of violations of the requirements described in ... subparagraph (A)(i)” is meaningless: Section 1185e(a)(2)(A) has no subparagraph (i). 29 U.S.C. § 1185e(a)(2)(A).

⁶ *See supra* n.5.

enforcement of the “shall ... pay” mandate. *See* 29 C.F.R. § 2590.716-1 *et seq.*⁷

Before the NSA was enacted, Congress had granted other authorities to the three agencies. But none of those existing powers enables the agencies to force an insurer to pay money to a provider.

In the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”),⁸ Congress gave HHS the power to enforce “provision[s]” of the Public Health Service Act (into which the NSA was later codified), but only if HHS first determines that a “State has failed to substantially enforce” the “provision” at issue. 42 U.S.C. § 300gg-22(a)(2). HHS may impose a “civil money penalty” of “\$100 for each day” of the insurer’s “failure.” *Id.* § 300gg-22(b)(2). That penalty would be paid to the government, not the provider. HHS has no power to compel any insurer to pay a provider.

⁷ The implementing regulations are largely codified in triplicate at 26 C.F.R. § 54.9816-1T *et seq.* (Treasury), 29 C.F.R. § 2590.716-1 *et seq.* (Labor), and 45 C.F.R. § 149.10 *et seq.* (HHS). This brief cites the Department of Labor regulation, except when the distinction is relevant.

⁸ Pub. L. No. 104-191, tit. I, § 102, 110 Stat. 1936, 1968 (Aug. 21, 1996) (adding 42 U.S.C. § 300gg-22); *id.* tit. IV, § 402, 110 Stat. at 2084 (adding 26 U.S.C. § 4980D).

In HIPAA, Congress gave a similar enforcement power to the Department of the Treasury to impose a “tax” of \$100 per day on insurers that “fail[] ... to meet the requirements of chapter 100” of the Internal Revenue Code, 26 U.S.C. §§ 9801-9834, into which the NSA was later codified, 26 U.S.C. § 4980D(a), (b)(1). Like the HHS “civil money penalty,” this “tax” is payable to the government not the provider. Treasury has no power to compel any insurer to pay a provider.

The Department of Labor does not even have the (meager) power to impose daily fines. ERISA authorizes the Secretary of Labor to bring a civil action “to enjoin any act or practice which violates any provision of” the subchapter in which the NSA was codified. 29 U.S.C. § 1132(a)(5). But that power only extends to group health plans (not insurance issuers). *Id.* § 1132(b)(3). And even as to group health plans, ERISA gives no out-of-court administrative authority to the Department of Labor to compel any plan to pay a provider. *See Halperin v. Richards*, 7 F.4th 534, 555 (7th Cir. 2021) (Section 1132(a)(5) “does not authorize suits for damages”).

E. Many Insurers (Including Defendant) Refuse to Pay IDR Determinations—Especially After the Fifth Circuit’s Decision in *Guardian Flight*

Insurers’ nonpayment rates are increasing. A forthcoming amicus brief by the Emergency Department Practice Management Association and the EMS Ambulance Operators Strategic and Innovation Alliance will provide further information on this widespread and growing problem and its dire effects on healthcare providers who depend on revenue from IDR determinations.

Similar appeals are pending in the Second, Third, and Ninth Circuits. *E.g.*, *E. Coast Advanced Plastic Surgery, LLC v. Cigna Health & Life Ins. Co.*, Case No. 25-2204 (2d Cir.); *SpecialtyCare Inc., et al v. Aetna Inc.*, Case No. 26-1114 (3d Cir.); *SpecialtyCare, Inc., et al. v. Kaiser Foundation Health Plan, Inc.*, Case No. 26-4722 (9th Cir.).

Only one court of appeals—the Fifth Circuit—has ruled whether the NSA gives providers a right of action to enforce the Act’s “shall ... pay” mandate. *Guardian Flight, LLC v. Health Care Serv. Corp.*, 140 F.4th 271 (5th Cir. 2025). The Fifth Circuit erroneously held that the NSA contains no private right of action. *Id.*

PHI has reviewed its payment records for air transports provided between January 1, 2023 and December 31, 2025. During those three years, PHI conducted 11,882 emergency medical transports that were covered by the NSA. PHI was forced to initiate IDR proceedings for 8,815 transports (roughly 74%). A certified IDR entity resolved 7,105 of those cases before June 12, 2026, and PHI received a favorable IDR determination for 6,644 (roughly 94%) of those transports. But PHI's records reflect that 5,100 IDR determinations, representing \$44 million in air transports, were still unpaid as of June 12, 2026. Of those unpaid awards, 2,874 were *more than one year* past due. PHI's records show that the rate of non-payment has increased significantly since the Fifth Circuit decided *Guardian Flight* on June 12, 2025. Since then, PHI's unpaid IDR awards have increased by 66%.

SpecialtyCare's payment records reflect the same trend. On June 6, 2025, less than a week before *Guardian Flight*, Defendant owed SpecialtyCare approximately \$1.85 million in unpaid IDR determinations. Today, Defendant has approximately \$4.58 million in unpaid balances that are more than 30 days old, nearly two-and-a-half times the June 2025 amount. Of that unpaid and overdue balance,

approximately \$4.10 million is for IDR determinations that were due more than 90 days ago, and approximately \$1.83 million is for IDR determinations that were due more than a year ago.

F. Factual Background and Prior Proceedings

1. Case No. 26-2401 (PHI)

a. PHI provided emergency air transport to a patient with health coverage issued or administered by Defendant. PHI billed Defendant \$72,372. Appx232. Defendant paid only \$11,991.77. *Id.* PHI attempted to negotiate a higher payment amount, but Defendant rejected PHI's offer and declared the "negotiation process complete." Appx220, Appx236. Defendant then instructed PHI, repeatedly, that PHI could pursue IDR to resolve the parties' dispute. Appx220, Appx226, Appx235, Appx236.

PHI initiated IDR. The certified IDR entity selected PHI's "offer" and determined that the appropriate "out-of-network rate" was \$57,862.08. Appx220, Appx246. Defendant did not pay the balance due to PHI. Appx224–26.

b. PHI filed a complaint against Defendant in the Circuit Court of Cook County, and Defendant removed to federal court. Appx187,

Appx194–214. PHI then amended its complaint. Appx215–29. The district court granted Defendant’s motion to dismiss. Appx253, Appx269.

c. The district court recognized that the NSA “uses rights-creating language suggestive of an implied right of action” by making IDR determinations “binding” and naming providers as beneficiaries. Appx257. But the court concluded that Congress did not intend “to create a judicial remedy.” *Id.* (quotation omitted).

The court also rejected PHI’s request to confirm the IDR determinations under Section 9 of the FAA. The district court held that the NSA’s limitation on judicial *review* of IDR determinations “necessarily” bars judicial *confirmation* of an award under Section 9 of the FAA, Appx261–62; and the court found (contrary to PHI’s allegations) that the parties lacked a “written agreement to arbitrate” that the court held the FAA requires, Appx260–61.

The court dismissed PHI’s claim under the ICFA because PHI’s air ambulance transport did not occur in Illinois. Appx267–68.

2. Case No. 26-2736 (PHI)

a. PHI billed Defendant for emergency medical transport for multiple patients who were insured by Defendant or who were covered by a group health plan administered by Defendant. Appx274, Appx280–81, Appx300. Defendant’s payments “were deficient.” Appx280. PHI attempted to negotiate increased payments, but the parties were “unable to agree.” *Id.* Defendant directed PHI, in writing, to participate in the IDR process to resolve these payment disputes. Appx286.

PHI initiated twelve IDRs. Appx280–81, Appx300. Defendant participated in these IDRs. Appx281, Appx302–03, Appx305–06, Appx308–09, Appx311–12, Appx314–15, Appx318–19, Appx321–22, Appx324–25, Appx328–29, Appx332–33, Appx336–37, Appx340–41. The certified IDR entities issued multiple awards in PHI’s favor, amounting to more than \$200,000 in additional payments owed to PHI by Defendant. Appx275, Appx300. Defendant did not make any additional payment. *Id.*

b. PHI sued Defendant to enforce the twelve IDR determinations, asserting claims under the NSA, Section 9 of the FAA, the Illinois

Uniform Arbitration Act (“IUAA”), Section 502(a)(1)(B) and (a)(3) of ERISA, and the ICFA. Appx283–96.⁹

c. The district court dismissed PHI’s complaint. Appx380. The court held that even though the NSA includes “rights-creating language, suggesting an implied right of action,” no such right was intended, due to the possibility of agency enforcement. Appx368–69, Appx372.

The district court dismissed PHI’s claims under the FAA and IUAA, holding that both “require written arbitration agreements,” Appx372, and asserting that PHI did not sufficiently allege the existence of such an agreement, Appx373.

The district court dismissed PHI’s ERISA claims because the court held those claims fell outside ERISA’s “zone of interests.” Appx375. According to the court, PHI impermissibly asserted its own claims, rather than claims of its assignor-patients. *Id.* The court also concluded that PHI could not sue under ERISA because PHI did “not allege that it is a participant, beneficiary, or fiduciary under ERISA.” Appx376.

⁹ PHI pleaded its ERISA claims only as to payment disputes involving seven patients alleged to have benefits from ERISA group health plans. Appx289.

The district court dismissed PHI's claim under the ICFA principally because the transports did not occur in Illinois. Appx378–79.

**3. Case Nos. 26-2269, 26-2279 and 26-2280
(SpecialtyCare)**

a. SpecialtyCare provided NSA-covered healthcare services to patients whose health coverage Defendant issued or administered. Appx55, Appx92, Appx133. Those patients assigned their right to payment and claims under their benefits plans to SpecialtyCare. Appx55, Appx92, Appx133. After Defendant failed adequately to pay SpecialtyCare for its services, SpecialtyCare initiated IDR to secure fair compensation. Appx53, Appx90, Appx131.

The IDRs resulted in hundreds of written determinations by certified IDR entities, which required Defendant to pay additional compensation to SpecialtyCare. Appx54, Appx67, Appx91, Appx104–08, Appx132, Appx145–67. Defendant consistently failed to pay within 30 days. Appx57, Appx94, Appx135. Defendant still owes at least \$2,181,308 pursuant to those IDR determinations. Appx57, Appx94, Appx135.

b. SpecialtyCare brought three suits to enforce its IDR determinations, asserting claims under the NSA, Section 9 of the FAA, Section 502(a)(1)(B) of ERISA, and various state-law causes of action.

Appx59–63, Appx96–101, Appx137–41. SpecialtyCare’s cases all proceeded before the same judge. Appx1–3, Appx51, Appx88, Appx129.

c. In three substantively identical decisions, the district court dismissed SpecialtyCare’s claims. Appx68–81, Appx109–22, Appx168–81.

The district court held that the NSA does not provide a private right of action—despite recognizing that the statute “confers a right for providers to payment.” *E.g.*, Appx78, Appx80. The court relied on the NSA’s limits on judicial *review*, *e.g.*, Appx76–77, as well as agencies’ authority “to assess penalties against insurers” for certain violations of the NSA, *e.g.*, Appx78–79. The court also asserted that the NSA “focus[es] on patients, not providers,” which meant Congress lacked a “clear intent” to grant a cause of action to providers. *E.g.*, Appx80.

The district court dismissed SpecialtyCare’s claims under the FAA for lack of a written arbitration agreement. *E.g.*, Appx76. The court rejected SpecialtyCare’s argument that the NSA incorporated section 9 of the FAA. *E.g.*, Appx75.

The court dismissed SpecialtyCare’s ERISA Section 502(a)(1)(B) claim principally on the ground SpecialtyCare contested its “rate of

payment,” rather than alleging that “payment was denied.” *E.g.*, Appx72–73. According to the court, claims contesting payment rates fall outside ERISA’s “zone of interests” because that “rate depends on terms outside the plans themselves”—here, the IDR process. *E.g.*, *id.* The court also held that the claim did not fall within an ERISA-regulated “zone of interests” because SpecialtyCare could not balance bill the patient. *E.g.*, Appx73 (citing 42 U.S.C. § 300gg-111(a)(1), (b)).

Having dismissed SpecialtyCare’s claims under federal law, the court declined to exercise supplemental jurisdiction over SpecialtyCare’s state-law claims. *E.g.*, Appx80.

SUMMARY OF ARGUMENT

1. The NSA’s text and structure demonstrate Congress’s intent to provide a private cause of action to enforce IDR determinations. The NSA includes explicit rights-creating language—requiring that payment on an IDR determination “shall be made directly to” a provider within thirty days, 29 U.S.C. § 1185f(b)(6), and making those determinations “binding upon the parties involved,” *id.* § 1185e(c)(5)(E)(i). Congress identified the obligated party, the amount due, and the deadline for satisfying the obligation. That language establishes Congress’s intention for the

beneficiaries of those rights—providers—to have a private remedy to enforce them. *See Alexander v. Sandoval*, 532 U.S. 275, 288–89 (2001).

The NSA contains *no* other mechanism (besides lawsuits like this one) by which providers can force insurers to pay what the NSA requires. Declining to recognize a private right of action would upend Congress’s statutory scheme. The IDR determinations—which Congress described as “binding”—would be merely voluntary recommendations, if this Court were to hold that the NSA contains no private right of action.

2. In the alternative, Plaintiffs have stated a claim, under Section 9 of the FAA and its Illinois state analogue. By declaring IDR determinations “binding,” Congress indicated its intent to permit confirmation of the IDR awards under Section 9. *Milwaukee Typographical Union*, 639 F.2d at 389–90.

Even if confirmation required an agreement to arbitrate, PHI alleged that Defendant made such an agreement. Defendant’s active participation in IDR also implied an agreement to arbitrate and waived any objection to confirmation. *E.g., Elmar Hotel Mgmt., LLC v. Unite Here Loc. 1*, 182 F.4th 609, 612 (7th Cir. 2026).

3. Plaintiffs have stated claims under Section 502(a)(1)(B) and (a)(3) of ERISA. Plaintiffs sue under ERISA and the terms of ERISA plans—which include an obligation to pay IDR awards—not third-party contracts between themselves and Defendant. Both Congress and Plaintiffs’ patients assigned the patients’ claims and benefits to Plaintiffs.

4. PHI has stated claims under the ICFA. The district court erroneously dismissed the ICFA claims on the ground that Defendant’s conduct did not occur “primarily and substantially” in Illinois. The Illinois-nexus requirement is fact-bound and ill-suited to resolution on a motion to dismiss. *Avery v. State Farm Mut. Auto. Ins. Co.*, 835 N.E.2d 801, 854 (Ill. 2005). Defendant’s nonpayment of IDR awards was directed from Illinois, Appx292, Appx294, which can satisfy the nexus requirement, *Morrison v. YTB Int’l, Inc.*, 649 F.3d 533, 537–38 (7th Cir. 2011).

5. Because the district court erred in dismissing SpecialtyCare’s federal claims, its decision to decline to exercise supplemental jurisdiction over SpecialtyCare’s state-law claims must be vacated.

STANDARD OF REVIEW

This Court reviews de novo the district court’s orders dismissing Plaintiffs’ claims for lack of subject-matter jurisdiction, *Int’l Union of Operating Eng’rs, Local 150 v. Ward*, 563 F.3d 276, 278 (7th Cir. 2009), and for failure to state a claim, *Franco v. Chobani, LLC*, 184 F.4th 599, 602 (7th Cir. 2026). The Court “construe[s] the complaint in the light most favorable to the plaintiff[s], accepting as true all well-pleaded facts alleged, and drawing all possible inferences in [their] favor,” *Cheli v. Taylorville Cmty. Sch. Dist.*, 986 F.3d 1035, 1038 (7th Cir. 2021) (quotations omitted).

ARGUMENT

I. The No Surprises Act Provides Plaintiffs a Private Cause of Action

“[T]o determine whether” the NSA creates “not just a private right but also a private remedy,” the Court must look to Congress’s “[s]tatutory intent.” *Sandoval*, 532 U.S. at 286. To divine Congress’s intent, this Court looks to both “the text and structure of” the statute. *Id.* at 288. The NSA’s text and structure confirm Congress’s intent to give healthcare providers, like Plaintiffs, a private right of action to enforce the NSA’s “shall ... pay” mandate.

A. The NSA’s Right of Action is Narrow and Targeted

The NSA’s implied right of action is narrow and straightforward. The court’s role is to compel the insurer to pay what the statute requires. In the vast majority of cases, the court need not and should not second-guess the certified IDR entity’s determination of the correct “out-of-network rate.” *See* 29 U.S.C. § 1185f(b)(5)(A). That determination is “binding upon the parties,” absent proof of fraud or misrepresentation, and is not “subject to judicial review,” absent proof of grounds for vacating an arbitral award under the FAA (*e.g.*, corruption, bias, arbitrator misconduct, or exceeding the arbitrator’s powers). 29 U.S.C. § 1185e(c)(5)(E)(i). Whether an IDR determination is “right or wrong is none of [the Court’s] business.” *Am. Zurich Ins. Co. v. Sun Holdings, Inc.*, 103 F.4th 475, 478 (7th Cir. 2024) (confirming arbitral award pursuant to the FAA).

Rather than review the IDR determination, a federal court instead *enforces* the NSA’s payment obligation. Calculating that payment obligation (the “total plan or coverage payment”) is a matter of simple math:

“Total plan or coverage payment” =
“out-of-network rate” (determined by the certified IDR entity)
minus
patient’s “cost-sharing requirement.”

29 U.S.C. § 1185f(a)(3)(B). The court then enters judgment against the insurer in that amount. That judgment is enforceable like any other. *See* Fed. R. Civ. P. 69(a).

Recognizing this narrow cause of action will not “open the floodgates.” Once insurers learn that federal courts will (if needed) enforce the NSA’s payment obligation, then insurers should pay and lawsuits like these will become unnecessary.

B. The Text of the No Surprises Act Demonstrates Congress’s Intent to Create a Private Cause of Action

1. Congress Mandated that Insurers “Shall Pay.”

The NSA’s text confirms Congress’s intent to give providers a right to receive payment from insurers. Congress’s instructions are detailed. The Act specifies who must pay what, to whom, and when. The “group health plan or health insurance issuer ... shall ... pay a total plan or coverage payment ... directly to [the] provider.” 29 U.S.C. § 1185f(a)(3). This payment “shall be made directly to the nonparticipating provider not later than 30 days after the date on which [the IDR] determination is

made.” *Id.* § 1185f(b)(6). These are *new rights* that providers did not have prior to the Act. Under the pre-NSA common law, healthcare providers had a right to payment from the *patient* but no right to payment from the patient’s *insurer*. *See supra*, pp. 7–8.

The mandatory “shall pay” language demonstrates Congress’s intent to give providers a remedy to enforce their new rights to payment.

A long line of Supreme Court precedent confirms that when Congress “say[s] that A shall be liable to B,” then Congress has created “a right of action.” *Key Tronic Corp. v. United States*, 511 U.S. 809, 818 n.11 (1994) (quotations omitted); *see also id.* at 822 (Scalia, J., dissenting in part) (same); *see also Bowen v. Massachusetts*, 487 U.S. 879, 923 (1988) (Scalia, J., dissenting) (“[A] statute commanding the payment of a specified amount of money ... impliedly authorizes ... a claim for damages in the defaulted amount.”).

Justice Story explained that when a statute provides that a party “shall be liable to pay a specific sum,” the statute also necessarily affords the payee a remedy if the payor fails to pay. *Bullard v. Bell*, 4 F. Cas. 624, 642 (C.C.D.N.H. 1817). To “deny” such a remedy “to pay the money” would “deny the authority of the statute itself.” *Id.*

The Supreme Court reaffirmed this rule in *Sandoval*, the seminal modern case on implied rights of action. 532 U.S. at 288–89. In *Sandoval*, the Court held that when Congress uses “rights-creating language” that identifies “the individuals protected,” Congress implies that those individuals have a cause of action against the party that violates their newly created rights. *Id.*

The Supreme Court again confirmed this rule in *Maine Community Health Options v. United States*, 590 U.S. 296 (2020). Where, as here, “a statutory obligation to pay money is mandatory, then the congressionally conferred right to receive money will typically display an intent to provide a damages remedy for the defaulted amount.” *Id.* at 324 n.12 (cleaned up).

In *Maine Community*, the relevant statute provided that, if a group health plan lost a certain amount of money, the government “shall pay to the plan” a prescribed sum. 42 U.S.C. § 18062(b)(1). The Court held that this statute provided a damages remedy against the United States under the Tucker Act. *Maine Cmty.*, 590 U.S. at 324–25. The Court noted that this inquiry (whether Congress meant to create a damages action against the United States, under the Tucker Act) was “precisely” the same as the

Sandoval inquiry into whether a rights-creating statute implies a private right of action. *Id.* at 324 n.12 (citing *Sandoval*).¹⁰

This Court has faithfully applied this rule in finding an implied right of action under the *Sandoval* framework. In *International Union of Operating Engineers v. Ward*, this Court considered the Labor-Management and Reporting Disclosure Act, which imposes fiduciary duties on union officers but does not *expressly* create a cause of action for the union to sue an unfaithful officer. 563 F.3d at 286. This Court found an *implied* cause of action because the statute “manifests an intent to ‘create new rights’ for labor unions.” *Id.* (quoting *Sandoval*, 532 U.S. at 289).

Like the statutes at issue in the cases cited above, the NSA imposes specific duties on insurers and creates new rights for providers: it sets forth in detail who must pay what to whom and by what deadline. Therefore, the NSA must afford providers a remedy for insurers’ breach.

¹⁰ In *FS Credit Opportunities Corp. v. Saba Capital Master Fund, Ltd.*, 146 S. Ct. 1546, 1553 (2026), the Court reaffirmed that identifying an implied right of action is a matter of statutory interpretation, which focuses on identifying “‘rights-creating language’ aimed at protecting ‘a particular class of persons.’” Unlike the NSA, the statute there did not “confer[] a right on a specified class of persons.” *Id.* (citation omitted).

Several district courts have correctly interpreted the NSA’s mandatory “shall ... pay” language as implying Congress’s intent to give providers a private right of action against the insurers. *Shareef Jandali Plastic Surgery LLC v. Cigna Health and Life Ins. Co.*, 2026 WL 2098149, at *5 (D. Conn. July 21, 2026); *PHI Health, LLC v. Optimum Choice, Inc.*, 826 F. Supp. 3d 654, 663–64 (D. Md. 2026); *Northeast Plastic Surgery Ctr., LLC v. Cigna Health & Life Ins. Co.*, 2026 WL 2098146, at *5 (D. Conn. July 21, 2026); *New England PA, LLC, v. Cigna Health & Life Ins. Co.*, 2026 WL 2099041, at *5 (D. Conn. July 21, 2026); *SpecialtyCare, Inc. v. CareFirst of Maryland, Inc.*, 2026 WL 1656946, at *2 (D. Md. June 9, 2026); *Guardian Flight LLC v. Aetna Life Ins. Co.*, 789 F. Supp. 3d 214, 228 (D. Conn. 2025).

2. By Making IDR Determinations “Binding,” Congress Evinced Its Intent for Judicial Enforcement.

a. Yet more textual evidence of Congress’s intent is found in its use of the term “binding” to describe the arbitrators’ IDR determinations. The *amount* of money that the provider is owed is determined (absent agreement) through IDR, and Congress instructed that the certified IDR entity’s determination “shall be binding upon the parties involved.” 29

U.S.C. § 1185e(c)(5)(E). Legislative history confirms the plain meaning of that text: Providers and insurers are “bound by” the certified IDR entity’s “decision.” H.R. Rep. No. 116-615, at 57 (Dec. 2. 2020).

The word “binding” means that the IDR entity’s determination is judicially enforceable in federal court. Congress is presumed to adopt the “legal tradition and meaning” of the words it uses. *Sekhar v. United States*, 570 U.S. 729, 733 (2013) (quotations omitted). A “binding” contract means a contract that courts will enforce. *See Ogden v. Saunders*, 25 U.S. 213, 257 (1827).¹¹ A “binding” judicial precedent means a precedent that “controls” what a court will do. *Savory v. Cannon*, 947 F.3d 409, 421 (7th Cir. 2020). And a “binding” arbitration award means an award that courts will enforce. *Lander Co. v. MMP Invs., Inc.*, 107 F.3d 476, 480 (7th Cir. 1997).

Congress’s use of “binding” to describe IDR determinations “clearly conveys an expectation that ... a provider with a favorable IDR determination who is not paid ... may enforce its rights in court.” *PHI*

¹¹ *See also United States v. Farmer*, 543 F.3d 363, 374 (7th Cir. 2008) (“A proffer agreement is a binding contract, enforced according to its terms.”); *Skycom Corp. v. Telstar Corp.*, 813 F.2d 810, 814 (7th Cir. 1987) (holding “agreement to agree” unenforceable because it does “not create binding obligations”).

Health, 826 F. Supp. 3d at 665; *see also Shareef Jandali Plastic Surgery*, 2026 WL 2098149, at *5–6 (“Congress could not have intended to leave providers with no judicial avenue to enforce the right it ... acknowledged as ‘binding,’ because to do so would be pointless.”); *Guardian Flight*, 789 F. Supp. 3d at 227–28.

b. Courts’ rationale for confirming “binding” arbitration awards under the Federal Insecticide, Fungicide, and Rodenticide Act (“FIFRA”) applies equally to IDR determinations. Like the NSA, FIFRA mandates “binding” arbitration of payment disputes. 7 U.S.C. § 136a(c)(1)(F)(iii). And when Congress enacted FIFRA, use of the terms “binding” and “final and conclusive” in a private arbitration agreement was already “understood to mean that an award will be enforceable in court.” *Cheminova A/S v. Griffin LLC*, 182 F. Supp. 2d 68, 74 (D.D.C. 2002) (citing *Lander Co.*, 107 F.3d at 480). In construing FIFRA, courts had to “assume that, absent a plain indication to the contrary, Congress intended the FIFRA arbitration scheme to fit within existing arbitration law” in which courts enforced “binding” arbitration awards. *Id.* at 74. Here too, the court should conclude that Congress, by describing IDR

determinations as “binding,” intended to make the NSA’s payment obligation enforceable in court.

The court’s additional reasons for permitting confirmation of FIFRA awards also apply here. First, Defendant sold insurance and administrative services “with full knowledge that it might be subject to ‘binding arbitration.’” *Cheminova A/S*, 182 F. Supp.2d at 74; *see also*, *e.g.*, Appx282, Appx293. Second, refusing to enforce the award would “defeat[]” a statutory “guarantee [of] compensation” to providers. *Cheminova A/S*, 182 F. Supp.2d at 74; *see also* 29 U.S.C. § 1185f(a)(3). Third, relying on agencies to enforce payment decisions would undermine Congress’s decision to rely on private arbitrators (rather than agency personnel) by “return[ing] compensation disputes to the [agencies] whenever a [party] elected not to pay.” *Cheminova A/S*, 182 F. Supp.2d at 75; *see also* 29 U.S.C. § 1185e(c)(4)(A); *id.* § 1185f(b)(2)(A). And, as in *Cheminova A/S*, the agencies “cannot order that compensation be paid” anyway. 182 F. Supp.2d at 75–76; *see supra* pp. 12–15. Finally, the statutes’ limitations of judicial review both “underscore[] the congressional interest in ensuring the finality of” awards. *Cheminova A/S*, 182 F. Supp. 2d at 77. “That interest would be undermined, not

furthered, if summary judicial confirmation and enforcement were unavailable.” *Id.*

C. The Structure of the No Surprises Act Also Proves Congress’s Intent to Create a Private Cause of Action

The NSA’s “structure” further confirms that Congress intended to create a private right of action. *See Sandoval*, 532 U.S. at 288 (to assess whether Congress intended to create a private cause of action, court should consider the statute’s “structure”); *Rice v. Off. of Servicemembers’ Grp. Life Ins.*, 260 F.3d 1240, 1246–47 (10th Cir. 2001) (recognizing a private cause of action based on a statute’s “structure”).

1. Congress Abolished Providers’ Right to Obtain Payment from Patients.

The NSA abolished providers’ pre-existing right to obtain payment from patients. 42 U.S.C. § 300gg-135; *see supra* pp. 7–9. Congress replaced that right with the NSA’s insurer-focused payment obligation. Congress necessarily intended providers to have recourse to a court to enforce that payment obligation. Otherwise, providers’ new right to payment by insurers would not substitute for the right that Congress eliminated.

Congress intended the NSA to correct a “failure in the health care market.” H.R. Rep. No. 116-615, at 53. A “key element” of Congress’s solution was the out-of-network “payment rate, which is the amount that payers must remit to providers.” *Id.* at 56. For the solution to work as Congress intended, “payers must remit” those payments. *Id.* And without a cause of action to eliminate any “obstacle to [a] provider being paid,” providers’ “federal rights” to payment would be “illusory.” *PHI Health*, 826 F. Supp. 3d at 664. Congress intended to make insurers pay for patients’ out-of-network care—not to grant insurers a free pass. *See Guardian Flight*, 789 F. Supp.3d at 226 (recognizing that the NSA is “plainly aimed at compensating providers for their services”).

Denying a private right of action, to enforce the NSA’s payment obligation, would render the NSA “meaningless.” *See Maine Cmty.*, 590 U.S. at 324 n.12. This Court “should not assume that Congress left such a gap in its scheme” as would cause it to “unravel.” *Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 180–81 (2005); *see also United States v. Castleman*, 572 U.S. 157, 178 (2014) (Scalia, J., concurring in part) (defining the “presumption against ineffectiveness” canon as “the idea that Congress presumably does not enact useless laws”); *PHI*

Health, 826 F. Supp. 3d at 668 (“It is inconceivable” that “when Congress extinguished a panoply of providers’ private rights” against patients, Congress also “considered itself to be leaving prevailing parties with no way to enforce” the NSA’s payment obligation).

2. Congress Did Not Create an Alternative Enforcement Mechanism.

Congress’s omission from the NSA of an alternative enforcement mechanism confirms Congress’s intent to create a private right of action. *See Rice*, 260 F.3d at 1246 (federal statute authorizing beneficiaries to “make ‘claim[s]’ for payment” against insurance company necessarily contains an “implied right of action” to sue the insurer because the statute “contains no mechanism (administrative or otherwise) to enforce the insurance contract” (alteration in original)); *see also Indiana Prot. & Advoc. Servs. v. Indiana Fam. & Soc. Servs. Admin.*, 603 F.3d 365, 379 (7th Cir. 2010) (lack of enforcement method, in the statute, indicates Congress’s intent to create a private cause of action).

Here, as in *Rice*, the statute contains no other enforcement mechanism (besides a provider-initiated lawsuit) by which insurers can be compelled to pay the “total plan or coverage payment.” Although the NSA directed the three agencies to take *other* actions (e.g., audit insurers’

calculation of the “qualifying payment amount”), the NSA contains no directive or authorization for the agencies to compel payment to providers. Nor did any of the agencies’ pre-existing powers include authority to force insurers to pay providers. *See supra* pp. 12–15. If Congress had intended for the agencies to enforce the NSA’s payment obligation, then Congress would have provided the agencies with powers to do so.

The district courts relied on HHS’s limited authority to impose civil monetary penalties based on a “fail[ure] to meet a provision” of the NSA. *E.g.*, Appx257–58 (citing 42 U.S.C. § 300gg-22(b)(2) (providing a maximum penalty of “\$100 for each day ... a failure occurs”)); Appx369 (same). But that limited civil-penalty authority does not force the insurer to pay the provider. Any fines would be paid *to the government*. Moreover, HHS has *no* authority to impose penalties on the ERISA group health plans that are at issue in this appeal.¹²

¹² HHS’s authority applies only to “*individual* health insurance coverage” or “group health plans that are *non-Federal governmental plans*,” (that is, plans maintained by state and local governments). 42 U.S.C. § 300gg-22(b)(1) (emphases added); *id.* § 300gg-91(a)(1), (b)(4)–(5), (d)(8)(C).

Even if HHS had authority over all plans at issue in this appeal, a \$100-per-day monetary penalty would not be an adequate substitute for judicial enforcement. The money at stake under the NSA’s payment obligations far exceeds possible penalties. *Agag v. Cigna Health & Life Ins. Co.*, 2026 WL 1021213, at *13 (D. Conn. Apr. 15, 2026) (comparing a \$97,500 award to \$100-per-day penalties). That disparity gives insurers a “significant incentive” to simply pay a penalty (if ever fined) “instead of ever paying the provider.” *Id.* Plaintiffs in these cases alone seek \$2,476,607.07 in unpaid balances. Appx52, Appx89, Appx130, Appx216, Appx300. That debt is equivalent to 12,110 single-day penalties—more than 33 years.¹³ A \$100 per day penalty authority—which only applies to some, not all, of the insurers covered by the NSA—is not the kind of “enforcement scheme” that precludes a private right of action. *PHI Health*, 826 F. Supp. 3d at 667 (quotation omitted); *see also Guardian Flight*, 789 F. Supp. 3d at 229 (HHS cannot “enforce individual IDR awards”).

¹³ Based on the most recent inflation-adjustments published by HHS. 91 Fed. Reg. 3,665, 3,681 (Jan. 28, 2026).

As a practical matter, the agencies *are not* enforcing the NSA’s payment obligation. Plaintiffs are unaware of a single government enforcement action brought against any insurer for failing to pay. The United States told the Fifth Circuit as much in its amicus brief in the *Guardian Flight* case: “[I]t is unreasonable to assume that the [Department of Labor] is capable of policing every employer-sponsored benefit plan in the country.”¹⁴ A private right of action is necessary because there simply are no “adequate alternative means to ensure that insurers pay out-of-network providers the money owed under the statute.”¹⁵

The Fifth Circuit in *Guardian Flight* badly erred when it stated that “the Centers for Medicare and Medicaid Services (CMS), an agency within HHS, has acted on that authority [to levy \$100-per-day penalties] by soliciting provider complaints and compelling payors to pay IDR awards where appropriate.” 140 F.4th at 277. The district courts in the

¹⁴ Amicus Brief of the United States, *Guardian Flight, LLC et al. v. Health Care Service Corp.*, No. 24-10561, 2024 WL 4451970, at *13 (5th Cir. Oct. 4, 2024) (quoting *Harrison v. Envision Mgmt. Holding, Inc.*, 59 F.4th 1090, 1112 (10th Cir. 2023)).

¹⁵ *Id.*

cases on appeal made the same error—citing *Guardian Flight* for this proposition. Appx120; Appx254; Appx368–69.

The Fifth Circuit’s sole citation in its *Guardian Flight* opinion, for the proposition that the agencies are enforcing the NSA’s payment obligation, is to page 35 of a three-year-old report by the Government Accountability Office (GAO). 140 F.4th at 277 n.6.¹⁶ The GAO is part of the *legislative* branch, not the agencies tasked with implementing the NSA.¹⁷ The GAO Report has no legal force.

The cited paragraph of the GAO Report stated that unnamed “CMS officials told us” that, “in the case of failure to make a payment following an adverse payment determination, the agency would require the issuer to pay the provider the determined award amount.” GAO Report, at 34–35. But the GAO also reported that “CMS officials told us the departments received 3,400 complaints regarding late payment issues

¹⁶ Citing U.S. GAO, Report No. GAO-24-106335, Private Health Insurance—Roll Out of Independent Dispute Resolution Process for Out-of-Network Claims Has Been Challenging (Dec. 2023), <https://www.gao.gov/assets/d24106335.pdf> (hereafter “GAO Report”).

¹⁷ “The GAO is an independent agency within the legislative branch that exists in large part to serve the needs of Congress.” *Bowsher v. Merck & Co.*, 460 U.S. 824, 844 (1983).

and 3,200 of those complaints were referred to the Department of Labor.” *Id.* at 35 n.59 (emphasis added). The GAO Report contained no evidence that the Department of Labor had any power to enforce the “shall pay” mandate. The report stated that the Department of Labor received 12,585 complaints related to the No Surprises Act through August 2023, *id.* at 37; and the report described what the Department of Labor did with nonpayment complaints: A Department “benefits advisor” might “work[] with the group health plan to get *voluntary compliance*,” *id.* at 36 (emphasis added). Voluntary compliance is not agency enforcement.

To foreclose a private right of action, Congress must provide “administrative enforcement mechanisms” that enforce the relevant “substantive rule.” *Indiana Prot. & Advoc. Servs.*, 603 F.3d at 379 (quoting *Sandoval*, 532 U.S. at 290). The “substantive rule” at issue in these cases is the insurer’s obligation to pay the “total plan or coverage payment” to the provider. 29 U.S.C. § 1185f(a)(3)(B). Nothing in the NSA (or in the agencies’ pre-existing authorities) contains any “administrative enforcement mechanism” for *that* substantive rule.

D. The NSA’s Prohibition on “Judicial Review” Does Not Entail a Prohibition on Judicial *Enforcement*

The Fifth Circuit in *Guardian Flight* (like the district courts, here) erroneously held that the NSA’s prohibition on “judicial review” of IDR determinations, 29 U.S.C. § 1185e(c)(5)(E)(i), is evidence that Congress did not intend to create a private right of action to enforce the NSA’s *payment obligation*. 140 F.4th at 275–76.

The NSA’s right of action is narrow—as described above in Part I.A. The provider, when invoking this right of action, does not ask the court to “review” the IDR entity’s determination. Rather, the provider “simply asks the court to do what the statute says—to give effect to a ‘binding’ award.” *Shareef Jandali Plastic Surgery*, 2026 WL 2098149, at *6. “[W]hen Congress limited the grounds on which a court could engage in ‘judicial review’ it was speaking to the limits on a court’s authority when a party has *challenged* an IDR determination, not to whether courts have authority to *enforce* an IDR award where a non-prevailing party refuses to pay.” *PHI Health*, 826 F. Supp. 3d at 666; *see also, e.g., Guardian Flight*, 789 F. Supp. 3d at 228 (explaining that the NSA’s judicial-review bar “clarif[ies] that courts should not undermine the substance or finality of these [IDR] awards”).

Enforcing the NSA’s payment obligation is different from conducting a “judicial review” of the IDR entity’s determination. In the analogous context of confirming arbitral awards under the FAA, courts have recognized this difference. *See Thomas v. Union Carbide Agr. Prod. Co.*, 473 U.S. 568, 591–92 (1985) (distinguishing circumscribed scope of judicial review of arbitration awards from enforcement of those awards); *compare* JUDICIAL REVIEW, *Black’s Law Dictionary* (12th ed. 2024) (“A court’s power to review the actions of other branches or levels of government; esp., the courts’ power to invalidate ... executive actions ...”), *with* ENFORCEMENT, *Black’s Law Dictionary* (12th ed. 2024) (“The act or process of compelling compliance with a law, mandate, command, decree, or agreement.”).¹⁸

¹⁸ The Fifth Circuit defined “review” as “[p]lenary power *to direct and instruct an agent or subordinate*, including the right to remand, modify, or vacate any action by the agent or subordinate, or to act directly in place of the agent or subordinate.” *Guardian Flight*, 140 F.4th at 275 (quoting REVIEW, *Black’s Law Dictionary* (12th ed. 2024)) (alteration and emphasis in original). But entering a judgment enforcing an IDR determination does not meet that definition: the court does not instruct a certified IDR entity to take action or act in its place; does not remand, modify or vacate the IDR determination; and does not exercise plenary power over the substance of the determination.

II. Plaintiffs Have a Cause of Action under the Federal Arbitration Act

In the alternative, Plaintiffs may enforce their IDR determinations under Section 9 of the FAA. The district court's contrary rulings rested on the false premises both that an arbitration agreement is required to enforce an IDR determination under Section 9 and that Defendant made no such agreement. *E.g.*, Appx115–16; Appx259–61; Appx373.

The NSA reflects Congress's intent to treat IDR determinations as equivalent to arbitrations awards subject to the FAA. No agreement to arbitrate is required because Congress mandated binding arbitration. But, even if an agreement were required, the district courts should have denied Defendant's motions to dismiss. First, PHI alleged that Defendant agreed to participate in binding arbitration through IDR. Second, Defendant fully participated in IDR, and its participation was an *implied* agreement to arbitrate that waived any objection to confirmation of the resulting IDR determination.

A. The NSA’s IDR Process is an Arbitration, and IDR Determinations are Arbitration Awards

Congress modeled IDR on arbitration: a private neutral entity, after considering evidence from both parties, renders a final decision that resolves the parties’ payment dispute. Using the same language that gives rise to confirmable arbitration awards, *e.g.*, *Milwaukee Typographical Union*, 639 F.2d at 389–90, Congress made IDR determinations “binding” on the parties, 29 U.S.C § 1185e(c)(5)(E)(i). Congress intended IDR determinations to be treated as equivalent to confirmable arbitration awards under the FAA.

1. IDR Determinations are Arbitration Awards.

IDR determinations are arbitration awards. The different nomenclature does not matter—“call[ing] a procedure” something other than “arbitration” does “not make that procedure less ‘arbitration.’” *Blue Cross Blue Shield of Massachusetts, Inc. v. BCS Ins. Co.*, 671 F.3d 635, 637 (7th Cir. 2011).

“[C]ommon indicia of arbitration” include “(i) an independent adjudicator, (ii) who applies substantive legal standards ..., (iii) considers evidence and argument ... from each party, and (iv) renders a decision that purports to resolve the rights and duties of the parties” *Int’l*

Union of Operating Eng'rs Loc. 649 v. Tyro Constr., Inc., 2026 WL 1833495, at *3 (C.D. Ill. June 25, 2026) (citation omitted)). Thus, for example, mediation does not qualify as arbitration because it does not yield a final, binding decision. *Drusco Restaurants, Inc. v. Steak n Shake Enters., Inc.*, 2013 WL 5779646, at *6 (S.D. Ind. Oct. 9, 2013), *aff'd*, 765 F.3d 776 (7th Cir. 2014).

IDR bears the hallmarks of arbitration. *First*, a neutral arbiter, the certified IDR entity, decides disputes. 29 U.S.C. § 1185e(c)(4)(A)(ii), (c)(4)(F)(i). *Second*, the certified IDR entity applies substantive standards when adjudicating. *Id.* §§ 1185f(b)(5)(C), 1185e(c)(5)(C). *Third*, the certified IDR entity must consider evidence and argument from each party. *Id.* § 1185f(b)(5)(B)(ii), (b)(5)(C)(i)(II). *Fourth*, the certified IDR entity must notify the parties of its determination, *id.* § 1185f(b)(5)(A), which is conclusive and “binding” on the parties, *id.* § 1185f(b)(5)(D); *id.* § 1185e(c)(5)(E); *see also* 29 C.F.R. § 2590.716-8(c)(5)(vi).

An agreement to arbitrate is not an essential element of binding arbitration. Congress has enacted numerous compulsory arbitration regimes. FIFRA mandates “binding arbitration” of certain payment disputes. 7 U.S.C. § 136a(c)(1)(F); *see also Thomas*, 473 U.S. at 589

(upholding binding arbitration under FIFRA). And the Postal Reorganization Act, 39 U.S.C. § 1207(2), similarly mandates certain “binding” “arbitration” with the U.S. Postal Service. IDR under the NSA similarly qualifies as arbitration.

2. By Declaring IDR Determinations “Binding,” Congress Intended Them to be Confirmable under the FAA.

a. Section 9 of the FAA provides for confirmation when an agreement provides “that a judgment of the court shall be entered upon the award.” 9 U.S.C. § 9. This Court and the Supreme Court have long held that Section 9 is satisfied when the parties agree to “final and binding” arbitration. *Milwaukee Typographical Union*, 639 F.2d at 389–90; *Marine Transit Corp. v. Dreyfus*, 284 U.S. 263, 276 (1932). Congress’s decision to make IDR determinations “binding” reflects its intent that courts would confirm IDR determinations pursuant to Section 9 of the FAA.

b. As noted in Part I.B.2, the NSA’s IDR process is very similar to the arbitration scheme under FIFRA. *See Smith v. City of Jackson*, 544 U.S. 228, 233 (2005) (presuming that “the same language in two statutes” has “the same meaning”).

Like the NSA, FIFRA imposes mandatory arbitration, declares the arbitration awards “binding,” and limits judicial “review” of the award. *Compare* 7 U.S.C. § 136a(c)(1)(F) (FIFRA), *with* 29 U.S.C. §§ 1185e(c)(5)(E)(i) (NSA). Like the NSA, FIFRA does not mention confirming awards. But, prior to enactment of the NSA, parties could confirm FIFRA awards, including under Section 9 of the FAA. *Spray Drift Task Force v. Burlington Bio-Med. Corp.*, 429 F. Supp. 2d 49, 50 (D.D.C. 2006) (confirming award under FAA). Given the parallels between FIFRA and NSA arbitration, the Court should conclude that Congress anticipated judicial enforcement of the NSA’s payment obligation.

B. Defendant Agreed to Arbitrate

Even if an agreement to arbitrate were required by Section 9 of the FAA, an agreement exists here. PHI sufficiently alleged an agreement, including in written correspondence from Defendant.¹⁹

¹⁹ SpecialtyCare’s operative complaints did not include the express-agreement allegations that PHI pleaded. If the Court concludes that a separate agreement is required under Section 9, SpecialtyCare could seek leave on remand to amend its complaints to allege an express agreement to arbitrate based on materially similar communications from Defendant.

1. PHI Plausibly Pleaded a Written Agreement to Arbitrate.

Under Section 9 of the FAA, an agreement to permit entry of judgment on an arbitration award “need not be explicit.” *Milwaukee Typographical Union*, 639 F.2d at 389. Agreeing to “binding” arbitration suffices. *Id.* And whether the parties have agreed to “binding” arbitration depends not only on the four corners of the agreement but also on the rules of any arbitration regime designated in the agreement. *Commonwealth Edison Co. v. Gulf Oil Corp.*, 541 F.2d 1263, 1272–73 (7th Cir. 1976).

PHI alleged that Defendant repeatedly agreed, in writing, to engage in binding arbitration through IDR. Appx226, Appx286. For example, on March 5, 2024, Defendant wrote PHI that, if the parties could not negotiate an agreement, PHI “may initiate the Independent Dispute Resolution Process.” Appx234. Defendant then sent two more letters, dated April 5 and April 11, 2024, restating that offer. Appx236 (rejecting PHI’s negotiation offer and stating dispute, therefore, “may be subject to a timely request for IDR”); Appx235 (instructing PHI that it “may file a dispute resolution form” using online “Independent Dispute Resolution (IDR) application” or hardcopy “Notice of IDR Initiation

form”). “[A]t BCBSTX’s invitation,” PHI then “initiated IDR proceedings by submitting a Notice of Initiation” through the federal agencies’ IDR Portal. Appx220.

Those allegations suffice to demonstrate an agreement to binding arbitration. As in *Commonwealth Edison*, 541 F.2d at 1272, Plaintiffs alleged that Defendant agreed, in writing, to proceeding through a specific arbitration regime: IDR. That regime provides that all arbitration awards are “binding,” equivalent to agreeing that a district court may confirm the award. *See Milwaukee Typographical Union*, 639 F.2d at 389–90.

**2. Defendant’s Participation in Arbitration
Constitutes an Implied Agreement to Arbitrate
and Waives any Objection to Confirmation.**

Defendant also actively participated in IDR. That participation constitutes an *implied* agreement to arbitrate and waives Defendant’s right to contest enforcement. Any other result would create a heads-I-win-tails-you-lose situation in which Defendant could benefit from IDR if it won but bear no risk of loss.

Although a party can preserve a “challenge [to] the arbitrator’s authority to bind it,” it must “clearly and explicitly reserve[] the right’ to

do so.” *Elmar Hotel Mgmt., LLC*, 182 F.4th at 612 (quotations omitted) (alteration in original); *see also AGCO Corp. v. Anglin*, 216 F.3d 589, 593 (7th Cir. 2000) (A party “cannot await the outcome” of arbitration and only “later argue that the arbitrator lacked authority to decide the matter.”).

This Court does not “provide a second bite at the apple” for parties that try their luck in arbitration and then challenge the result. *Slaney v. The Int’l Amateur Athletic Fed’n*, 244 F.3d 580, 591 (7th Cir. 2001). In *Elmar Hotel Management*, the Court affirmed confirmation of an award over objections that certain parties had never agreed to arbitrate. 182 F.4th at 612. Although those parties had not signed the arbitration agreement, they had participated in the arbitration “without reserving the right to later object to arbitrability.” *Id.* Having failed to preserve an objection, those parties “cannot now argue that [the arbitrator] ‘had no authority’ to bind them.” *Id.*

In *Comprehensive Accounting Corp. v. Rudell*, 760 F.2d 138, 139–40 (7th Cir. 1985), the Court similarly rejected a challenge to an arbitration award, when the challenger had failed to argue that the parties lacked an agreement. The challenger could not “sit back and allow

the arbitration to go forward” and only afterward “say: oh by the way, we never agreed to the arbitration clause.” *Id.* at 140; *see also, e.g., Slaney*, 244 F.3d at 590–91 (rejecting analogous argument where the challenger had “freely participated” in an arbitration).

Here, Defendant participated fully in IDR without protest.²⁰ Defendant submitted a payment offer, as well as evidence in support of that offer. *E.g.*, Appx246; *see also supra* pp. 17–19. The certified IDR entity considered Defendant’s submissions. *E.g.*, Appx247. Defendant even paid to participate in the arbitration. *E.g.*, Appx247–48.

Having tried to win the “binding” IDR determination, Defendant cannot now object that it never agreed to binding arbitration.

²⁰ Although Defendant objected that PHI had initiated IDR prematurely in certain cases due to an unexpired “cooling-off period,” Appx222; *see* 29 U.S.C. § 1185e(c)(5)(E)(ii)–(iii) (imposing 90-day cooling-off period between certain IDRs), Defendant did not object to arbitrability. The arbitrator gave both parties an opportunity to “submit information regarding the merits of the” cooling-off objection, Appx238, and then denied Defendant’s objection, Appx222; *see also* Appx335 (same); Appx329 (same); Appx333 (same). The judicial-review bar of 29 U.S.C. § 1185e(c)(5)(E)(i) precludes the Court from vacating that timeliness determination.

III. Plaintiffs Have a Cause of Action under the Illinois Uniform Arbitration Act

The district court dismissed PHI's claim under Section 11 of the Illinois Uniform Arbitration Act ("IUAA"), 710 Ill. Comp. Stat. Ann. 5/11, for lack of a written agreement to arbitrate. Appx372–73. Not only did that conclusion ignore PHI's allegations of an agreement, *supra* pp. 19–20, but it also rested on a misreading of Illinois law. Section 11 of the IUAA does not require a written agreement.

Unlike section 9 of the FAA, section 11 of the IUAA makes no mention of a written agreement. Instead, Section 11 provides, "[u]pon application of a party, the court shall confirm an award, unless within the time limits hereinafter imposed grounds are urged for vacating or modifying or correcting the award." 710 Ill. Comp. Stat. Ann. 5/11. Because Defendant did not move to vacate or modify the IDR determination, the IUAA required confirmation.

The district court's ruling turned on an inapplicable jurisdictional provision in the IUAA. Section 16 of the IUAA provides that entering a written contract to arbitrate in Illinois "confers jurisdiction on" Illinois's circuit courts "to enforce the agreement" and "to enter judgment on an award thereunder." 710 Ill. Comp. Stat. Ann. 5/16. The only case relied

on by the district court, Appx373, *Chicago Southshore & South Bend Railroad v. North Indiana Commuter Transportation District*, 703 N.E.2d 7, 9 (Ill. 1998), concerned the need for a written agreement to vest Illinois state courts with jurisdiction under Section 16.

But state-law jurisdictional predicates are irrelevant in federal court. In *Rodgers-Rouzier v. American Queen Steamboat Operating Co., LLC*, 104 F.4th 978, 988 (7th Cir. 2024), the Court held that an analogous jurisdictional provision in the Indiana Uniform Arbitration Act would not constrain a federal court’s jurisdiction to enforce the Act’s substantive provisions. There, the parties had no agreement to arbitrate in Indiana—as required by that jurisdictional provision—but the federal court could still compel arbitration. *Id.* Here, too, any state-court jurisdictional requirement does not apply to PHI’s claims in federal court.

IV. Plaintiffs Have a Cause of Action under ERISA

The district court erred in dismissing Plaintiffs’ claims under ERISA §§ 502(a)(1)(B) and 502(a)(3)—codified at 29 U.S.C. § 1132.²¹ The court erred in finding that the terms of patients’ plans do not require

²¹ SpecialtyCare only asserted claims under ERISA § 502(a)(1)(B). *E.g.*, Appx60–62.

Defendant to pay what the NSA requires. Every substantive requirement in the ERISA statute—including those statutory provisions that were added by the NSA—is deemed to be incorporated into the terms of every ERISA plan. *May Dep’t Stores Co. v. Fed. Ins. Co.*, 305 F.3d 597, 601 (7th Cir. 2002). Regardless, PHI expressly pleaded that its patients’ ERISA plans mandated payment of the amounts required by the NSA. And Section 502(a)(3) permits suits to enforce ERISA’s statutory requirements—as well as plan terms. 29 U.S.C. § 1132(a)(3).

The district courts also erred in holding that Plaintiffs cannot sue as ERISA beneficiaries. That was error twice over. First, the NSA’s amendments to ERISA made out-of-network providers, like Plaintiffs, statutory beneficiaries that are independently entitled to sue. *See* 29 U.S.C. § 1002(8). Second, Plaintiffs also obtained assignments of rights from the patients. It makes no difference that the patients were protected, by the NSA, from “balance bills.” A provider’s authority to sue as assignee of its patient does not require the patient to have any further liability to the provider. *Kennedy v. Connecticut Gen. Life Ins. Co.*, 924 F.2d 698, 700 (7th Cir. 1991). And patients’ balance-billing protections

would evaporate were providers unable to enforce IDR awards, 42 U.S.C. § 300gg-135 (limiting protection to cases where benefits are “available”).

A. Claims for the Nonpayment of Benefits Due Pursuant to IDR Determinations Fall Within ERISA’s “Zone of Interest”

Section 502(a)(1)(B) of ERISA grants plan participants and beneficiaries—including provider assignees—a cause of action “to recover benefits due to [them] under the terms of [their] plan.” 29 U.S.C. § 1132(a)(1)(B).²² “This provision is relatively straightforward. If a participant or beneficiary believes that benefits promised to him under the terms of the plan are not provided, he can bring suit seeking provision of those benefits.” *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004).

The SpecialtyCare court erred in holding that Section 502(a)(1)(B) cannot cover Plaintiffs’ claims because, in the district court’s view, Plaintiffs disputed the “rate of payment” rather than an “outright denial of payment,” and the “rate of payment” depended “on terms outside the plans themselves (here, the independent dispute resolution process).” Appx172 (quotations omitted).

²² The district courts properly accepted Plaintiffs’ allegations that they were assigned their patients’ rights and benefits under the plans. *E.g.*, Appx72, Appx373.

1. Because Every ERISA Plan Incorporates NSA Requirements, Withholding the Amount Due under the IDR Denies Benefits Due under the Terms of the Plan.

a. The district court erred in assuming that benefits recoverable under Section 502(a)(1)(B) are limited to those stated within the four corners of the plan document. To the contrary, “plans governed by ERISA contain provisions implied by law.” *May Dep’t Stores Co.*, 305 F.3d at 601; *see also* 29 U.S.C. § 1104(a)(1)(D) (requiring plan fiduciary to act “in accordance with the [plan] documents ... insofar as [they] are consistent with” ERISA).²³ Here, ERISA itself implied a mandatory obligation to pay benefits due under IDR awards. 29 U.S.C. § 1185f(a)(3), (b)(6).

Both the Supreme Court and this Court have confirmed that Section 502(a)(1)(B) permits recovery of benefits due pursuant to plan terms implied by law. In *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358, 376–77 (1999), California’s mandatory “notice-prejudice” rule, although outside a plan document, “supplied the relevant rule of

²³ “[E]xisting and valid statutory provisions enter into and form a part of all contracts of insurance to which they are applicable ... [and] become a part of the contract as much as if they were actually incorporated therein.” *Plumb v. Fluid Pump Serv., Inc.*, 124 F.3d 849, 861 (7th Cir. 1997) (quotations omitted).

decision” for the plaintiff’s Section 502(a)(1)(B) claim.²⁴ In *May Department Stores Co.*, 305 F.3d at 601, this Court held that claims fell within the scope of Section 502(a)(1)(B) even though they rested not on “language in the plan but provisions of ERISA.”²⁵ Here, provisions of ERISA supply the mandatory obligation to satisfy IDR awards.

b. The district court’s distinction between suits over “rates” of payment and “rights” to payment rests on a misapplication of the “independent legal duty” test set forth in *Davila*, 542 U.S. at 210. Under *Davila*, an individual can sue under Section 502(a)(1)(B) when “entitled to [benefits] only because of the terms of an ERISA-regulated employee benefit plan” and “no legal duty ... independent of ERISA or the plan

²⁴ The notice-prejudice rule bars an insurer from “avoid liability although the proof of claim is untimely, unless the insurer shows it was prejudiced by the delay.” *Id.* at 364.

²⁵ *May Department Stores* concerned the applicability of an insurance policy exclusion for claims made under Section 502(a)(1)(B). 305 F.3d at 600; *see also Cent. Labs.’ Pension Fund v. Heinz*, 541 U.S. 739, 750 (2004) (recognizing ERISA claim to recover benefits due under plan based on statutory anti-cutback rule, 29 U.S.C. § 1054(g), which “regulates the substantive content of pension plans” with the effect of “add[ing] a mandatory term to all” plans); *Plumb*, 124 F.3d at 860–62 (holding statutory coverage requirement “becomes a substantive term in all Illinois insurance policies, and § 502(a)(1)(B) of ERISA allows [the plaintiff] to sue to recover the benefits due under those terms”).

terms is violated.” *Id.* That’s the case here since patients’ right to have benefits paid (at the rate determined in IDR) and Plaintiffs’ right to receive payment (at that rate) both arise under ERISA and the patients’ ERISA plan.

The rate-versus-right line invoked by the district court has purchase in suits between providers and insurers over fee schedules set in separate network agreements—*i.e.*, in third-party contracts that do not define the terms of the patient’s plan. Every case cited by the district courts at Appx72, Appx113, and Appx172 concerned breach of such contracts. *DB Healthcare, LLC v. Blue Cross Blue Shield of Ariz., Inc.*, 852 F.3d 868, 877–78 (9th Cir. 2017) (noting availability of “state law claims for breach of the provider agreements”); *Brown v. BlueCross BlueShield of Tennessee, Inc.*, 827 F.3d 543, 548–49 (6th Cir. 2016) (“[T]he recoupment of payments is governed by the Provider Agreement between Harrogate and Blue Cross, not the employee benefits agreements between Blue Cross and its members.”); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 530 (5th Cir. 2009) (“[D]etermination of the rate that Aetna owes Lone Star under the Provider Agreement does not require any kind of benefit determination

under the ERISA plan..., does not run afoul of *Davila* and is not preempted by ERISA.”).

In contrast, where, as here, a provider contests the rate of payment based upon the terms of the ERISA plan, the provider may sue under Section 502(a)(1)(B). *E.g.*, *Griffin v. TeamCare*, 909 F.3d 842, 845 (7th Cir. 2018) (reversing dismissal of Section 502(a)(1)(B) claim brought by provider who sued for underpayment based on plan’s terms).

2. Underpayment of IDR Awards also Breaches Express Terms of the Plan Documents.

Even were claims under Section 502(a)(3) limited by the four corners of the plan document, the district court’s reasoning would not merit dismissal of Plaintiffs’ claims. “[P]laintiffs alleging claims under 29 U.S.C. § 1132(a)(1)(B) for plan benefits need not necessarily identify the specific language of every plan provision at issue to survive a motion to dismiss under Rule 12(b)(6).” *Griffin*, 909 F.3d at 845 (quotation omitted). Here, PHI pleaded that “the terms of the ERISA Plans incorporate NSA requirements,” including “the obligation for IDR written determinations to be fully paid within 30 days.” Appx290; *see also* Appx291 (terms of plan provided for payment of “amounts due pursuant to the written determinations”). SpecialtyCare also pleaded that Defendant denied

“payment and benefits under the plan terms.” Appx139. The SpecialtyCare court erred in failing to construe these allegations in Plaintiffs’ favor.

3. Section 502(a)(3) Expressly Authorizes Suits for Breaches of ERISA, Irrespective of Plan Terms.

Even if Section 502(a)(1) were limited to enforcing terms in the four corners of the plan document, Section 502(a)(3) of ERISA is not. Section 502(a)(3) authorizes suits “to enjoin any act or practice which *violates any provision of this subchapter* or the terms of the plan, or (B) 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) (emphasis added).²⁶ That Subchapter I includes the NSA’s payment requirements, codified at 29 U.S.C. §§ 1185e, 1185f. The Court should therefore reverse dismissal of PHI’s claims under Section 502(a)(3). Appx289–92.

²⁶ See *Midthun-Hensen v. Grp. Health Coop. of S. Cent. Wisconsin, Inc.*, 672 F. Supp. 3d 662, 678 (W.D. Wis. 2023) (holding the Mental Health Parity Act, codified at 29 U.S.C. § 1185a, “is enforceable through a cause of action under 29 U.S.C. § 1132(a)(3)”).

B. The NSA’s Balance Billing Prohibition Does Not Remove Plaintiffs’ Claims from ERISA’s “Zone of Interest”

The district court also erred in holding that providers cannot sue as patients’ assignees. Although the district court correctly held that Plaintiffs had Article III standing, *e.g.*, Appx71, Appx375, the court still found that Plaintiffs had no ERISA claim because the patients—protected by the NSA’s balance-billing prohibition—face no additional out-of-pocket liability. Appx73, Appx114, Appx173; *see also* Appx375 (“[P]atients could not bring a claim to enforce the awards, and thus the patients have no claim to assign to PHI”). That ruling misunderstands the post-NSA structure of ERISA, the nature of patients’ injury, and the source of providers’ claims.

First, the plain language of ERISA—as amended by the NSA—allows providers to sue directly under Section 502 and not only as contractual assignees. Section 502(a)(1)(B) and 502(a)(3) each permit suits by a “beneficiary.” 29 U.S.C. § 1132(a)(1)(B), (a)(3). ERISA defines “beneficiary” as “a person designated by a participant, *or by the terms of an employee benefit plan*, who is or may become entitled to a benefit thereunder.” 29 U.S.C. § 1002(8) (emphasis added). The terms of the

plans designated Plaintiffs as entitled to benefits thereunder. *Supra* p. 58 n.23. Thus, Section 502(a)(1)(B) or 502(a)(3) authorize suit by Plaintiffs as beneficiaries—regardless of whether their patients could also have sued as participants. Contrary to the district court’s assumption, providers are not merely “standing in the shoes” of their assignor-patients. *Cf.* Appx375.

The district court’s contrary holding turned on the other half of ERISA’s statutory definition of “beneficiary”: “a person designated by a participant” to receive benefits. 29 U.S.C. § 1002(8). That language grounded providers’ right to sue *prior to* the NSA—since providers’ right to benefits derived only from their patients’ contractual assignments of benefits. *See Kennedy*, 924 F.2d at 700. But, as a result of the NSA, the terms of every plan must provide for the direct payment of benefits to providers. *E.g.*, 29 U.S.C. § 1185f(a)(3).

Second, even before the NSA, providers could bring ERISA claims as patients’ assignee-beneficiaries, regardless of whether the patients faced residual personal liability. For example, a provider could grant a release to the patient in exchange for an assignment of benefits; and the provider could then use that assignment to sue under Section 502.

Kennedy, 924 F.2d at 699–700 (finding provider had standing to sue under ERISA where provider “agreed to accept as full compensation whatever the insurer would pay”).²⁷ The plain language of Section 1002(8) authorizes Plaintiffs to sue as assignee-beneficiaries because they have been “designated by a participant” to receive benefits. 29 U.S.C. § 1002(8). Section 1002(8) does not require the patients to retain residual liability.

Third, and relatedly, the district court failed to consider the structure of the NSA and *why* patients lack residual liability. Congress did not simply grant them a release. Rather, Congress mandated the assignment of patients’ benefits to providers in exchange for that release. 29 U.S.C. § 1185f(a)(3); 42 U.S.C. § 300gg-135. That context matters: Congress could not have intended that its release for patients would nullify its simultaneous assignment of benefits to providers. Still less

²⁷ In *Kennedy*, the provider’s claims failed on the merits because the plan’s terms did not provide any benefits for services for which the patient was “not legally required to pay.” *Id.* at 701–02 (quotations omitted). In contrast, the terms of the plans at issue here *must* provide coverage under such circumstances. 29 U.S.C. § 1185f(a)(3); 42 U.S.C. § 300gg-135.

could Congress have intended to bar patients from assigning benefits to providers by enacting a statute that mandated such an assignment.

Fourth, the district court erred in assuming that patients lack residual liability. The NSA’s balance-billing prohibition only protects patients when providers can obtain payment:

In the case of a participant ... with benefits under a group health plan ... who is furnished ... services (*for which benefits are available under such plan or coverage*) from a nonparticipating provider ... with respect to such plan or coverage, such provider ... shall not bill, and shall not hold liable, such participant.

42 U.S.C. § 300gg-135 (emphasis added). The NSA defines what those *available benefits* must comprise: direct payment to the provider of a sum determined in IDR. 29 U.S.C. § 1185f(a)(3). If neither the patient-participant nor provider-beneficiary could obtain payment of those mandated benefits, then the benefits would not be “available” under the patient’s plan. *See Ross v. Blake*, 578 U.S. 632, 642 (2016) (identifying the “ordinary meaning” of “available” as “‘capable of use for the accomplishment of a purpose,’ and that which ‘is accessible or may be obtained,’” in contrast to a provision that is “officially on the books” but “not capable of use”). If these “benefits” (payments to the provider) were not “available,” then the balance-billing prohibition would not apply.

Providers could bill patients. Patients therefore have a direct interest in suing to compel payment under 502(a)(1)(B) or (a)(3), and patients can assign that right to Plaintiffs.

Finally, the district court myopically viewed the patients' interest, under Section 502(a)(1)(B) and 502(a)(3), as limited to personally pocketing benefits payments. It is not. Suits under Section 502(a)(1)(B) are in the nature of contract claims. *See Larson v. United Healthcare Ins. Co.*, 723 F.3d 905, 911 (7th Cir. 2013); *Tolle v. Carroll Touch, Inc.*, 977 F.2d 1129, 1133 (7th Cir. 1992). Patients bargained to obtain NSA-compliant coverage—exchanging, as consideration, both cash premiums and labor service to plan sponsors. *See Appx290*; *Kennedy*, 924 F.2d at 699 (recognizing enhanced health benefits as alternative to wage compensation). When a plan pockets that consideration without providing the promised NSA-compliant coverage, beneficiaries can sue to obtain the benefit of their bargain. *Kennedy*, 924 F.2d at 699.

The scope of the Section 502(a)(3) remedy is even broader: plan beneficiaries can sue to “enjoin any act or practice which violates any provision of” ERISA “to enforce any provisions” of ERISA. 29 U.S.C. § 1132(a)(3). That remedy encompasses fiduciary duty claims. *Varity*

Corp. v. Howe, 516 U.S. 489, 492 (1996). Thus, patients could have sued Defendant under Section 502(a)(3) to force Defendant to pay Plaintiffs what the NSA requires (a requirement that is also incorporated into every ERISA plan document). Plaintiffs can bring these same claims as assignee-beneficiaries of the patients.

C. The District Court Erred in Dismissing PHI's ERISA Claims Based on an Alleged Failure to Plead that PHI is a Beneficiary

The district court's alternative basis for dismissing PHI's ERISA claims rested on inaccurate assertion that PHI did not plead that it was a "beneficiary." Appx376. That ruling makes no sense. PHI alleged that it is a beneficiary by assignment. Appx289–91. PHI also pleaded allegations sufficient to infer that PHI is a beneficiary under the terms of the plans and ERISA. *See* Appx290.

V. The District Courts Erred in Dismissing Plaintiffs' State-Law Claims

A. The District Court Erred in Dismissing PHI's Claims under the ICFA

The district court dismissed PHI's claims under the ICFA solely because PHI did not provide its air ambulance services in Illinois. Appx267–68. That ruling misapplied Illinois law and failed to construe allegations in PHI's favor.

The ICFA’s Illinois-nexus requirement is ill-suited to a motion to dismiss because it is highly fact-bound. *See Cosmetique, Inc. v. ValueClick, Inc.*, 753 F. Supp. 2d 716, 723 (N.D. Ill. 2010). Although the disputed transaction must “occur primarily and substantially in Illinois . . . there is no single formula or bright-line test for determining whether a transaction occurs within this state.” *Avery*, 835 N.E.2d at 854. “Rather, each case must be decided on its own facts.” *Id.* “That’s a fuzzy standard,” *Morrison*, 649 F.3d at 536, which “gives the trier of fact substantial latitude,” *id.* at 538. Thus, in *Morrison*, the Court reversed dismissal because, although the complaint’s allegations were “not enough to *compel* a conclusion” that the ICFA applied, neither did those allegations “*defeat* application of Illinois law.” *Id.* at 538.

PHI alleged that Defendant is headquartered and incorporated in Illinois. Appx276. PHI also alleged that Defendant’s nonpayment of IDR awards stemmed from decisions and actions taken by Defendant in Illinois.²⁸ Those allegations are more than enough at motion to dismiss.

²⁸ *E.g.*, Appx292 (“HCSC maintains centralized claims administration, payment processing, and corporate policy functions in Illinois. Decisions regarding whether to honor and remit payment on IDR determinations are made, approved, directed, and implemented in Illinois.”); Appx294 (“HCSC has implemented corporate policies,

See, e.g., Morrison, 649 F.3d at 537–38 (allegations centered on misconduct by defendant in Illinois sufficient to survive motion to dismiss, even though plaintiffs interacted with defendant from their out-of-state residences and sustained losses in those other states).

In Appeal No. 26-2736, the district court also improperly relied on an assertion by Defendant “at oral argument,” Appx378, rather than allegations in the complaint, *Jacobs v. City of Chicago*, 215 F.3d 758, 766 (7th Cir. 2000); *Federated Mut. Ins. Co. v. Coyle Mech. Supply Inc.*, 983 F.3d 307, 315–16, 318 (7th Cir. 2020).

B. In Nos. 26-2269, 26-2279, and 26-2280, SpecialtyCare’s State-Law Claims Should Be Reinstated on Remand

The district court dismissed SpecialtyCare’s state-law claims without prejudice only after dismissing every federal claim and declining supplemental jurisdiction under 28 U.S.C. § 1367(c)(3). Appx80, Appx180, Appx121. If this Court reverses the dismissal of Appellants’ federal claims, the premise for that disposition disappears. The Court

procedures, internal directives, or payment review practices originating from its Illinois offices that delay, deny, or disregard payment of binding IDR awards.”).

should therefore vacate the dismissal of the state-law claims and remand them for further proceedings alongside the reinstated federal claims.

CONCLUSION

For the foregoing reasons, the district courts' judgments should be reversed.

Respectfully submitted,

Joshua D. Arters
Kevin T. Elkins
Savannah L. Kolodziej
Rachel M. Roberson
Olivia D. Winnett
POL SINELLI PC
501 Commerce Street
Suite 1300
Nashville, TN 37203-6252
615.252.3923
jarters@polsinelli.com

*Counsel for Plaintiffs-Appellants
SpecialtyCare, Inc.; Remote
Neuromonitoring Physicians, PC;
and Sentient Physicians, PC*

s/ Stephen M. Shepard
Steven M. Shepard
Max I. Straus
Casen B. Ross
SUSMAN GODFREY LLP
One Manhattan West
50th Floor
New York, NY 10001
212.336.8330
sshepard@susmangodfrey.com
mstraus@susmangodfrey.com
cbross@susmangodfrey.com

*Counsel for Plaintiff-Appellant
PHI Health, LLC*

September 2026

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) and Circuit Rule 32(c) because it contains 13,780 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)–(6) because it was prepared using Word for Microsoft 365 in Century Schoolbook 14-point font, a proportionally spaced typeface.

s/ Stephen M. Shepard
STEPHEN M. SHEPARD

CERTIFICATE OF SERVICE

I hereby certify that on September 9, 2026, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

s/ Stephen M. Shepard
STEPHEN M. SHEPARD

SEVENTH CIRCUIT RULE 30(D) STATEMENT

Pursuant to Circuit Rule 30(d), counsel certifies that all material required by Circuit Rule 30(a) and (b) is included in the appendix.

s/ Stephen M. Shepard
STEPHEN M. SHEPARD

SHORT APPENDIX

SHORT APPENDIX
TABLE OF CONTENTS

	<u>Page</u>
 <u><i>SpecialtyCare, Inc. v. Health Care Service Corp., No. 24-cv-12902</i></u> <u><i>(N.D. Ill.), on appeal No. 26-2269 (7th Cir.)</i></u>	
Memorandum Opinion & Order, ECF No. 77 (June 2, 2026).....	APPX68
Final Judgment, ECF No. 78 (June 2, 2026).....	APPX82
 <u><i>SpecialtyCare, Inc. v. Health Care Service Corp., No. 24-cv-12935</i></u> <u><i>(N.D. Ill.), on appeal No. 26-2279 (7th Cir.)</i></u>	
Memorandum Opinion & Order, ECF No. 73 (June 2, 2026)	APPX109
Final Judgment, ECF No. 74 (June 2, 2026).....	APPX123
 <u><i>SpecialtyCare, Inc. v. Health Care Service Corp., No. 24-cv-12945</i></u> <u><i>(N.D. Ill.), on appeal No. 26-2280 (7th Cir.)</i></u>	
Memorandum Opinion & Order, ECF No. 73 (June 2, 2026).....	APPX168
Final Judgment, ECF No. 74 (June 2, 2026).....	APPX182

PHI Health, LLC v. Health Care Service Corp., No. 25-cv-12406
(N.D. Ill.), on appeal No. 26-2401 (7th Cir.)

Memorandum Opinion,
ECF No. 62 (June 23, 2026).....APPX249

Final Judgment,
ECF No. 66 (July 1, 2026).....APPX270

PHI Health, LLC v. Health Care Service Corp., No. 26-cv-2954
(N.D. Ill.), on appeal No. 26-2736 (7th Cir.)

Memorandum Opinion & Order,
ECF No. 42 (Aug. 5, 2026).....APPX363

Final Judgment,
ECF No. 45 (Aug. 18, 2026).....APPX381

**UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

SPECIALTYCARE INC., REMOTE
NEUROMONITORING PHYSICIANS, PC
and SENTIENT PHYSICIANS, PC,

Plaintiffs,

v.

HEALTH CARE SERVICE CORPORATION
d/b/a BLUE CROSS BLUE SHIELD OF
NEW MEXICO,

Defendant.

No. 25 CV 12902

Judge Manish S. Shah

MEMORANDUM OPINION AND ORDER

Plaintiffs SpecialtyCare Inc., Remote Neuromonitoring Physicians, and Sentient Physicians sued defendant Health Care Service Corporation d/b/a Blue Cross Blue Shield of New Mexico for its failure to pay SpecialtyCare money it was ordered to pay after an independent dispute resolution process pursuant to the No Surprises Act. Defendants move to dismiss the complaint for lack of subject-matter jurisdiction and for failure to state a claim upon which relief can be granted. For the reasons discussed below, the motion is granted.

I. Legal Standards

A complaint requires only “a short and plain statement” showing that the plaintiff is entitled to relief. Fed. R. Civ. P. 8(a)(2); *Ashcroft v. Iqbal*, 556 U.S. 662, 677–78 (2009). To survive a motion to dismiss under Fed. R. Civ. P. 12(b)(6), the plaintiff must allege facts that “allow[] the court to draw the reasonable inference

that the defendant is liable for the misconduct alleged.” *Iqbal*, 556 U.S. at 678. “Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements” are insufficient. *Iqbal*, 556 U.S. at 678.

Federal Rule of Civil Procedure 12(b)(1) governs dismissals based on a lack of subject-matter jurisdiction. A complaint must contain “a short and plain statement of the grounds for the court’s jurisdiction.” Fed. R. Civ. P. 8(a)(1). The plaintiff bears the burden of establishing jurisdiction. *Apex Digital, Inc. v. Sears, Roebuck & Co.*, 572 F.3d 440, 443 (7th Cir. 2009).

At this stage, I accept all factual allegations in the complaint as true and draw all reasonable inferences in the plaintiff’s favor. *Iqbal*, 556 U.S. at 678; *Lee v. City of Chicago*, 330 F.3d 456, 468 (7th Cir. 2003).

II. Background

Congress passed the No Surprises Act to protect patients from surprise medical bills when receiving care from out-of-network healthcare providers. *See* 42 U.S.C. § 300gg-111, et seq. Under the Act, health plans and issuers, like Blue Cross Blue Shield of New Mexico, are required to provide coverage for participants and beneficiaries and reimburse providers directly for out-of-network services. 42 U.S.C. § 300gg-111; [37] ¶ 15.¹ The Act sets up an independent dispute resolution process for billing disputes between providers and insurers. 42 U.S.C. § 300gg-111(c). First, the healthcare provider and insurer must try to agree on a price for the services. 42

¹ Bracketed numbers refer to entries on the district court docket. Referenced page numbers are taken from the CM/ECF header placed at the top of filings. The facts are taken from plaintiffs’ amended complaint, [37].

U.S.C. § 300gg-111(c)(1)(A). If the parties cannot come to an agreement, either party may initiate independent dispute resolution proceedings. 42 U.S.C. § 300gg-111(c)(1)(B). A certified independent dispute resolution entity is selected by either the parties or the Department of Health and Human Services and the entity determines the amount the insurer owes the provider by choosing between offers submitted by the parties. 42 U.S.C. § 300gg-111(c)(4)–(5). The certified independent dispute resolution entity’s award is binding on the parties, and payment of the award “shall be made ... not later than 30 days after the date on which such determination is made.” 42 U.S.C. § 300gg-111(c)(5)(E)(i).

Plaintiffs allege that a certified independent dispute resolution entity ordered Blue Cross Blue Shield of New Mexico to pay plaintiffs for services rendered. [37] ¶¶ 6, 21. They allege that Blue Cross Blue Shield of New Mexico has failed to pay and owes \$42,312 in unpaid past due amounts. [37] ¶¶ 6, 22. These payments, plaintiffs say, are well past the thirty-day payment window set in the No Surprises Act. [37] ¶ 23.

III. Analysis

A. Employee Retirement Income Security Act

Plaintiffs bring a claim under ERISA alleging that Blue Cross Blue Shield of New Mexico improperly denied benefits, including the right to payment, to plaintiffs. [37] ¶¶ 46–54. Blue Cross Blue Shield of New Mexico moves to dismiss the claim for lack of subject-matter jurisdiction, arguing that plaintiffs lack “statutory standing.”

Plaintiffs allege that they are beneficiaries under ERISA and are the “real part[ies] in interest as to these claims,” and so have standing. [37] ¶ 47.

The issue in this suit is not one of jurisdictional standing, but “whether [plaintiffs’] claim comes within the zone of interests regulated by a specific statute.” *Penn. Chiropractic Ass’n v. Independence Hosp. Indem. Plan, Inc.*, 802 F.3d 926, 928 (7th Cir. 2015). I “avoid the language of standing and ask instead whether plaintiffs are participants or beneficiaries as ERISA uses those words.” *Id.* Because the issue is whether plaintiffs can state a claim under the ERISA statute, it is analyzed under Rule 12(b)(6), not Rule 12(b)(1).

“A civil action may be brought by a participant or beneficiary [of an ERISA plan] to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B). Plaintiffs are not participants in the plans. *See* 29 U.S.C. § 1002(7) (participant is an employee or former employee who seeks a plan’s benefits). Instead, they say they are beneficiaries. A beneficiary is “a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.” 29 U.S.C. § 1002(8).

“When a ‘participant’ assigns to a medical provider the right to receive the participant’s entitlement under the plan, this makes the provider a ‘beneficiary’” under ERISA. *See Penn. Chiropractic Ass’n*, 802 F.3d at 928. “[A]n assignment puts the assignee into the shoes of the assignor.” *Milam v. Selene Fin., LP*, 163 F.4th 416, 420 (7th Cir. 2025). An assignee cannot have greater rights than the assignor

possessed and can only assert claims that could be brought by the assignor themselves. *Decatur Mem'l Hosp. v. Conn. Gen. Life Ins. Co.*, 990 F.2d 925, 927 (7th Cir. 1993).

Plaintiffs were assigned participants' plan entitlements and so are "beneficiaries" of the Blue Cross Blue Shield of New Mexico plans through assignment. [37] ¶ 47. This includes any entitlement to payment for healthcare services. *See Griffin v. TeamCare*, 909 F.3d 842, 845–46 (7th Cir. 2018). But plaintiffs do not allege that payment was denied, rather, they allege that they were underpaid for their services. [37] ¶¶ 6, 16, 18, 22, 27. There is a difference between a claim that implicates the *rate* of payment, and one that implicates the *right* to payment. *See DB Healthcare, LLC v. Blue Cross Blue Shield of Ariz., Inc.*, 852 F.3d 868, 877–78 (9th Cir. 2017) (claim relating to process of post-payment claims review and practice of recouping erroneous payments are not within the scope of assignment); *Brown v. BlueCross BlueShield of Tennessee, Inc.*, 827 F.3d 543, 548–49 (6th Cir. 2016) (recoupment of payments governed by separate contract between provider and insurer, not the employee benefits agreements, and so outside the scope of assignment); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 530–31 (5th Cir. 2009) (claims for underpayment were "entirely separate from coverage and arise out of the independent legal duty contained in the contract"). The "right to payment" falls within ERISA's "zone of interests" because an outright denial of payment is a denial of benefits, but the "rate of payment" does not, because the rate depends on terms outside the plans themselves (here, the independent dispute

resolution process). *Brown*, 827 F.3d at 548. The Blue Cross Blue Shield of New Mexico plan participants were not parties to the independent dispute resolution process, so they could not bring a suit for underpayment. *Id.* at 549. Because the participants could not bring a suit, the dispute about underpayment “cannot be covered by those members’ assignment of benefits.” *Id.* “While the ultimate effect on [plaintiffs] may be the same (i.e., non-payment), [plaintiffs’] grievance with Blue Cross is uniquely its own; it is not derivative of [plaintiffs’] patients.” *Id.*

That the plaintiffs’ claim falls outside the “zone of interests” regulated by ERISA is “further bolstered by the fact that the patient-assignors are unaffected by the outcome of this litigation.” *Id.* The plan’s participants cannot be billed by the providers to make up for any shortfall. *See* 42 U.S.C. § 300gg-111(a)(1), (b). Because the participants received “all the ‘benefits due to [them] under the terms of [the] plan,” *DaVita Inc. v. Amy’s Kitchen, Inc.*, 981 F.3d 664, 678–79 (9th Cir. 2020), plaintiffs fail to state a claim for improper denial of benefits under ERISA.

B. Section 9 of the Federal Arbitration Act

Plaintiffs say that I can confirm the independent dispute resolution award through Section 9 of the Federal Arbitration Act. Defendants counter that Congress did not incorporate the section into the No Surprises Act, and so it does not apply to the independent dispute resolution award.

FAA Section 9 says that if the parties “in their agreement have agreed that a judgment of the court shall be entered upon the award made pursuant to the arbitration,” a party to an arbitration may apply to the court to confirm the award,

which it must do unless the award is vacated, modified, or corrected as laid out in sections 10 and 11 of the Act. 9 U.S.C. § 9. Section 10 allows a district court to vacate an award if (1) the award was “procured by corruption, fraud, or undue means”; (2) there was “evident partiality or corruption in the arbitrators”; (3) the arbitrators were guilty of misconduct because they refused to postpone a hearing when there was sufficient cause shown, refused to hear pertinent and material evidence, or misbehaved in a way to prejudice the rights of any party; or (4) the arbitrators exceeded their powers or improperly executed them so that a “mutual, final, and definite award” was not made. 9 U.S.C. § 10(a).

Plaintiffs do not argue that the parties had an arbitration agreement; instead, they say that Section 9 does not require one. But the plain language of Section 9 of the FAA requires an “agreement” between the parties that “a judgment of the court shall be entered upon the award made pursuant to [] arbitration.” 9 U.S.C. § 9. “[T]he clear plain language and ordinary meaning of a text controls unless it leads to absurd results contrary to the obvious intent of the drafters.” *United States ex. rel. Streck v. Eli Lilly & Co.*, 152 F.4th 816, 834 (7th Cir. 2025). The text of the statute requires an agreement.

And arbitration “is a matter of contract.” *Gupta v. Morgan Stanley Smith Barney, LLC*, 934 F.3d 705, 710 (7th Cir. 2019). Indeed, it is “strictly ‘a matter of consent,’ ... and thus ‘is a way to resolve those disputes—but only those disputes—that the parties have agreed to submit to arbitration.” *Granite Rock Co. v. Int’l Bhd. of Teamsters*, 561 U.S. 287, 299 (2010) (internal citations omitted) (emphasis in

original). The independent dispute resolution process was not the result of an arbitration agreement, but pursuant to a statute authorizing the process. 42 U.S.C. § 300gg-111(c)(1)(B). It would not lead to absurd results contrary to the intent of the drafters if Section 9 of the FAA did not apply to a statutorily required process.

Plaintiffs argue that an agreement is not necessary for Section 9 to apply. But in each of their cited cases, there was an arbitration agreement. *See Hall St. Assocs., LLC v. Mattel, Inc.*, 552 U.S. 576, 587 n.6 (2008) (discussing the specific language in the agreement and whether specific standards must exist in the agreement to judicially enforce the arbitration award); *Qorvis Comm'ns, LLC v. Wilson*, 549 F.3d 303, 305–06, 308 (4th Cir. 2008) (arbitration clause in employment agreement); *Booth v. Hume Publ'g*, 902 F.2d 925, 930 (11th Cir. 1990) (employment agreement with provision that arbitrator's determination would be final and binding); *George Watts & Son, Inc. v. Tiffany & Co.*, 248 F.3d 577, 579–80 (7th Cir. 2001) (“But Watts does not contend that the arbitrator violated the arbitration agreement in such a fashion.”). Plaintiffs offer no other authority to support their argument that they do not need an agreement to arbitrate for Section 9 to apply.

That the No Surprises Act references 9 U.S.C. § 10(a) does not mean it also incorporated § 9. The Act does not incorporate § 10(a) entirely and instead cross-references four circumstances where a federal court can vacate an arbitration award. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II); 9 U.S.C. § 10(a)(1)–(4). The statute does not reference 9 U.S.C. § 9 in any way. “It is a fundamental principle of statutory interpretation that absent provision[s] cannot be supplied by the courts.” *Rotkiske v.*

Klemm, 589 U.S. 8, 14 (2019) (internal quotation marks and citation omitted). I decline to read an unreferenced provision into the No Surprises Act.

Because there was no arbitration agreement, Section 9 of the FAA does not apply, and Count 1 must be dismissed.

C. Private Cause of Action under the No Surprises Act

Plaintiffs also allege violations of the No Surprises Act, asserting that there is an implied cause of action under the Act.

“[P]rivate rights of action to enforce federal law must be created by Congress.” *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). There are two types of private rights of action: express and implied. *Chi. Tchr. Union, Loc. 1 v. Educators for Excellence, Inc.*, 159 F.4th 524, 528 (7th Cir. 2025). An express right of action is in a statute’s text; an implied right of action is “judicially inferred.” *Id.* To find an implied right of action, “[t]he judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy.” *Sandoval*, 532 U.S. at 286. There is a “strong presumption” against the creation of an implied right of action. *Chi. Tchr. Union*, 159 F.4th at 530. Without congressional intent to create a cause of action, “courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute.” *Sandoval*, 532 U.S. at 286–87.

There is no express right of action in the No Surprises Act. And beyond its silence, the Act bars judicial review of a determination of a certified independent dispute resolution entity except in a case described in paragraphs (1) through (4) of

Section 10(a) of the FAA. 42 U.S.C. § 300gg-111(c)(5)(E). Section 10, in turn, allows a court to vacate an arbitration award for corruption, fraud, partiality, misconduct, or if the arbitrators exceeded their power. 9 U.S.C. § 10(a)(1)–(4); *see* Section III.B. at 7. On its face, the No Surprises Act bars judicial review except in a few limited circumstances, none of which are relevant here. I do not have authority to review the independent dispute resolution entity’s determination.

Plaintiffs argue that implying a private right to seek confirmation or enforcement of an award is not “judicial review.” I disagree. The Supreme Court has explained that the “Federal Arbitration Act ... provides for expedited judicial review to *confirm*, vacate, or modify arbitration awards.” *Hall St. Assocs.*, 552 U.S. at 578 (emphasis added); *see also Concrete Pipe & Prods. of Cali., Inc. v. Constr. Laborers Pension Tr. for S. Cali.*, 508 U.S. 602, 611 (1993) (“The statute provides for judicial review of the arbitrator’s decision by an action in the district court to enforce, vacate, or modify the award.”). Because confirmation of an arbitrator’s award is included in judicial review, I am barred from confirming any independent dispute resolution award.

Even if confirmation of an independent dispute resolution award is not judicial review, the statute’s language does not reflect Congress’s intent to create a private remedy necessary to find an implied cause of action. Under the No Surprises Act, independent dispute resolution determinations “shall be binding upon the parties involved.” 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I). The Act also says that payment “shall be made ... not later than 30 days after the date on which such determination is

made.” 42 U.S.C. § 300gg-111(c)(6). Payment “shall be made directly to the nonparticipating provider or facility.” 42 U.S.C. § 300gg-111(c)(6)

The No Surprises Act confers a right for providers to payment. The Act says that payment “shall” be made to providers, which is “rights-creating” language suggesting an implied right of action. *See Me. Cmty. Health Options v. United States*, 590 U.S. 296, 324 (2020). But “Congress’s use of mandatory language alone is not enough to create an implied private right of action.” *Saloojas, Inc. v. Aetna Health of Cali., Inc.*, 80 F.4th 1011, 1015 (9th Cir. 2023). Congress must intend to create a private remedy. *Sandoval*, 532 U.S. at 286. “Most revealing of Congress’s intent is that [the No Surprises Act] already has a method of enforcement: [42 U.S.C. § 300gg-22(b)(2)].” *Chi. Tchrs. Union*, 159 F.4th at 530. When Congress creates an enforcement mechanism other than a private right of action, it “suggests that Congress intended to preclude others.” *Id.* (quoting *Sandoval*, 532 U.S. at 290).

Congress empowered the Department of Health and Human Services to assess penalties against insurers for failure to comply with the No Surprises Act. *See* 42 U.S.C. § 300gg-22(b)(2); 45 C.F.R. § 150.303. Under the enforcement provision, any health plan or health insurance issuer that fails to comply with an independent dispute resolution determination is liable for up to \$100 for each day of noncompliance. 42 U.S.C. § 300gg-22(b)(2)(C)(i). The regulations implementing the statute also describe the processes for investigating potential violations and assessing civil money penalties for failing to comply with the No Surprises Act. 45 C.F.R. §§ 150.303–150.345. That Congress created an enforcement mechanism for the

Department of Health and Human Services is the “most revealing” clue about Congress’s intent and suggests that Congress did not intend to create a private remedy for providers.

Plaintiffs cite to *Me. Cmty. Health Options* in support of their position. That case involved obligations by the government to pay for goods and services, and whether that obligation fell within the Tucker Act’s immunity waiver, allowing the petitioners to sue the government for unpaid obligations. *Id.* at 307–08, 322. The Tucker Act waives the United States’s immunity for certain damages suits in the Court of Federal Claims. *Id.* at 322. The court held that the “shall pay” language in the statute created an obligation for the government to pay. *Id.* at 314. This language in the Tucker Act context, “often reflects congressional intent to create both a right and remedy.” *Id.* at 324 (internal quotation marks omitted). The Court also reasoned that there was a right of action because the statute focused on “compensating insurers for past conduct” and because there was no separate remedial scheme to enforce the statute. *Id.* at 325–26.

Maine Community, while supportive in some ways of plaintiff’s claim, is not controlling. The Court said that the mandatory language “often” reflects an intent to create a right and remedy, but not always. And the No Surprises Act’s focus is on protecting *patients* from surprise medical bills. *Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 273 (5th Cir. 2025). The Court in *Maine Community* also explained that there was no other enforcement mechanism in the statute, despite the mandatory language. The No Surprises Act has a separate remedial scheme,

which is the “most revealing” factor in determining Congress’s intent. Although the language in the Act is mandatory, which can reflect Congress’s intent in some circumstances, here, where there is an administrative enforcement mechanism and a focus on patients, not providers, there is no clear intent to create an implied cause of action. Because there is no implied cause of action to bring claims for violations of the No Surprises Act, Counts 2 and 3 are dismissed.

D. State-Law Claims

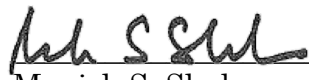
Plaintiffs bring state-law open account, bad faith, and unjust enrichment claims. There is no independent basis for federal jurisdiction, because there are no federal claims remaining and there is no complete diversity between the parties. 28 U.S.C. § 1332; *Jimenez v. Kiefer*, 100 F.4th 931, 936 (7th Cir. 2024); [37] ¶¶ 8–9.² I decline to exercise supplemental jurisdiction under 28 U.S.C. § 1367(c)(3). Plaintiffs’ state-law claims are dismissed.

² Both plaintiff Sentient Physicians, PC and defendant Blue Cross Blue Shield of New Mexico are citizens of Illinois.

IV. Conclusion

Defendant's motion to dismiss, [40], is granted. The federal claims are dismissed with prejudice and the state-law claims are dismissed without prejudice.³ Enter judgment and terminate civil case.

ENTER:



Manish S. Shah
United States District Judge

Date: June 2, 2026

³ Plaintiffs are “generally entitled to at least one chance to amend their complaint to cure an error in response to a district court’s dismissal order unless amendment would be futile.” *Hernandez v. Ill. Inst. of Tech.*, 63 F.4th 661, 671–72 (7th Cir. 2023) (internal quotation marks and citation omitted). Because underpayment is not within the zone of interests regulated by ERISA, Section 9 of the FAA does not apply, and the No Surprises Act does not confer a private cause of action, any amendment to these counts would be futile.

**IN THE UNITED STATES DISTRICT COURT
FOR THE
NORTHERN DISTRICT OF ILLINOIS**

SpecialtyCare, Inc., et al.,

Plaintiffs,

v.

Health Care Service Corporation d/b/a Blue Cross
Blue Shield of New Mexico,

Defendants.

Case No. 24-cv-12902
Judge Manish Shah

JUDGMENT IN A CIVIL CASE

Judgment is hereby entered (check appropriate box):

☐ in favor of plaintiff(s)
and against defendant(s)
in the amount of \$ _____,

which ☐ includes _____ pre-judgment interest.
☐ does not include pre-judgment interest.

Post-judgment interest accrues on that amount at the rate provided by law from the date of this judgment.

Plaintiff(s) shall recover costs from defendant(s).

☐ in favor of defendant(s)
and against plaintiff(s)

Defendant(s) shall recover costs from plaintiff(s).

☒ other: In favor of defendant Health Care Service Corporation d/b/a Blue Cross Blue Shield of New Mexico and against plaintiffs SpecialtyCare, Inc., Remote Neuromonitoring Physicians, PC, and Sentient Physicians, PC. The federal claims are dismissed with prejudice and the state-law claims are dismissed without prejudice.

This action was (*check one*):

☐ tried by a jury with Judge Manish Shah presiding, and the jury has rendered a verdict.
☐ tried by Judge Manish Shah without a jury and the above decision was reached.
☒ decided by Judge Manish Shah on a motion.

Date: 6/2/2026

Thomas G. Bruton, Clerk of Court

APPX82

/Susan McClintic , Deputy Clerk

**UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

SPECIALTYCARE INC., REMOTE
NEUROMONITORING PHYSICIANS, PC
and SENTIENT PHYSICIANS, PC,

Plaintiffs,

v.

HEALTH CARE SERVICE CORPORATION
d/b/a BLUE CROSS BLUE SHIELD OF
ILLINOIS,

Defendant.

No. 25 CV 12935

Judge Manish S. Shah

MEMORANDUM OPINION AND ORDER

Plaintiffs SpecialtyCare Inc., Remote Neuromonitoring Physicians, and Sentient Physicians sued defendant Health Care Service Corporation d/b/a Blue Cross Blue Shield of Illinois for its failure to pay SpecialtyCare money it was ordered to pay after an independent dispute resolution process pursuant to the No Surprises Act. Defendants move to dismiss the complaint for lack of subject-matter jurisdiction and for failure to state a claim upon which relief can be granted. For the reasons discussed below, the motion is granted.

I. Legal Standards

A complaint requires only “a short and plain statement” showing that the plaintiff is entitled to relief. Fed. R. Civ. P. 8(a)(2); *Ashcroft v. Iqbal*, 556 U.S. 662, 677–78 (2009). To survive a motion to dismiss under Fed. R. Civ. P. 12(b)(6), the plaintiff must allege facts that “allow[] the court to draw the reasonable inference

that the defendant is liable for the misconduct alleged.” *Iqbal*, 556 U.S. at 678. “Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements” are insufficient. *Iqbal*, 556 U.S. at 678.

Federal Rule of Civil Procedure 12(b)(1) governs dismissals based on a lack of subject-matter jurisdiction. A complaint must contain “a short and plain statement of the grounds for the court’s jurisdiction.” Fed. R. Civ. P. 8(a)(1). The plaintiff bears the burden of establishing jurisdiction. *Apex Digital, Inc. v. Sears, Roebuck & Co.*, 572 F.3d 440, 443 (7th Cir. 2009).

At this stage, I accept all factual allegations in the complaint as true and draw all reasonable inferences in the plaintiff’s favor. *Iqbal*, 556 U.S. at 678; *Lee v. City of Chicago*, 330 F.3d 456, 468 (7th Cir. 2003).

II. Background

Congress passed the No Surprises Act to protect patients from surprise medical bills when receiving care from out-of-network healthcare providers. *See* 42 U.S.C. § 300gg-111, et seq. Under the Act, health plans and issuers, like Blue Cross Blue Shield of Illinois, are required to provide coverage for participants and beneficiaries and reimburse providers directly for out-of-network services. 42 U.S.C. § 300gg-111; [33] ¶ 15.¹ The Act sets up an independent dispute resolution process for billing disputes between providers and insurers. 42 U.S.C. § 300gg-111(c). First, the healthcare provider and insurer must try to agree on a price for the services. 42 U.S.C.

¹ Bracketed numbers refer to entries on the district court docket. Referenced page numbers are taken from the CM/ECF header placed at the top of filings. The facts are taken from plaintiffs’ amended complaint, [33].

§ 300gg-111(c)(1)(A). If the parties cannot come to an agreement, either party may initiate independent dispute resolution proceedings. 42 U.S.C. § 300gg-111(c)(1)(B). A certified independent dispute resolution entity is selected by either the parties or the Department of Health and Human Services and the entity determines the amount the insurer owes the provider by choosing between offers submitted by the parties. 42 U.S.C. § 300gg-111(c)(4)–(5). The certified independent dispute resolution entity’s award is binding on the parties, and payment of the award “shall be made ... not later than 30 days after the date on which such determination is made.” 42 U.S.C. § 300gg-111(c)(5)(E)(i).

Plaintiffs allege that a certified independent dispute resolution entity ordered Blue Cross Blue Shield of Illinois to pay plaintiffs for services rendered. [33] ¶¶ 6, 21. They allege that Blue Cross Blue Shield of Illinois has failed to pay and owes \$274,434 in unpaid past due amounts. [33] ¶¶ 6, 22. These payments, plaintiffs say, are well past the thirty-day payment window set in the No Surprises Act. [33] ¶ 23.

III. Analysis

A. Employee Retirement Income Security Act

Plaintiffs bring a claim under ERISA, alleging that Blue Cross Blue Shield of Illinois improperly denied benefits, including the right to payment, to plaintiffs. [33] ¶¶ 52–60. Blue Cross Blue Shield of Illinois moves to dismiss the claim for lack of subject-matter jurisdiction, arguing that plaintiffs lack “statutory standing.” Plaintiffs allege that they are beneficiaries under ERISA and are the “real part[ies] in interest as to these claims,” and so have standing. [33] ¶ 53.

The issue in this suit is not one of jurisdictional standing, but “whether [plaintiffs’] claim comes within the zone of interests regulated by a specific statute.” *Penn. Chiropractic Ass’n v. Independence Hosp. Indem. Plan, Inc.*, 802 F.3d 926, 928 (7th Cir. 2015). I “avoid the language of standing and ask instead whether plaintiffs are participants or beneficiaries as ERISA uses those words.” *Id.* Because the issue is whether plaintiffs can state a claim under the ERISA statute, it is analyzed under Rule 12(b)(6), not Rule 12(b)(1).

“A civil action may be brought by a participant or beneficiary [of an ERISA plan] to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B). Plaintiffs are not participants in the plans. *See* 29 U.S.C. § 1002(7) (participant is an employee or former employee who seeks a plan’s benefits). Instead, they say they are beneficiaries. A beneficiary is “a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.” 29 U.S.C. § 1002(8).

“When a ‘participant’ assigns to a medical provider the right to receive the participant’s entitlement under the plan, this makes the provider a ‘beneficiary’” under ERISA. *See Penn. Chiropractic Ass’n*, 802 F.3d at 928. “[A]n assignment puts the assignee into the shoes of the assignor.” *Milam v. Selene Fin., LP*, 163 F.4th 416, 420 (7th Cir. 2025). An assignee cannot have greater rights than the assignor possessed and can only assert claims that could be brought by the assignor

themselves. *Decatur Mem'l Hosp. v. Conn. Gen. Life Ins. Co.*, 990 F.2d 925, 927 (7th Cir. 1993).

Plaintiffs were assigned participants' plan entitlements and so are "beneficiaries" of the Blue Cross Blue Shield of Illinois plans through assignment. [33] ¶ 53. This includes any entitlement to payment for healthcare services. *See Griffin v. TeamCare*, 909 F.3d 842, 845–46 (7th Cir. 2018). But plaintiffs do not allege that payment was denied, rather, they allege that they were underpaid for their services. [33] ¶¶ 6, 16, 18, 22, 27. There is a difference between a claim that implicates the *rate* of payment, and one that implicates the *right* to payment. *See DB Healthcare, LLC v. Blue Cross Blue Shield of Ariz., Inc.*, 852 F.3d 868, 877–78 (9th Cir. 2017) (claim relating to process of post-payment claims review and practice of recouping erroneous payments are not within the scope of assignment); *Brown v. BlueCross BlueShield of Tennessee, Inc.*, 827 F.3d 543, 548–49 (6th Cir. 2016) (recoupment of payments governed by separate contract between provider and insurer, not the employee benefits agreements, and so outside the scope of assignment); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 530–31 (5th Cir. 2009) (claims for underpayment were "entirely separate from coverage and arise out of the independent legal duty contained in the contract"). The "right to payment" falls within ERISA's "zone of interests" because an outright denial of payment is a denial of benefits, but the "rate of payment" does not, because the rate depends on terms outside the plans themselves (here, the independent dispute resolution process). *Brown*, 827 F.3d at 548. The Blue Cross Blue Shield of Illinois plan participants were

not parties to the independent dispute resolution process, so they could not bring a suit for underpayment. *Id.* at 549. Because the participants could not bring a suit, the dispute about underpayment “cannot be covered by those members’ assignment of benefits.” *Id.* “While the ultimate effect on [plaintiffs] may be the same (i.e., non-payment), [plaintiffs’] grievance with Blue Cross is uniquely its own; it is not derivative of [plaintiffs’] patients.” *Id.*

That the plaintiffs’ claim falls outside the “zone of interests” regulated by ERISA is “further bolstered by the fact that the patient-assignors are unaffected by the outcome of this litigation.” *Id.* The plan’s participants cannot be billed by the providers to make up for any shortfall. *See* 42 U.S.C. § 300gg-111(a)(1), (b). Because the participants received “all the ‘benefits due to [them] under the terms of [the] plan,” *DaVita Inc. v. Amy’s Kitchen, Inc.*, 981 F.3d 664, 678–79 (9th Cir. 2020), plaintiffs fail to state a claim for improper denial of benefits under ERISA.

B. Section 9 of the Federal Arbitration Act

Plaintiffs say that I can confirm the independent dispute resolution award through Section 9 of the Federal Arbitration Act. Defendants counter that Congress did not incorporate the section into the No Surprises Act, and so it does not apply to the independent dispute resolution award.

FAA Section 9 says that if the parties “in their agreement have agreed that a judgment of the court shall be entered upon the award made pursuant to the arbitration,” a party to an arbitration may apply to the court to confirm the award, which it must do unless the award is vacated, modified, or corrected as laid out in

sections 10 and 11 of the Act. 9 U.S.C. § 9. Section 10 allows a district court to vacate an award if (1) the award was “procured by corruption, fraud, or undue means”; (2) there was “evident partiality or corruption in the arbitrators”; (3) the arbitrators were guilty of misconduct because they refused to postpone a hearing when there was sufficient cause shown, refused to hear pertinent and material evidence, or misbehaved in a way to prejudice the rights of any party; or (4) the arbitrators exceeded their powers or improperly executed them so that a “mutual, final, and definite award” was not made. 9 U.S.C. § 10(a).

Plaintiffs do not argue that the parties had an arbitration agreement; instead, they say that Section 9 does not require one. But the plain language of Section 9 of the FAA requires an “agreement” between the parties that “a judgment of the court shall be entered upon the award made pursuant to [] arbitration.” 9 U.S.C. § 9. “[T]he clear plain language and ordinary meaning of a text controls unless it leads to absurd results contrary to the obvious intent of the drafters.” *United States ex. rel. Streck v. Eli Lilly & Co.*, 152 F.4th 816, 834 (7th Cir. 2025). The text of the statute requires an agreement.

And arbitration “is a matter of contract.” *Gupta v. Morgan Stanley Smith Barney, LLC*, 934 F.3d 705, 710 (7th Cir. 2019). Indeed, it is “strictly ‘a matter of consent,’ ... and thus ‘is a way to resolve those disputes—but only those disputes—that the parties have agreed to submit to arbitration.” *Granite Rock Co. v. Int’l Bhd. of Teamsters*, 561 U.S. 287, 299 (2010) (internal citations omitted) (emphasis in original). The independent dispute resolution process was not the result of an

arbitration agreement, but pursuant to a statute authorizing the process. 42 U.S.C. § 300gg-111(c)(1)(B). It would not lead to absurd results contrary to the intent of the drafters if Section 9 of the FAA did not apply to a statutorily required process.

Plaintiffs argue that an agreement is not necessary for Section 9 to apply. But in each of their cited cases, there was an arbitration agreement. *See Hall St. Assocs., LLC v. Mattel, Inc.*, 552 U.S. 576, 587 n.6 (2008) (discussing the specific language in the agreement and whether specific standards must exist in the agreement to judicially enforce the arbitration award); *Qorvis Comm'ns, LLC v. Wilson*, 549 F.3d 303, 305–06, 308 (4th Cir. 2008) (arbitration clause in employment agreement); *Booth v. Hume Publ'g*, 902 F.2d 925, 930 (11th Cir. 1990) (employment agreement with provision that arbitrator's determination would be final and binding); *George Watts & Son, Inc. v. Tiffany & Co.*, 248 F.3d 577, 579–80 (7th Cir. 2001) (“But Watts does not contend that the arbitrator violated the arbitration agreement in such a fashion.”). Plaintiffs offer no other authority to support their argument that they do not need an agreement to arbitrate for Section 9 to apply.

That the No Surprises Act references 9 U.S.C. § 10(a) does not mean it also incorporated § 9. The Act does not incorporate § 10(a) entirely and instead cross-references four circumstances where a federal court can vacate an arbitration award. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II); 9 U.S.C. § 10(a)(1)–(4). The statute does not reference 9 U.S.C. § 9 in any way. “It is a fundamental principle of statutory interpretation that absent provision[s] cannot be supplied by the courts.” *Rotkiske v.*

Klemm, 589 U.S. 8, 14 (2019) (internal quotation marks and citation omitted). I decline to read an unreferenced provision into the No Surprises Act.

Because there was no arbitration agreement, Section 9 of the FAA does not apply, and Count 1 must be dismissed.

C. Private Cause of Action under the No Surprises Act

Plaintiffs also allege violations of the No Surprises Act, asserting that there is an implied cause of action under the Act.

“[P]rivate rights of action to enforce federal law must be created by Congress.” *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). There are two types of private rights of action: express and implied. *Chi. Tchr. Union, Loc. 1 v. Educators for Excellence, Inc.*, 159 F.4th 524, 528 (7th Cir. 2025). An express right of action is in a statute’s text; an implied right of action is “judicially inferred.” *Id.* To find an implied right of action, “[t]he judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy.” *Sandoval*, 532 U.S. at 286. There is a “strong presumption” against the creation of an implied right of action. *Chi. Tchr. Union*, 159 F.4th at 530. Without congressional intent to create a cause of action, “courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute.” *Sandoval*, 532 U.S. at 286–87.

There is no express right of action in the No Surprises Act. And beyond its silence, the Act bars judicial review of a determination of a certified independent dispute resolution entity except in a case described in paragraphs (1) through (4) of

Section 10(a) of the FAA. 42 U.S.C. § 300gg-111(c)(5)(E). Section 10, in turn, allows a court to vacate an arbitration award for corruption, fraud, partiality, misconduct, or if the arbitrators exceeded their power. 9 U.S.C. § 10(a)(1)–(4); *see* Section III.B. at 7. On its face, the No Surprises Act bars judicial review except in a few limited circumstances, none of which are relevant here. I do not have authority to review the independent dispute resolution entity’s determination.

Plaintiffs argue that implying a private right to seek confirmation or enforcement of an award is not “judicial review.” I disagree. The Supreme Court has explained that the “Federal Arbitration Act ... provides for expedited judicial review to *confirm*, vacate, or modify arbitration awards.” *Hall St. Assocs.*, 552 U.S. at 578 (emphasis added); *see also Concrete Pipe & Prods. of Cali., Inc. v. Constr. Laborers Pension Tr. for S. Cali.*, 508 U.S. 602, 611 (1993) (“The statute provides for judicial review of the arbitrator’s decision by an action in the district court to enforce, vacate, or modify the award.”). Because confirmation of an arbitrator’s award is included in judicial review, I am barred from confirming any independent dispute resolution award.

Even if confirmation of an independent dispute resolution award is not judicial review, the statute’s language does not reflect Congress’s intent to create a private remedy necessary to find an implied cause of action. Under the No Surprises Act, independent dispute resolution determinations “shall be binding upon the parties involved.” 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I). The Act also says that payment “shall be made ... not later than 30 days after the date on which such determination is

made.” 42 U.S.C. § 300gg-111(c)(6). Payment “shall be made directly to the nonparticipating provider or facility.” 42 U.S.C. § 300gg-111(c)(6)

The No Surprises Act confers a right for providers to payment. The Act says that payment “shall” be made to providers, which is “rights-creating” language suggesting an implied right of action. *See Me. Cmty. Health Options v. United States*, 590 U.S. 296, 324 (2020). But “Congress’s use of mandatory language alone is not enough to create an implied private right of action.” *Saloojas, Inc. v. Aetna Health of Cali., Inc.*, 80 F.4th 1011, 1015 (9th Cir. 2023). Congress must intend to create a private remedy. *Sandoval*, 532 U.S. at 286. “Most revealing of Congress’s intent is that [the No Surprises Act] already has a method of enforcement: [42 U.S.C. § 300gg-22(b)(2)].” *Chi. Tchrs. Union*, 159 F.4th at 530. When Congress creates an enforcement mechanism other than a private right of action, it “suggests that Congress intended to preclude others.” *Id.* (quoting *Sandoval*, 532 U.S. at 290).

Congress empowered the Department of Health and Human Services to assess penalties against insurers for failure to comply with the No Surprises Act. *See* 42 U.S.C. § 300gg-22(b)(2); 45 C.F.R. § 150.303. Under the enforcement provision, any health plan or health insurance issuer that fails to comply with an independent dispute resolution determination is liable for up to \$100 for each day of noncompliance. 42 U.S.C. § 300gg-22(b)(2)(C)(i). The regulations implementing the statute also describe the processes for investigating potential violations and assessing civil money penalties for failing to comply with the No Surprises Act. 45 C.F.R. §§ 150.303–150.345. That Congress created an enforcement mechanism for the

Department of Health and Human Services is the “most revealing” clue about Congress’s intent and suggests that Congress did not intend to create a private remedy for providers.

Plaintiffs cite to *Me. Cmty. Health Options* in support of their position. That case involved obligations by the government to pay for goods and services, and whether that obligation fell within the Tucker Act’s immunity waiver, allowing the petitioners to sue the government for unpaid obligations. *Id.* at 307–08, 322. The Tucker Act waives the United States’s immunity for certain damages suits in the Court of Federal Claims. *Id.* at 322. The court held that the “shall pay” language in the statute created an obligation for the government to pay. *Id.* at 314. This language in the Tucker Act context, “often reflects congressional intent to create both a right and remedy.” *Id.* at 324 (internal quotation marks omitted). The Court also reasoned that there was a right of action because the statute focused on “compensating insurers for past conduct” and because there was no separate remedial scheme to enforce the statute. *Id.* at 325–26.

Maine Community, while supportive in some ways of plaintiff’s claim, is not controlling. The Court said that the mandatory language “*often*” reflects an intent to create a right and remedy, but not always. And the No Surprises Act’s focus is on protecting *patients* from surprise medical bills. *Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 273 (5th Cir. 2025). The Court in *Maine Community* also explained that there was no other enforcement mechanism in the statute, despite the mandatory language. The No Surprises Act has a separate remedial scheme,

which is the “most revealing” factor in determining Congress’s intent. Although the language in the Act is mandatory, which can reflect Congress’s intent in some circumstances, here, where there is an administrative enforcement mechanism and a focus on patients, not providers, there is no clear intent to create an implied cause of action. Because there is no implied cause of action to bring claims for violations of the No Surprises Act, Counts 3 and 4 are dismissed.

D. State-Law Claims

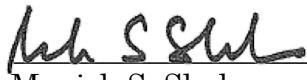
Plaintiffs bring state-law claims for open account, bad faith, unjust enrichment, and violations of the Illinois statute requiring compliance with the No Surprises Act. There is no independent basis for federal jurisdiction, because there are no federal claims remaining and there is no complete diversity between the parties. 28 U.S.C. § 1332; *Jimenez v. Kiefer*, 100 F.4th 931, 936 (7th Cir. 2024); [33] ¶¶ 8–9.² I decline to exercise supplemental jurisdiction under 28 U.S.C. § 1367(c)(3). Plaintiffs’ state-law claims are dismissed.

² Both plaintiff Sentient Physicians, PC and defendant Blue Cross Blue Shield of Illinois are citizens of Illinois.

IV. Conclusion

Defendant's motion to dismiss, [36], is granted. The federal claims are dismissed with prejudice and the state-law claims are dismissed without prejudice.³ Enter judgment and terminate civil case.

ENTER:



Manish S. Shah
United States District Judge

Date: June 2, 2026

³ Plaintiffs are “generally entitled to at least one chance to amend their complaint to cure an error in response to a district court’s dismissal order unless amendment would be futile.” *Hernandez v. Ill. Inst. of Tech.*, 63 F.4th 661, 671–72 (7th Cir. 2023) (internal quotation marks and citation omitted). Because underpayment is not within the zone of interests regulated by ERISA, Section 9 of the FAA does not apply, and the No Surprises Act does not confer a private cause of action, any amendment to these counts would be futile.

**IN THE UNITED STATES DISTRICT COURT
FOR THE
NORTHERN DISTRICT OF ILLINOIS**

SpecialtyCare, Inc.,

Plaintiff,

v.

Health Care Service Corporation d/b/a Blue Cross
Blue Shield of Illinois, et al.,

Defendants.

Case No. 24-cv-12935
Judge Manish Shah

JUDGMENT IN A CIVIL CASE

Judgment is hereby entered (check appropriate box):

☐ in favor of plaintiff(s)
and against defendant(s)
in the amount of \$ _____,

which ☐ includes _____ pre-judgment interest.
☐ does not include pre-judgment interest.

Post-judgment interest accrues on that amount at the rate provided by law from the date of this judgment.

Plaintiff(s) shall recover costs from defendant(s).

☐ in favor of defendant(s)
and against plaintiff(s)

Defendant(s) shall recover costs from plaintiff(s).

☒ other: In favor of defendant Health Care Service Corporation d/b/a Blue Cross Blue Shield of Illinois and against plaintiffs SpecialtyCare, Inc., Remote Neuromonitoring Physicians, PC, and Sentient Physicians, PC. The federal claims are dismissed with prejudice and the state-law claims are dismissed without prejudice.

This action was (*check one*):

☐ tried by a jury with Judge Manish Shah presiding, and the jury has rendered a verdict.
☐ tried by Judge Manish Shah without a jury and the above decision was reached.
☒ decided by Judge Manish Shah on a motion.

Date: 6/2/2026

Thomas G. Bruton, Clerk of Court

APPX123

ILND 450 (Rev. 10/13) Judgment in a Civil Action Case: 1:24-cv-12935 Document #: 74 Filed: 06/02/26 Page 2 of 2 PageID #:585

/Susan McClintic , Deputy Clerk

APPX124

**UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

SPECIALTYCARE INC., REMOTE
NEUROMONITORING PHYSICIANS, PC
and SENTIENT PHYSICIANS, PC,

Plaintiffs,

v.

HEALTH CARE SERVICE CORPORATION
d/b/a BLUE CROSS BLUE SHIELD OF
TEXAS,

Defendant.

No. 25 CV 12945

Judge Manish S. Shah

MEMORANDUM OPINION AND ORDER

Plaintiffs SpecialtyCare Inc., Remote Neuromonitoring Physicians, and Sentient Physicians sued defendant Health Care Service Corporation d/b/a Blue Cross Blue Shield of Texas for its failure to pay SpecialtyCare money it was ordered to pay after an independent dispute resolution process pursuant to the No Surprises Act. Defendants move to dismiss the complaint for lack of subject-matter jurisdiction and for failure to state a claim upon which relief can be granted. For the reasons discussed below, the motion is granted.

I. Legal Standards

A complaint requires only “a short and plain statement” showing that the plaintiff is entitled to relief. Fed. R. Civ. P. 8(a)(2); *Ashcroft v. Iqbal*, 556 U.S. 662, 677–78 (2009). To survive a motion to dismiss under Fed. R. Civ. P. 12(b)(6), the plaintiff must allege facts that “allow[] the court to draw the reasonable inference

that the defendant is liable for the misconduct alleged.” *Iqbal*, 556 U.S. at 678. “Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements” are insufficient. *Iqbal*, 556 U.S. at 678.

Federal Rule of Civil Procedure 12(b)(1) governs dismissals based on a lack of subject-matter jurisdiction. A complaint must contain “a short and plain statement of the grounds for the court’s jurisdiction.” Fed. R. Civ. P. 8(a)(1). The plaintiff bears the burden of establishing jurisdiction. *Apex Digital, Inc. v. Sears, Roebuck & Co.*, 572 F.3d 440, 443 (7th Cir. 2009).

At this stage, I accept all factual allegations in the complaint as true and draw all reasonable inferences in the plaintiff’s favor. *Iqbal*, 556 U.S. at 678; *Lee v. City of Chicago*, 330 F.3d 456, 468 (7th Cir. 2003).

II. Background

Congress passed the No Surprises Act to protect patients from surprise medical bills when receiving care from out-of-network healthcare providers. *See* 42 U.S.C. § 300gg-111, et seq. Under the Act, health plans and issuers, like Blue Cross Blue Shield of Texas, are required to provide coverage for participants and beneficiaries and reimburse providers directly for out-of-network services. 42 U.S.C. § 300gg-111; [33] ¶ 15.¹ The Act sets up an independent dispute resolution process for billing disputes between providers and insurers. 42 U.S.C. § 300gg-111(c). First, the healthcare provider and insurer must try to agree on a price for the services. 42 U.S.C.

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§ 300gg-111(c)(1)(A). If the parties cannot come to an agreement, either party may initiate independent dispute resolution proceedings. 42 U.S.C. § 300gg-111(c)(1)(B). A certified independent dispute resolution entity is selected by either the parties or the Department of Health and Human Services and the entity determines the amount the insurer owes the provider by choosing between offers submitted by the parties. 42 U.S.C. § 300gg-111(c)(4)–(5). The certified independent dispute resolution entity’s award is binding on the parties, and payment of the award “shall be made ... not later than 30 days after the date on which such determination is made.” 42 U.S.C. § 300gg-111(c)(5)(E)(i).

Plaintiffs allege that a certified independent dispute resolution entity ordered Blue Cross Blue Shield of Texas to pay plaintiffs for services rendered. [33] ¶¶ 6, 21. They allege that Blue Cross Blue Shield of Texas has failed to pay and owes \$1,864,562 in unpaid past due amounts. [33] ¶¶ 6, 22. These payments, plaintiffs say, are well past the thirty-day payment window set in the No Surprises Act. [33] ¶ 23.

III. Analysis

A. Employee Retirement Income Security Act

Plaintiffs bring a claim under ERISA, alleging that Blue Cross Blue Shield of Texas improperly denied benefits, including the right to payment, to plaintiffs. [33] ¶¶ 46–54. Blue Cross Blue Shield of Texas moves to dismiss the claim for lack of subject-matter jurisdiction, arguing that plaintiffs lack “statutory standing.” Plaintiffs allege that they are beneficiaries under ERISA and are the “real part[ies] in interest as to these claims,” and so have standing. [33] ¶ 47.

The issue in this suit is not one of jurisdictional standing, but “whether [plaintiffs’] claim comes within the zone of interests regulated by a specific statute.” *Penn. Chiropractic Ass’n v. Independence Hosp. Indem. Plan, Inc.*, 802 F.3d 926, 928 (7th Cir. 2015). I “avoid the language of standing and ask instead whether plaintiffs are participants or beneficiaries as ERISA uses those words.” *Id.* Because the issue is whether plaintiffs can state a claim under the ERISA statute, it is analyzed under Rule 12(b)(6), not Rule 12(b)(1).

“A civil action may be brought by a participant or beneficiary [of an ERISA plan] to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B). Plaintiffs are not participants in the plans. *See* 29 U.S.C. § 1002(7) (participant is an employee or former employee who seeks a plan’s benefits). Instead, they say they are beneficiaries. A beneficiary is “a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.” 29 U.S.C. § 1002(8).

“When a ‘participant’ assigns to a medical provider the right to receive the participant’s entitlement under the plan, this makes the provider a ‘beneficiary’” under ERISA. *See Penn. Chiropractic Ass’n*, 802 F.3d at 928. “[A]n assignment puts the assignee into the shoes of the assignor.” *Milam v. Selene Fin., LP*, 163 F.4th 416, 420 (7th Cir. 2025). An assignee cannot have greater rights than the assignor possessed and can only assert claims that could be brought by the assignor

themselves. *Decatur Mem'l Hosp. v. Conn. Gen. Life Ins. Co.*, 990 F.2d 925, 927 (7th Cir. 1993).

Plaintiffs were assigned participants' plan entitlements and so are "beneficiaries" of the Blue Cross Blue Shield of Texas plans through assignment. [33] ¶ 47. This includes any entitlement to payment for healthcare services. *See Griffin v. TeamCare*, 909 F.3d 842, 845–46 (7th Cir. 2018). But plaintiffs do not allege that payment was denied, rather, they allege that they were underpaid for their services. [33] ¶¶ 6, 16, 18, 22, 27. There is a difference between a claim that implicates the *rate* of payment, and one that implicates the *right* to payment. *See DB Healthcare, LLC v. Blue Cross Blue Shield of Ariz., Inc.*, 852 F.3d 868, 877–78 (9th Cir. 2017) (claim relating to process of post-payment claims review and practice of recouping erroneous payments are not within the scope of assignment); *Brown v. BlueCross BlueShield of Tennessee, Inc.*, 827 F.3d 543, 548–49 (6th Cir. 2016) (recoupment of payments governed by separate contract between provider and insurer, not the employee benefits agreements, and so outside the scope of assignment); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 530–31 (5th Cir. 2009) (claims for underpayment were "entirely separate from coverage and arise out of the independent legal duty contained in the contract"). The "right to payment" falls within ERISA's "zone of interests" because an outright denial of payment is a denial of benefits, but the "rate of payment" does not, because the rate depends on terms outside the plans themselves (here, the independent dispute resolution process). *Brown*, 827 F.3d at 548. The Blue Cross Blue Shield of Texas plan participants were

not parties to the independent dispute resolution process, so they could not bring a suit for underpayment. *Id.* at 549. Because the participants could not bring a suit, the dispute about underpayment “cannot be covered by those members’ assignment of benefits.” *Id.* “While the ultimate effect on [plaintiffs] may be the same (i.e., non-payment), [plaintiffs’] grievance with Blue Cross is uniquely its own; it is not derivative of [plaintiffs’] patients.” *Id.*

That the plaintiffs’ claim falls outside the “zone of interests” regulated by ERISA is “further bolstered by the fact that the patient-assignors are unaffected by the outcome of this litigation.” *Id.* The plan’s participants cannot be billed by the providers to make up for any shortfall. *See* 42 U.S.C. § 300gg-111(a)(1), (b). Because the participants received “all the ‘benefits due to [them] under the terms of [the] plan,” *DaVita Inc. v. Amy’s Kitchen, Inc.*, 981 F.3d 664, 678–79 (9th Cir. 2020), plaintiffs fail to state a claim for improper denial of benefits under ERISA.

B. Section 9 of the Federal Arbitration Act

Plaintiffs say that I can confirm the independent dispute resolution award through Section 9 of the Federal Arbitration Act. Defendants counter that Congress did not incorporate the section into the No Surprises Act, and so it does not apply to the independent dispute resolution award.

FAA Section 9 says that if the parties “in their agreement have agreed that a judgment of the court shall be entered upon the award made pursuant to the arbitration,” a party to an arbitration may apply to the court to confirm the award, which it must do unless the award is vacated, modified, or corrected as laid out in

sections 10 and 11 of the Act. 9 U.S.C. § 9. Section 10 allows a district court to vacate an award if (1) the award was “procured by corruption, fraud, or undue means”; (2) there was “evident partiality or corruption in the arbitrators”; (3) the arbitrators were guilty of misconduct because they refused to postpone a hearing when there was sufficient cause shown, refused to hear pertinent and material evidence, or misbehaved in a way to prejudice the rights of any party; or (4) the arbitrators exceeded their powers or improperly executed them so that a “mutual, final, and definite award” was not made. 9 U.S.C. § 10(a).

Plaintiffs do not argue that the parties had an arbitration agreement; instead, they say that Section 9 does not require one. But the plain language of Section 9 of the FAA requires an “agreement” between the parties that “a judgment of the court shall be entered upon the award made pursuant to [] arbitration.” 9 U.S.C. § 9. “[T]he clear plain language and ordinary meaning of a text controls unless it leads to absurd results contrary to the obvious intent of the drafters.” *United States ex. rel. Streck v. Eli Lilly & Co.*, 152 F.4th 816, 834 (7th Cir. 2025). The text of the statute requires an agreement.

And arbitration “is a matter of contract.” *Gupta v. Morgan Stanley Smith Barney, LLC*, 934 F.3d 705, 710 (7th Cir. 2019). Indeed, it is “strictly ‘a matter of consent,’ ... and thus ‘is a way to resolve those disputes—but only those disputes—that the parties have agreed to submit to arbitration.” *Granite Rock Co. v. Int’l Bhd. of Teamsters*, 561 U.S. 287, 299 (2010) (internal citations omitted) (emphasis in original). The independent dispute resolution process was not the result of an

arbitration agreement, but pursuant to a statute authorizing the process. 42 U.S.C. § 300gg-111(c)(1)(B). It would not lead to absurd results contrary to the intent of the drafters if Section 9 of the FAA did not apply to a statutorily required process.

Plaintiffs argue that an agreement is not necessary for Section 9 to apply. But in each of their cited cases, there was an arbitration agreement. *See Hall St. Assocs., LLC v. Mattel, Inc.*, 552 U.S. 576, 587 n.6 (2008) (discussing the specific language in the agreement and whether specific standards must exist in the agreement to judicially enforce the arbitration award); *Qorvis Comm'ns, LLC v. Wilson*, 549 F.3d 303, 305–06, 308 (4th Cir. 2008) (arbitration clause in employment agreement); *Booth v. Hume Publ'g*, 902 F.2d 925, 930 (11th Cir. 1990) (employment agreement with provision that arbitrator's determination would be final and binding); *George Watts & Son, Inc. v. Tiffany & Co.*, 248 F.3d 577, 579–80 (7th Cir. 2001) (“But Watts does not contend that the arbitrator violated the arbitration agreement in such a fashion.”). Plaintiffs offer no other authority to support their argument that they do not need an agreement to arbitrate for Section 9 to apply.

That the No Surprises Act references 9 U.S.C. § 10(a) does not mean it also incorporated § 9. The Act does not incorporate § 10(a) entirely and instead cross-references four circumstances where a federal court can vacate an arbitration award. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II); 9 U.S.C. § 10(a)(1)–(4). The statute does not reference 9 U.S.C. § 9 in any way. “It is a fundamental principle of statutory interpretation that absent provision[s] cannot be supplied by the courts.” *Rotkiske v.*

Klemm, 589 U.S. 8, 14 (2019) (internal quotation marks and citation omitted). I decline to read an unreferenced provision into the No Surprises Act.

Because there was no arbitration agreement, Section 9 of the FAA does not apply, and Count 1 must be dismissed.

C. Private Cause of Action under the No Surprises Act

Plaintiffs also allege violations of the No Surprises Act, asserting that there is an implied cause of action under the Act.

“[P]rivate rights of action to enforce federal law must be created by Congress.” *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). There are two types of private rights of action: express and implied. *Chi. Tchr. Union, Loc. 1 v. Educators for Excellence, Inc.*, 159 F.4th 524, 528 (7th Cir. 2025). An express right of action is in a statute’s text; an implied right of action is “judicially inferred.” *Id.* To find an implied right of action, “[t]he judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy.” *Sandoval*, 532 U.S. at 286. There is a “strong presumption” against the creation of an implied right of action. *Chi. Tchr. Union*, 159 F.4th at 530. Without congressional intent to create a cause of action, “courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute.” *Sandoval*, 532 U.S. at 286–87.

There is no express right of action in the No Surprises Act. And beyond its silence, the Act bars judicial review of a determination of a certified independent dispute resolution entity except in a case described in paragraphs (1) through (4) of

Section 10(a) of the FAA. 42 U.S.C. § 300gg-111(c)(5)(E). Section 10, in turn, allows a court to vacate an arbitration award for corruption, fraud, partiality, misconduct, or if the arbitrators exceeded their power. 9 U.S.C. § 10(a)(1)–(4); *see* Section III.B. at 7. On its face, the No Surprises Act bars judicial review except in a few limited circumstances, none of which are relevant here. I do not have authority to review the independent dispute resolution entity’s determination.

Plaintiffs argue that implying a private right to seek confirmation or enforcement of an award is not “judicial review.” I disagree. The Supreme Court has explained that the “Federal Arbitration Act ... provides for expedited judicial review to *confirm*, vacate, or modify arbitration awards.” *Hall St. Assocs.*, 552 U.S. at 578 (emphasis added); *see also Concrete Pipe & Prods. of Cali., Inc. v. Constr. Laborers Pension Tr. for S. Cali.*, 508 U.S. 602, 611 (1993) (“The statute provides for judicial review of the arbitrator’s decision by an action in the district court to enforce, vacate, or modify the award.”). Because confirmation of an arbitrator’s award is included in judicial review, I am barred from confirming any independent dispute resolution award.

Even if confirmation of an independent dispute resolution award is not judicial review, the statute’s language does not reflect Congress’s intent to create a private remedy necessary to find an implied cause of action. Under the No Surprises Act, independent dispute resolution determinations “shall be binding upon the parties involved.” 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I). The Act also says that payment “shall be made ... not later than 30 days after the date on which such determination is

made.” 42 U.S.C. § 300gg-111(c)(6). Payment “shall be made directly to the nonparticipating provider or facility.” 42 U.S.C. § 300gg-111(c)(6)

The No Surprises Act confers a right for providers to payment. The Act says that payment “shall” be made to providers, which is “rights-creating” language suggesting an implied right of action. *See Me. Cmty. Health Options v. United States*, 590 U.S. 296, 324 (2020). But “Congress’s use of mandatory language alone is not enough to create an implied private right of action.” *Saloojas, Inc. v. Aetna Health of Cali., Inc.*, 80 F.4th 1011, 1015 (9th Cir. 2023). Congress must intend to create a private remedy. *Sandoval*, 532 U.S. at 286. “Most revealing of Congress’s intent is that [the No Surprises Act] already has a method of enforcement: [42 U.S.C. § 300gg-22(b)(2)].” *Chi. Tchrs. Union*, 159 F.4th at 530. When Congress creates an enforcement mechanism other than a private right of action, it “suggests that Congress intended to preclude others.” *Id.* (quoting *Sandoval*, 532 U.S. at 290).

Congress empowered the Department of Health and Human Services to assess penalties against insurers for failure to comply with the No Surprises Act. *See* 42 U.S.C. § 300gg-22(b)(2); 45 C.F.R. § 150.303. Under the enforcement provision, any health plan or health insurance issuer that fails to comply with an independent dispute resolution determination is liable for up to \$100 for each day of noncompliance. 42 U.S.C. § 300gg-22(b)(2)(C)(i). The regulations implementing the statute also describe the processes for investigating potential violations and assessing civil money penalties for failing to comply with the No Surprises Act. 45 C.F.R. §§ 150.303–150.345. That Congress created an enforcement mechanism for the

Department of Health and Human Services is the “most revealing” clue about Congress’s intent and suggests that Congress did not intend to create a private remedy for providers.

Plaintiffs cite to *Me. Cmty. Health Options* in support of their position. That case involved obligations by the government to pay for goods and services, and whether that obligation fell within the Tucker Act’s immunity waiver, allowing the petitioners to sue the government for unpaid obligations. *Id.* at 307–08, 322. The Tucker Act waives the United States’s immunity for certain damages suits in the Court of Federal Claims. *Id.* at 322. The court held that the “shall pay” language in the statute created an obligation for the government to pay. *Id.* at 314. This language in the Tucker Act context, “often reflects congressional intent to create both a right and remedy.” *Id.* at 324 (internal quotation marks omitted). The Court also reasoned that there was a right of action because the statute focused on “compensating insurers for past conduct” and because there was no separate remedial scheme to enforce the statute. *Id.* at 325–26.

Maine Community, while supportive in some ways of plaintiff’s claim, is not controlling. The Court said that the mandatory language “*often*” reflects an intent to create a right and remedy, but not always. And the No Surprises Act’s focus is on protecting *patients* from surprise medical bills. *Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 273 (5th Cir. 2025). The Court in *Maine Community* also explained that there was no other enforcement mechanism in the statute, despite the mandatory language. The No Surprises Act has a separate remedial scheme,

which is the “most revealing” factor in determining Congress’s intent. Although the language in the Act is mandatory, which can reflect Congress’s intent in some circumstances, here, where there is an administrative enforcement mechanism and a focus on patients, not providers, there is no clear intent to create an implied cause of action. Because there is no implied cause of action to bring claims for violations of the No Surprises Act, Counts 2 and 3 are dismissed.

D. State-Law Claims

Plaintiffs bring state-law open account, bad faith, and unjust enrichment claims. There is no independent basis for federal jurisdiction, because there are no federal claims remaining and there is no complete diversity between the parties. 28 U.S.C. § 1332; *Jimenez v. Kiefer*, 100 F.4th 931, 936 (7th Cir. 2024); [33] ¶¶ 8–9.² I decline to exercise supplemental jurisdiction under 28 U.S.C. § 1367(c)(3). Plaintiffs’ state-law claims are dismissed.

² Both plaintiff Sentient Physicians, PC and defendant Blue Cross Blue Shield of Texas are citizens of Illinois.

IV. Conclusion

Defendant's motion to dismiss, [36], is granted. The federal claims are dismissed with prejudice and the state-law claims are dismissed without prejudice.³ Enter judgment and terminate civil case.

ENTER:


Manish S. Shah
United States District Judge

Date: June 2, 2026

³ Plaintiffs are “generally entitled to at least one chance to amend their complaint to cure an error in response to a district court’s dismissal order unless amendment would be futile.” *Hernandez v. Ill. Inst. of Tech.*, 63 F.4th 661, 671–72 (7th Cir. 2023) (internal quotation marks and citation omitted). Because underpayment is not within the zone of interests regulated by ERISA, Section 9 of the FAA does not apply, and the No Surprises Act does not confer a private cause of action, any amendment to these counts would be futile.

IN THE UNITED STATES DISTRICT COURT
FOR THE
NORTHERN DISTRICT OF ILLINOIS

SpecialtyCare, Inc.,

Plaintiff,

v.

Health Care Service Corporation d/b/a Blue Cross
Blue Shield of Texas,

Defendants.

Case No. 24-cv-12945
Judge Manish Shah

JUDGMENT IN A CIVIL CASE

Judgment is hereby entered (check appropriate box):

☐ in favor of plaintiff(s)
and against defendant(s)
in the amount of \$ _____,

which ☐ includes _____ pre-judgment interest.
☐ does not include pre-judgment interest.

Post-judgment interest accrues on that amount at the rate provided by law from the date of this judgment.

Plaintiff(s) shall recover costs from defendant(s).

☐ in favor of defendant(s)
and against plaintiff(s)

Defendant(s) shall recover costs from plaintiff(s).

☒ other: In favor of defendant Health Care Service Corporation d/b/a Blue Cross Blue Shield of Texas and against plaintiffs SpecialtyCare, Inc., Remote Neuromonitoring Physicians, PC, and Sentient Physicians, PC. The federal claims are dismissed with prejudice and the state-law claims are dismissed without prejudice.

This action was (*check one*):

- ☐ tried by a jury with Judge Manish Shah presiding, and the jury has rendered a verdict.
☐ tried by Judge Manish Shah without a jury and the above decision was reached.
☒ decided by Judge Manish Shah on a motion.

Date: 6/2/2026

Thomas G. Bruton, Clerk of Court

APPX182

ILND 450 (Rev. 10/13) Judgment in a Civil Action Case: 1:24-cv-12945 Document #: 74 Filed: 06/02/26 Page 2 of 2 PageID #:604

/Susan McClintic , Deputy Clerk

APPX183

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

PHI HEALTH, LLC,	)	
	)	
Plaintiff,	)	
	)	
v.	)	25 C 12406
	)	Honorable Charles P. Kocoras
HEALTH CARE SERVICE CORP., a	)	
Mutual Legal Reserve Co. d/b/a BLUE	)	
CROSS BLUE SHIELD OF TEXAS,	)	
	)	
Defendant.	)	

MEMORANDUM OPINION

CHARLES P. KOCORAS, District Judge:

Plaintiff PHI Health, LLC (“PHI”), an air ambulance service provider, brings this action against Defendant Health Care Service Corp. d/b/a Blue Cross Blue Shield of Texas (“BCBSTX”) in an effort to enforce payment of Independent Dispute Resolution (“IDR”) determinations issued under the No Surprises Act (“NSA”), 29 U.S.C. § 1185e. PHI purports to bring claims under the NSA, Section 9 of the Federal Arbitration Act (“FAA”), 9 U.S.C. § 9, and the Declaratory Judgment Act (“DJA”), 28 U.S.C. § 2201. PHI also brings a claim for violation of the Illinois Consumer Fraud and Deceptive Business Practices Act (“ICFA”), 8115 ILCS 505/1 *et seq.* Before the Court is BCBSTX’s motion to dismiss PHI’s amended complaint in its entirety under Federal Rule of Civil Procedure 12(b)(6). For the reasons that follow, BCBSTX’s motion is granted.

BACKGROUND

Congress enacted the NSA “to protect patients from surprise medical bills incurred when they receive emergency medical services from out-of-network healthcare providers.” *Guardian Flight, LLC. v. Health Care Serv. Corp.*, 140 F.4th 271, 273 (5th Cir. 2025) (citing 42 U.S.C. §§ 300gg-111, 300gg-112). “Because the NSA shifts the cost of some out-of-network care away from patients, it created a system for health care providers and private insurers to determine fair cost sharing.” *T.V. Seshan, M.D., P.C. v. Aetna, Inc.*, 2026 WL 867151, at *1 (S.D.N.Y. Mar. 30, 2026). After providing a qualified out-of-network service for an insured patient, the health care provider sends a bill for the cost of the medical service to the applicable insurer. The insurer responds with an initial payment or notice of denial of payment. *See* 42 U.S.C. § 300gg-131(b)(1)(C). The provider may then, within 30 days, initiate open negotiations to seek a more desirable cost-sharing arrangement for the service or item. *Id.* § 300gg-111(c)(1)(A). Where negotiations are unsuccessful after 30 days, either party may initiate the IDR process to resolve the dispute. *Id.* § 300gg-111(c)(1)(B). The IDR process is “‘baseball-style’ dispute resolution,” wherein each party submits a payment offer with supporting information, and the “IDR entity” chooses between the two offers. *Guardian Flight*, 140 F.4th at 273; 42 U.S.C. § 300gg-111(c)(5)(A)–(B).

The IDR determination:

- (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.A. § 300gg-111(c)(5)(E) (emphases added); 29 U.S.C. § 1185e(c)(5)(E). Payment “with respect to a qualified IDR item or service for which a determination is made . . . *shall* be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made.” 42 U.S.C. § 300gg-111(c)(6) (emphasis added).

The only “judicial review” expressly authorized under the NSA is when a party seeks to *vacate* an arbitration award in one of four scenarios, none of which are applicable here. *See* 9 U.S.C. § 10(a)(1)–(4). The NSA empowers the Departments of Health and Human Services (“HHS”), Labor, and Treasury with enforcement authority over the IDR process, including the ability to impose civil monetary penalties. *See, e.g.*, 42 U.S.C. § 300gg-22(b)(2), 42 U.S.C. § 300gg-134(b).

In this case, PHI won an IDR dispute against BCBSTX for providing emergency air ambulance services, and BCBSTX so far has refused to pay. PHI thus brought this action to enforce payment of the IDR award under either the NSA or the FAA. PHI also seeks a declaratory judgment that the IDR award is binding on BCBSTX, and BCBSTX’s refusal to timely pay the IDR award is unlawful. PHI also brings a claim under the ICFA.

BCBSTX moves to dismiss PHI’s amended complaint with prejudice under Rule 12(b)(6) for four reasons: (1) the NSA does not create a private right of action;

(2) PHI cannot “confirm” an IDR award under Section 9 of the FAA because Congress explicitly chose not to incorporate Section 9 into the NSA; (3) PHI cannot use the DJA to circumvent Congress’s policy choice to restrict judicial review in favor of agency enforcement; and (4) PHI is not a consumer under the ICFA, the alleged conduct did not primarily take place in Illinois, and PHI failed to plead facts plausibly showing a violation of the ICFA.

LEGAL STANDARD

A motion to dismiss under Rule 12(b)(6) challenges the sufficiency of the complaint, not its merits. Fed. R. Civ. P. 12(b)(6); *Gibson v. City of Chicago*, 910 F.2d 1510, 1520 (7th Cir. 1990). “To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face.” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quotes omitted). “This means that the complaint must offer factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.” *Farhan v. 2715 NMA LLC*, 161 F.4th 475, 482 (7th Cir. 2025) (cleaned up). The Court will accept “well-pleaded facts in the complaint as true and draw reasonable inferences in plaintiffs’ favor—but [will] not presume the truth of legal conclusions and conclusory allegations.” *Cielak v. Nicolet Union High Sch. Dist.*, 112 F.4th 472, 475 (7th Cir. 2024). For these reasons, “threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice.” *Orr v. Shicker*, 147 F.4th

734, 741 (7th Cir. 2025) (quoting *Peterson v. Wexford Health Sources, Inc.*, 986 F.3d 746, 751 (7th Cir. 2021)).

DISCUSSION

The following discussion proceeds in four parts. First, the Court analyzes whether the NSA contains an implied right of action that would enable PHI to bring the present case and finds that it does not. Second, the Court determines that PHI similarly cannot obtain relief under Section 9 of the FAA, because the NSA forecloses that claim. Third, the Court finds that because there is no private right of action under the NSA, PHI cannot use the DJA to enforce IDR payment determinations. Lastly, the Court concludes that PHI fails to state an ICFA claim.

I. Whether the NSA Creates a Private Right of Action

“[C]reating a cause of action is a legislative endeavor.” *Egbert v. Boule*, 596 U.S. 482, 491 (2022). An implied right of action “is an increasingly rare creature, one that requires [courts] to infer that Congress created a private *right* and provided for a private *remedy*, all without taking the conventional route of doing so expressly.” *Ohlendorf v. United Food & Com. Workers Int’l Union, Local 876*, 883 F.3d 636, 640 (6th Cir. 2018) (emphasis in original), *cert. denied*, 586 U.S. 869 (2018). An implied right of action must be supported by statutory language. *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001).

Although the Seventh Circuit¹ has not yet opined on this issue, nearly every court that has considered it—including the Fifth Circuit and multiple district courts across the country—has declined to find that the NSA creates either an express or implied private right of action. *See, e.g., Guardian Flight*, 140 F.4th at 277 (“The NSA’s structure conveys Congress’s policy choice to enforce the statute through administrative penalties, not a private right of action.”); *Axis Neuromonitoring, LLC v. Aetna Inc.*, 2026 WL 795260, at *5–*8 (D. Conn. Mar. 20, 2026) (collecting cases and finding no express or implied private right of action); *Mitchell F. Reiter MD PC v. Horizon Blue Cross Blue Shield of N.J.*, 2025 WL 3514300, at *5 (D.N.J. Dec. 8, 2025) (noting “substantial majority of federal court decisions across the country that have examined this issue and declined to recognize an implied right of action under the NSA”) (cleaned up); *SpecialtyCare Inc. v. Aetna, Inc.*, 2025 WL 3719227, at *4 (M.D. Pa. Dec. 23, 2025) (no private right of action under NSA); *Interventional Pain Mgmt. v. Horizon Blue Cross Blue Shield of N.J.*, 2025 WL 3470569, at *8 (D.N.J. Dec. 3, 2025) (same); *Mod. Orthopaedics of N.J. v. Premera Blue Cross*, 2025 WL 3063648, at *14 (D.N.J. Nov. 3, 2025) (same); *T.V. Seshan*, 2025 WL 3496382, at *9 (same); *Worldwide*

¹ At least one court within this district has considered the issue and determined there is no private right of action under the NSA, and that Section 9 of the FAA does not apply. *See SpecialtyCare Inc., Remote Neuromonitoring Physicians, PC and Sentient Physicians, PC v. Health Care Service Corporation d/b/a Blue Cross Blue Shield of Illinois*, 2026 WL 1556442 (N.D. Ill. June 2, 2026) (Shah, J.); *SpecialtyCare Inc., Remote Neuromonitoring Physicians, PC v. Health Care Service Corporation d/b/a Blue Cross Blue Shield of New Mexico*, 2026 WL 1556244 (N.D. Ill. June 2, 2026) (Shah, J.); *SpecialtyCare, Inc. v. Health Care Service Corporation d/b/a Blue Cross Blue Shield of Texas*, 2026 WL 1556346 (June 2, 2026) (Shah, J.).

Aircraft Servs., Inc. v. United Healthcare, 2025 WL 3312169, at *2 (M.D. Fla. Nov. 28, 2025) (same); *E. Coast Advanced Plastic Surgery, LLC v. Cigna Health & Life Ins. Co.*, 2025 WL 2371537, at *17 (S.D.N.Y. Aug. 14, 2025) (“The statutory text [of the NSA] thus forecloses of a private right of action to enforce IDR determinations.”); *Jeffrey Farkas, M.D., LLC v. Horizon Blue Cross Blue Shield of N.J.*, 790 F. Supp. 3d 129, 137 (E.D.N.Y. 2025) (“[B]y seeking confirmation here, Plaintiff asks the Court to impermissibly invent a cause of action to confirm an award under the NSA. It may not do so.” (internal citations omitted)); *Freeman Pain Inst. v. Horizon Blue Cross Blue Shield of N.J.*, 2025 WL 3268289, *6 (D.N.J. Nov. 24, 2025) (“Congress plainly knows how to provide a private right of action—and has done so in other statutes—but chose not to do so here. Not only does the statute fail to create a private right of action, the NSA clearly bars judicial review of IDR awards except as to the specific vacatur provisions borrowed from the FAA[.]”); *Advanced Vascular Assocs. v. Horizon Blue Cross Blue Shield of N.J.*, 2026 WL 935833, at *5 (E.D. Pa. Apr. 7, 2026) (“Congress made IDR determinations binding, limited judicial review to narrow circumstances, and created an administrative enforcement scheme. . . . [I]t did not create a private cause of action to compel payment of the IDR arbitration awards.”); *SpecialtyCare Inc. v. Meritain Health, Inc.*, 2026 WL 353259, at *3 (D. Del. Feb. 9, 2026), *report and recommendation adopted*, 2026 WL 745341 (D. Del. Mar. 17, 2026); *Neuroshield Network SE, LLC v. Phx. Adm’rs, LLC*, 2026 WL 863869, at *6 (N.D. Ohio Mar. 30, 2026); *FHMC LLC v. Blue Cross & Blue Shield of Ariz., Inc.*, 2024 WL 1461989, at *3

(D. Ariz. Apr. 4, 2024) (noting that “[a]n implied right of action is incongruous with such a detailed statutory scheme, in which judicial review is limited to specific instances”).²

There are a few outliers, however. At least two district courts have concluded that the NSA does provide a private right of action: *Guardian Flight LLC v. Aetna Life Ins. Co.* (“*Aetna*”), 789 F. Supp. 3d 214 (D. Conn. 2025)³, and *PHI Health, LLC v. Optimum Choice, Inc. d/b/a United Health Care*, 2026 WL 850453 (D. Md. Mar. 27, 2026) (Abelson, J.); *Specialtycare, Inc. v. Carefirst of Maryland, Inc.*, 2026 WL 1656946, at *2 (D. Md. June 9, 2026) (Abelson, J.). A district court in Connecticut concluded that while the NSA does not provide a private right of action, the court may nevertheless “confirm” IDR payment determinations because the NSA’s bar on judicial review does not preclude confirmation of the IDR award. *Agag v. Cigna Health and*

² Some of these courts dismissed on jurisdictional grounds. *See, e.g., Farkas*, 790 F. Supp. 3d at 137–38; *T.V. Seshan*, 2026 WL 3496382, at *7). Here, the parties framed all issues under Rule 12(b)(6), and the Court is dismissing for failure to state a claim. *See Advanced Monitoring Services Holdings, LLC v. Blue Cross Blue Shield of Okla.*, Case No. 25-CV-466-SHE-JFJ, Dkt. # 30, at 13 n.5 (N.D. Okla. May 14, 2026) (recommending dismissal under Rule 12(b)(6)); *Agag v. Cigna Health and Life Ins. Co.*, 2026 WL 1021213, at *6–7 (D. Conn. Apr. 15, 2026) (NSA provides federal question jurisdiction).

³ The *Aetna* court noted in a subsequent order denying leave to file an interlocutory appeal that the Fifth Circuit relied in significant part on Section 300gg-22 in finding statutory evidence that Congress had opted to provide for a “general administrative remedy” rather than a private cause of action to enforce payment of IDR awards. As noted in the court’s earlier order, the parties did not address Section 300gg-22 in their briefing and so the court declined to consider whether that provision provides a method of enforcing the substantive rule in the NSA’s timing of payment provision. The court stated in the order denying permission to file an interlocutory appeal, “[i]t is possible I would have reached a different conclusion had that issue been briefed.” Case No. 3:24-cv-00680, Dkt. # 295 (D. Conn. Sep. 30, 2025).

Life Ins. Co., 2026 WL 1021213, at *11–12 (D. Conn. Apr. 15, 2026). This Court joins the majority and finds there is no implied right of action within the NSA.⁴

To be sure, by providing that IDR determinations are automatically “binding on the parties involved,” 42 U.S.C. § 300gg-111(c)(5)(E), and naming the medical provider as the “beneficiary of the non-prevailing party’s payment obligations,” *T.V. Seshan*, 2025 WL 3496382, at *7, the NSA does use rights-creating language suggestive of an implied right of action. However, “the remainder of the statute, including its provision of alternative methods of enforcement, evinces Congressional intent *not* to create a judicial remedy.” *Axis Neuromonitoring*, 2026 WL 795260, at *6 (emphasis in original).

There are two primary reasons for this. First, Congress expressly chose to permit petitions brought under Section 10 of the FAA, but not Section 9. And second, by providing for alternative enforcement mechanisms, Congress chose agency enforcement as the tool for enforcing IDR awards, not litigation. *See Agag*, 2026 WL 1021213, at *3 (describing administrative framework). Congress empowered the Department of Health and Human Services to assess penalties against insurers for failure to comply with the NSA. *See* 42 U.S.C. § 300gg-22(b)(2); 45 C.F.R. § 150.303. Under the enforcement provision, any health plan or health insurance issuer that fails

⁴ The Court also disagrees with the approach taken in *Agag*. There, the court held the “focus on the private right of action question is misplaced” because a plaintiff seeking enforcement of an IDR award is not seeking to enforce substantive rights. *See Agag*, 2026 WL 1021213, at *9. The court analyzed the text of the statute and found that a judicial enforcement remedy was not precluded. *See id.* at *10–12.

to comply with an IDR determination is liable for up to \$100 for each day of noncompliance. 42 U.S.C. § 300gg-22(b)(2)(C)(i). The regulations implementing the statute also describe the processes for investigating potential violations and assessing civil money penalties for failing to comply with the NSA. 45 C.F.R. §§ 150.303–150.345.

“Generally, ‘[t]he express provision of one method of enforcing a substantive rule,’ such as through an agency proceeding, ‘suggests that Congress intended to preclude others,’ like a private cause of action.” *Murphy Med. Assocs., LLC v. Yale Univ.*, 120 F.4th 1107, 1112 (2d Cir. 2024) (quoting *Alexander*, 532 U.S. at 290); *see also Mid-Am. Nat’l Bank of Chi. v. First Sav. & Loan Ass’n of S. Holland*, 737 F.2d 638, 642 (7th Cir. 1984) (“It is manifest that the existence of supervisory and enforcement authority at the administrative level suggests that broad private remedies were not intended.”) (citing *Transamerica Mortgage Advisors, Inc. v. Lewis*, 444 U.S. 11, 20 (1979)). PHI contends that failing to recognize a private right of action “would undermine the structure of the NSA and transform IDR determinations into worthless slips of paper.” Dkt. # 32, at 15. But PHI’s dissatisfaction with Congress’s chosen administrative remedy “does not confer authority to overstep a clear statutory boundary.” *Freeman Pain Inst.*, 2025 WL 3268289, at *7.

“[I]f (as here) the statute displays no intent to create a private remedy, ‘courts may not create one, no matter how desirable that might be as a policy matter.’” *Chessie Logistics Co. v. Krinos Holdings, Inc.*, 867 F.3d 852, 858 (7th Cir. 2017) (quoting

Alexander, 532 U.S. at 286–87). It is not the Court’s “duty to be alert to provide such remedies as are necessary to make effective” Congress’s purpose. *Id.* (cleaned up) (citation omitted). PHI’s “remedy is with Congress, not [this court], to fix the statute if it thinks there is a problem.” *Advanced Vascular Assocs. v. Horizon Blue Cross Blue Shield of New Jersey*, 2026 WL 935833, at *3 (E.D. Pa. Apr. 7, 2026). Count I of the amended complaint is dismissed with prejudice.

II. Confirmation Under Section 9 of the FAA

PHI cannot seek confirmation of an NSA IDR award under the FAA. Section 9 requires that there be an “agreement” by the parties that a judgment “shall be entered upon the award made pursuant to the arbitration” 9 U.S.C. § 9. The agreement must be in writing. *See* 9 U.S.C. § 2; *Advanced Vascular Assocs.*, 2026 WL 935833, at *2 (“The statute enforces agreements to arbitrate; it does not create them. And those agreements must be in writing. . . . Without a written agreement to arbitrate, Section 9 has no application.”). PHI nevertheless argues an agreement exists, citing: (1) the Provider Claim Summary expressly extended an invitation to participate in the open negotiation process; (2) PHI’s acceptance of that offer by initiating open negotiation; (3) BCBSTX’s direction to PHI to initiate IDR once it determined negotiations were unsuccessful; (4) PHI’s acceptance of that invitation by initiating IDR; and (5) BCBSTX’s participation in the IDR through both first objecting to the process and then submitting a bid. *See* Dkt. # 32, at 21.

PHI further argues that “[i]f Congress truly did not intend for the IDR award to function as an arbitration award, the NSA would not provide for binding, expedited dispute resolution by a third-party neutral that can only be vacated by certain provisions in the FAA.” Dkt. # 32, at 19. In PHI’s view, the NSA’s “IDR process *is* arbitration.” Dkt. # 32, at 18 (emphasis in original). Courts have repeatedly rejected this argument. Congress did not incorporate Section 9 into the NSA, and “while there are superficial similarities between the IDR and arbitration,” there are also fundamental differences between the two processes, and “they are premised on fundamentally different authorities.” *Mod. Orthopaedics*, 2025 WL 3063648, at *5; *see also Freeman Pain Inst.*, 2025 WL 3268289, at *5–6 (explaining the “key differences [that] permeate the IDR and arbitration frameworks,” and concluding “the very nature of the IDR process is too different from a traditional arbitration as contemplated by the FAA for this Court to find that Congress intended for the FAA to govern the IDR process. Absent a valid arbitration, this Court lacks the necessary jurisdiction to confirm an IDR award under the FAA.”).

For example, at the most basic level, “to begin arbitration the parties must have an unambiguous agreement to arbitrate; conversely, an IDR is limited to parties that have no agreement whatsoever and have failed to find alternative way to resolve their dispute.” *Mod. Orthopaedics*, 2025 WL 3063648, at *6 (comparing 9 U.S.C. § 2 with 42 U.S.C. § 300gg-111(b)(1)(B)). Here, the parties only engaged in the IDR process because a *statute*, not a written agreement to arbitrate, compelled participation in the

IDR process. *See Freeman Pain Inst.*, 2025 WL 3268289, at *5 (dismissing FAA Section 9 claim because “Plaintiff and Defendant have no contract or written arbitration agreement. Their participation in the IDR process was statutorily compelled, with no prior agreement to submit to arbitration . . . The lack of a written agreement between the parties to submit to arbitration removes the IDR process entirely from eligibility for confirmation under the FAA[.]”); *Farkas*, 790 F. Supp. 3d at 136 (noting that arbitration under the FAA assumes an agreement or contract to arbitrate, and the NSA’s IDR is statutorily compelled).

PHI also contends that by making IDR awards statutorily “binding,” Congress indicated that they are as enforceable in court as if they arose from arbitration agreements. The Court disagrees. “That IDR awards are ‘binding’ does not mean that Congress contemplated judicial review to confirm these awards.” *T.V. Seshan*, 2026 WL 867151, at *5.

Additionally, the Court is not persuaded by PHI’s argument that the NSA only constrains courts’ right to set aside awards, rather than courts’ ability to confirm or enforce awards. This “is a distinction without a difference. The term ‘judicial review’ is broad enough to include a court’s order to enforce an IDR award.” *Guardian Flight*, 140 F.4th at 275; *Hall St. Assocs. v. Mattel, Inc.*, 552 U.S. 576, 578 (2008) (the FAA “provides for expedited judicial review to *confirm*, vacate, or modify arbitration awards.”) (emphasis added)). The preclusion of “judicial review,” as used in the NSA, necessarily encompasses preclusion of a judicial enforcement action akin to that

provided in Section 9 of the FAA. *See Reiter*, 2025 WL 3514300, at *4. Count II of the amended complaint is dismissed with prejudice.

III. The Declaratory Judgment Act

Next, PHI seeks a declaration that the IDR award is binding on BCBSTX, and BCBSTX's refusal to timely pay the IDR award is unlawful. Federal courts are permitted to issue declaratory judgments only in cases of "actual controversy." 28 U.S.C. § 2201. Unfortunately for PHI, "[a] justiciable actual controversy exists only when a private right of action is available." *Mellott v. Sprague*, 334 F. Supp. 3d 916, 922–23 (C.D. Ill. 2017) (citing *Schilling v. Rogers*, 363 U.S. 666, 677 (1960) ("the Declaratory Judgments Act is not an independent source of federal jurisdiction, the availability of such relief presupposes the existence of a judicially remedial right")); *see also Bartucci v. Wells Fargo Bank N.A.*, 2015 WL 6955482, at *3 (N.D. Ill. Nov. 10, 2015); *Villasenor v. Am. Signature, Inc.*, 2007 WL 2025739, at *6 (N.D. Ill. July 9, 2007) (collecting cases). As explained above, there is no private right of action under the NSA and therefore Count III is dismissed. *See, e.g., E. Coast Advanced Plastic Surgery*, 2025 WL 2371537, at *18 (denying relief under the declaratory judgment act, holding that "to the extent ECAPS seeks a declaration under the NSA itself, ECAPS has not . . . shown that there is a private right of action under the NSA.").

IV. The ICFA

This leaves PHI's state law claim for a violation of the ICFA.⁵ In its ICFA claim, PHI alleges that BCBSTX engages in unfair business practices, including that BCBSX: (1) provides low initial payments to providers like PHI; (2) makes PHI and other providers jump through hoops to get paid; (3) improperly delays payment or ignores IDR awards altogether, and when awards are paid, they are paid late and do not include interest; and (4) has failed to implement compliance systems to meet its obligations. BCBSTX moves to dismiss this claim, arguing PHI lacks standing to assert the claim, there is an insufficient connection between the alleged conduct and Illinois, and PHI has not properly alleged the elements of a successful claim.

To prevail on a claim for violation of the ICFA, "a plaintiff must plead and prove that the defendant committed a deceptive or unfair act with the intent that others rely on the deception, that the act occurred in the course of trade or commerce, and that it caused actual damages." *Benson v. Fannie May Confections Brands, Inc.*, 944 F.3d 639, 646 (7th Cir. 2019) (quoting *Vanzant v. Hill's Pet Nutrition, Inc.*, 934 F.3d 730, 736 (7th Cir. 2019)). For an unfair conduct claim, which is what PHI alleges in this case, a plaintiff need only allege that (1) the practice offends public policy; (2) is

⁵ PHI argues that if the Court were to dismiss its claims under the NSA, the Court should refrain from ruling on the ICFA claim and instead remand the matter to state court. BCBSTX, however, points out that even if the federal claims are dismissed, the Court retains diversity jurisdiction because both parties are completely diverse, and the amount in controversy exceeds \$75,000. BCBSTX is correct.

immoral, unethical, oppressive, or unscrupulous, and (3) causes substantial injury to consumers. *Id.* at 647.

Before delving into the merits of PHI's ICFA claim, the Court must first determine whether PHI either meets the statutory definition of "consumer" or satisfies the consumer nexus test. *Tile Unlimited, Inc. v. Blanke Corp.*, 788 F. Supp. 2d 734, 738 (N.D. Ill. 2011). PHI does not claim to be a consumer as defined by the ICFA.⁶ Instead, PHI argues it satisfies the consumer nexus test. "Illinois courts are skeptical of business-v.-business ICFA claims when neither party is actually a consumer in the transaction." *Cnty. Bank of Trenton v. Schnuck Mkts. Inc.*, 887 F.3d 803, 823 (7th Cir. 2018); *see also JMR Sales, Inc. v. MMC Elecs. Am., Inc.*, 2002 WL 31269612, at *3 (N.D. Ill. Oct. 10, 2002) ("It is clear that the ICFA is primarily concerned with protecting consumers, not business entities.").

In general, "a non-consumer plaintiff must allege 'conduct [that] involves trade practices addressed to the market generally or otherwise implicates consumer protection concerns.'" *Roppo v. Travelers Co.*, 100 F. Supp. 3d 636, 651 (N.D. Ill. 2015) (citation omitted). In other words, "[t]o implicate consumer protection concerns, there must be a connection between the alleged misconduct and the wider marketplace, as well as a connection between the requested relief and consumers generally." *ATC Healthcare Servs., Inc. v. RCM Techs., Inc.*, 282 F. Supp. 3d 1043, 1051 (N.D. Ill. 2017)

⁶ The ICFA defines a "consumer" as "any person who purchases or contracts for the purchase of merchandise not for resale in the ordinary course of his trade or business but for his use or that of a member of his household." 815 ILCS 505/1(e).

(citing *Brody v. Finch Univ. of Health Scis./The Chi. Med. Sch.*, 298 Ill. App. 3d 146, 159 (1998)). “Requiring a connection between the requested relief and *consumers* is thus important because it ensures that non-consumers do not expand the Consumer Fraud Act beyond its intended purpose.” *Id.* (emphasis in original).

PHI argues it satisfies the consumer nexus test because it alleges that (1) its services require substantial investments in equipment, technology, personnel, and regulatory compliance; (2) BCBSTX is “engaged in widespread underpayment and delay and other abuses of the IDR process that impact PHI and other providers of emergency healthcare services;” and (3) BCBSTX’s “delay and avoidance of payment undermines the NSA process and is antithetical to the rational and proper functioning of the U.S. Healthcare system.” Dkt. # 32, at 22–23.

BCBSTX’s scheme as alleged by PHI is not directed to the market generally. In *Beatty v. Accident Fund Gen. Ins. Co.*, a plastic surgeon contended that multiple insurers’ scheme of failing to pay interest rates on late-paid and unpaid bills was directed to the market generally because it impacted “every patient and provider in the entire Illinois healthcare market[.]” 2018 WL 3219936, at *10 (S.D. Ill. July 2, 2018). The district court rejected that contention, explaining that “[w]hile the [insurer’s] conduct may have repercussions for Illinois consumers,” the conduct targeted medical providers only, not the market generally. *Id.* The same can be said for this case.

Because BCBSTX’s practices were not directed to the market generally, the alleged conduct must “implicate consumer protection concerns.” To establish an

implication of consumer protection concerns, PHI must have pleaded: (1) actions that establish a link between it and consumers; (2) BCBSTX's unfair practices concerned consumers other itself; and (3) "how the requested relief would serve the interest of consumers." *Walsh Chiropractic, Ltd. v. StrataCare, Inc.*, 752 F. Supp. 2d 896, 913 (S.D. Ill. 2010) (quoting *Brody*, 298 Ill. App. 3d at 160).

PHI says that BCBSTX's "conduct, directed to the healthcare market, threatens the ability of providers, including PHI, to fund substantial operation costs. This conduct, and the financial havoc wreaked by it, threatens the quality of service that PHI and others are able to provide to the public at large, which implicates consumer protection concerns." Dkt. # 32, at 23. Citing *Guardian Flight*, BCBSTX counters that "[t]he NSA shields' consumers 'from liability for any out-of-network coverage costs,' so consumers 'have not suffered – and could not suffer – any concrete injury from [BCBSTX's] failure to cover medical bills that fall within the scope of the NSA.'" Dkt. # 24, at 13 (quoting *Guardian Flight*, 140 F.4th at 278).

"Passing on costs to customers is a recognized consumer protection concern." *Conn. Gen. Life Ins. Co. v. Sw. Surgery Ctr., LLC*, 349 F. Supp. 3d 718, 725 (N.D. Ill. 2018); *see also Beatty*, 2018 WL 3219936, at *11 (plaintiff doctor adequately alleged "implication of consumer protection concerns" against insurer by stating that insurer's unpaid interest charges may shift to the doctor's patients); *Walsh Chiropractic*, 752 F. Supp. 2d at 913 (holding that a consumer nexus is met where complaint alleged facts from which the court could infer that patients of medical providers may be subject to

fee increases as a result of the defendant's alleged fraud on the medical providers). At this stage, the Court is satisfied that PHI's allegations implicate consumer protection concerns.

The ICFA, however, has limited territorial reach. *Avery v. State Farm Mut. Auto. Ins. Co.*, 216 Ill. 2d 100, 185 (2005). A plaintiff must allege "circumstances that relate to the disputed transaction occur primarily and substantially in Illinois." *Id.* at 187. There is "no single formula or bright-line test for determining whether a transaction occurs within [Illinois]." *Id.* Instead, courts consider factors such as where the company is located, where the alleged deception took place, the plaintiff's residence, and where the damage to the plaintiff occurred. *Id.* at 187–88.

PHI argues its amended complaint establishes a sufficient nexus to Illinois because it alleges that BCBSTX is organized under Illinois law and headquartered in Chicago, the non-payment of IDR awards takes place in Chicago, and BCBSTX "sells insurance/administrative services 'from within the state' and engages in trade/commerce as defined by the ICFA." Dkt. # 32, at 24. BCBSTX, in response, points out that PHI provides air ambulance services in Texas, not Illinois, BCBSTX issues and administers health plans in Texas, and BCBSTX communicates with providers like PHI from a Texas address.

PHI's allegations are insufficient. As an initial matter, "the administration of defendant's business in Illinois is insufficient to give a nonresident plaintiff a claim." *Sieving v. Cont'l Cas. Co.*, 535 F. Supp. 3d 762, 771–72 (N.D. Ill. 2021) (quoting

Robinson v. DeVry Educ. Grp., Inc., 2018 WL 828050, at *4 (N.D. Ill. Feb. 12, 2018)). PHI asserts that the non-payment of IDR awards takes place in Chicago, but this claim is contradicted by PHI's own exhibits. The "Provider Claim Summary" and the letter advising PHI that it may avail itself of the IDR process, attached to the amended complaint as Exhibits A and B, were sent from a Texas address. Additionally, none of the services giving rise to the payment disputes between BCBSTX and PHI took place in Illinois. None of health plans covering PHI's services were administered to Illinois residents. PHI does not allege it dealt with any BCBSTX representatives in Illinois. And PHI did not suffer damages in Illinois.

The only reason Illinois is implicated is because BCBSTX is a division of a company headquartered in Illinois. "[W]hether a defendant's headquarters is located in Illinois is a factor to be considered by the Court, but is far from dispositive." *Van Tassel v. United Mktg. Grp., LLC*, 795 F. Supp. 2d 770, 782 (N.D. Ill. 2011). And PHI's claim that it "alleges a policy-drive, systemic business practice rather than one-off Texas field activity," Dkt. # 32, at 24, also does not help its case because "[t]he dissemination of a scheme to defraud from Illinois headquarters is not dispositive either." *Robinson*, 2018 WL 828050, at *4. Considering the totality of PHI's allegations, the Court cannot conclude that "the circumstances that relate to the disputed transaction occur[ed] primarily and substantially in Illinois." *Id.* at *3. Count IV is dismissed, without prejudice.

CONCLUSION

For the foregoing reasons, BCBSTX's Motion to Dismiss [23] is granted. If PHI believes in good faith that it can amend its operative complaint to state a viable claim, it may do so by 7/14/2026. A telephonic status hearing is set for 7/21/2026 at 9:50 a.m.

It is so ordered.

A handwritten signature in black ink, appearing to read "Charles P. Kocoras".

Charles P. Kocoras
United States District Judge

Date: June 23, 2026

**IN THE UNITED STATES DISTRICT COURT
FOR THE
NORTHERN DISTRICT OF ILLINOIS**

PHI Health, LLC,

Plaintiff,

v.

Health Care Service Corporation,

Defendant.

Case No. 25 C 12406

Judge Charles P. Kocoras

JUDGMENT IN A CIVIL CASE

Judgment is hereby entered (check appropriate box):

☐ in favor of plaintiff
and against defendants

which ☐ includes \$ pre-judgment interest.
☐ does not include pre-judgment interest.

Post-judgment interest accrues. Plaintiff shall recover costs from defendants.

☐ in favor of defendant.
and against plaintiff

☒ other: Case is dismissed with prejudice and Count IV is dismissed without prejudice.

This action was (*check one*):

☐ tried by a jury with Judge presiding, and the jury has rendered a verdict.
☐ tried by Judge without a jury and the above decision was reached.
☒ decided by Judge Charles P. Kocoras on 7/1/2026.

Date: 7/1/2026

Thomas G. Bruton, Clerk of Court

Amanda Scherer, Deputy Clerk

APPX270

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

PHI HEALTH, LLC,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No. 26 C 2954
	)	
HEALTH CARE SERVICE CORP.,	)	
	)	
Defendant.	)	

MEMORANDUM OPINION AND ORDER

MATTHEW F. KENNELLY, District Judge:

PHI Health, LLC has sued Health Care Services Corporation for its failure to pay overdue payment awards issued under the federal No Surprises Act (NSA). PHI asserts claims under the NSA, the Federal Arbitration Act (FAA), the Employee Retirement Income Security Act (ERISA), and the Illinois Consumer Fraud and Deceptive Business Practices Act. HCSC has moved to dismiss PHI's complaint.

Background

At the pleading stage, the Court must "accept all well-pleaded facts in the complaint as true and draw all reasonable inferences in the plaintiff's favor." *NewSpin Sports, LLC v. Arrow Elecs., Inc.*, 910 F.3d 293, 299 (7th Cir. 2018).

HCSC operates Blue Cross Blue Shield (BCBS) entities and adjudicates health insurance claims on behalf of those entities. PHI provided air ambulance services to participants or beneficiaries of HCSC-operated health plans. These were "out-of-network" services, meaning that PHI was not a provider that had contracted with HCSC or the relevant health plans to perform the services. PHI alleges that it followed industry

standard billing for these transports. HCSC sent PHI an Explanation of Benefits form setting forth initial underpayments for bills arising from twelve air ambulance transports. HCSC declined to pay the full amount PHI sought.

In 2022, Congress enacted the NSA to protect patients from surprise medical bills incurred when they receive emergency medical services from out-of-network providers. 42 U.S.C. §§ 300gg-111, 300gg-112. The NSA relieves patients of financial liability for surprise bills, and it created an IDR process for billing disputes between providers and insurers. *Id.* § 300gg-111(c)(1)-(5). The NSA requires a provider and insurer to first try to agree on a price for the services. This is referred to as the open negotiation process. If the open negotiation process fails, the provider has four days to initiate independent dispute resolution (IDR) proceedings. After a provider initiates IDR proceedings, the U.S. Department of Health and Human Services (HHS) selects a certified independent dispute resolution entity (CIDRE) to arbitrate the dispute.

The amount due is decided via a "baseball-style" dispute resolution in which the provider and insurer each submit an offer, and the CIDRE selects one party's offer as the award. The CIDRE must consider the insurer's "qualifying payment amount," a heavily regulated rate that reflects the "median of the contracted rates recognized by the plan or issuer . . . for the same or a similar item or service" offered in the same insurance market and geographic area. *Id.* § 300gg-111(a)(3)(E)(i). In the absence of a fraudulent claim or evidence of a misrepresentation of facts to the CIDRE, the IDR award "shall be binding upon the parties involved," and payment of the award "shall be made . . . not later than 30 days after the date on which such determination is made." *Id.* § 300gg-112(b)(5)(D).

Under 42 U.S.C. § 300gg-111(c)(5)(E), any IDR award is binding on the parties and is subject to judicial review only in circumstances described in section 10(a) of the FAA. The four grounds upon which a district court may vacate the award are:

- (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).

PHI turned to the dispute resolution process set forth in the NSA. PHI timely initiated the open negotiation process, but the parties were ultimately unable to agree to a payment amount during the open negotiation period. When open negotiations failed, PHI timely initiated IDR proceedings under the NSA. As a result of the IDR process, the CIDRE entered awards that required HCSC to pay PHI certain amounts. According to PHI, HCSC has not paid the IDR awards, nor has it sought vacatur, modification, or correction of any of the awards.

According to PHI, HCSC frequently does not comply with the statute's 30-day payment requirement. PHI further contends that when claims for services are paid, HCSC provides low reimbursement—in other words, less than the industry standard amount—in the hope that providers will find the IDR process too burdensome or will fail in one of the numerous steps in the IDR process and/or miss one of the NSA's strict deadlines. This, PHI says, forces providers to go through the costly and burdensome

IDR process for every out-of-network transport they provide. And PHI says that when all of these steps to delay and deny have failed, and PHI finally has binding award determinations in its favor, HCSC simply ignores them.

Under the NSA, the HHS, the Department of Labor, and the Department of Treasury have the authority to enforce provider and payor non-compliance with the NSA's provisions. 42 U.S.C. § 300gg-134(b). This enforcement mechanism involves assessment of a \$100 fine for each day of non-compliance. *Id.* § 300gg-134(b)(2). If an entity fails to pay an assessed fine, HHS must refer the matter to the Attorney General, who may seek to recover the amount due by filing an action in the appropriate federal district court. *Id.* § 300gg-134(b)(2)(F).

In this lawsuit, PHI seeks enforcement, or confirmation, of the IDR awards in its favor and against BCBS plans administered by HCSC. PHI asserts claims under the NSA (count 1), the Federal Arbitration Act (FAA) (count 2), Illinois Uniform Arbitration Act (IUAA) (count 3) and ERISA (count 5). PHI also seeks declaratory and injunctive relief related to these claims (count 4) and asserts a violation of the Illinois Consumer Fraud and Deceptive Business Practices Act (count 6). In the alternative, PHI's complaint includes a "motion to confirm" the awards.

HCSC has moved to dismiss under Federal Rule of Civil Procedure 12(b)(6).

Discussion

To survive a motion to dismiss for failure to state a claim under Rule 12(b)(6), "the plaintiff must allege 'enough facts to state a claim to relief that is plausible on its face.'" *NewSpin Sports*, 910 F.3d at 299 (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). At the pleading stage, the Court must "accept all well-pleaded facts in

the complaint as true and draw all reasonable inferences in the plaintiff's favor." *Id.* In ruling on a Rule 12(b)(6) motion to dismiss, a court is limited to assessing the allegations in the complaint, documents attached to the complaint, documents that are critical to the complaint and referred to in it, and information subject to proper judicial notice. *Wertmyer v. Walmart, Inc.*, 142 F.4th 491, 498 (7th Cir. 2025).

A. No Surprises Act (Count 1)

HCSC argues that the NSA does not provide a private right of action to enforce or confirm IDR awards, for three reasons. First, the Act bars "judicial review" of IDR awards except in circumstances involving fraud, corruption, partiality, or other misconduct, none of which is alleged here. Second, the Act omits any terms authorizing private enforcement, despite including those terms in other statutes. Third, the Act establishes an administrative scheme of enforcement. PHI responds that HCSC's arguments would render IDR awards optional rather than mandatory. PHI argues that it does not seek judicial review of the decisions but instead seeks to enforce them. PHI also contends that the modest civil penalties that federal agencies can assess for violation of the NSA are not an effective enforcement scheme.

"[P]rivate rights of action to enforce federal law must be created by Congress." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). A private right of action can be express or implied. *Chi. Tchrs. Union, Loc. 1 v. Educators for Excellence, Inc.*, 159 F.4th 524, 528 (7th Cir. 2025). An express right of action is in a statute's text; an implied right of action is "judicially inferred." *Id.* To find an implied right of action, "[t]he judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy." *Sandoval*, 532 U.S. at

286. There is a "strong presumption" against the creation of an implied right of action. *Chi. Tchrs. Union*, 159 F.4th at 530. Without congressional intent to create a cause of action, "courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute." *Alexander*, 532 U.S. at 286–87.

The NSA does not contain an express private right of action. The only appellate court and majority of district courts to address whether the NSA implies a private right of action (including two judges in this District) have held that that it does not. *Guardian Flight, LLC v. Health Care Servs. Corp.*, 140 F.4th 271 (5th Cir. 2025); *PHI Healthcare LLC v. Heath Care Servs. Corp.*, No. 25 C 12406, 2026 WL 1802985, *3 (N.D. Ill. June 23, 2026) (Kocoras, J.) (collecting cases); *SpecialtyCare Inc. v. Health Care Servs. Corp.*, No. 25 C 12935, 2026 WL 1556442 (N.D. Ill. June 2, 2026) (Shah, J.).

When addressing this issue, Judge Manish Shah noted that the NSA states that payment "shall" be made to providers, "which is 'rights-creating' language suggesting an implied right of action." *Id.* (citing *Me. Cmty. Health Options v. United States*, 590 U.S. 296, 324 (2020)). Judge Shah went on to explain, however, that this language alone was not sufficient to find an implied private right of action. *Id.* Instead, "Congress must intend to create a private remedy." *Id.* In Judge Shah's view, the fact that Congress created an enforcement mechanism for HHS to enforce the NSA is the "'most revealing' clue about Congress's intent and suggests that Congress did not intend to create a private remedy for providers." *Id.* Thus Judge Shah concluded that the text and structure of the NSA do not imply a private right of action. *Id.*

Judge Charles Kocoras agreed with Judge Shah's analysis. *PHI Healthcare*, 2026 WL 1802985, at *3–4. Judge Kocoras also noted that this result is supported by

Congress's decision to expressly choose "to permit petitions brought under Section 10 of the FAA, but not Section 9." *Id.* at *4. Section 9 of the FAA empowers courts to confirm or enforce arbitration awards. *Guardian Flight*, 140 F.4th at 276.

The Court must look to the statute and the legislative intent when considering whether a statute implies a private right of action. Although PHI is correct that the NSA provides that the awards "shall be binding upon the parties involved," this is not sufficient, alone, to create an implied right of action. 42 U.S.C. § 300gg-11(c)(5)(E)(i)(I); *see Chi. Tchrs. Union*, 159 F.4th at 530 ("Our court has recognized a strong presumption exists against the creation of such implied rights of action.").

Congress must also intend to create a private remedy before one may be judicially inferred. The creation of an enforcement mechanism other than a private judicial remedy is "[m]ost revealing of Congress's intent" in this regard. *Chi. Tchrs. Union*, 159 F.4th at 530. In the NSA, Congress empowered the Department of Health and Human Services, the Department of Labor, and the Department of Treasury with enforcement of the NSA. 42 U.S.C. § 300gg-22(b)(2). The agencies may assess penalties against insurers for failure to comply with the NSA. *Id.* Thus Congress chose a remedy that provides for enforcement of statutory obligations through penalties accessed by federal agencies, not a private right of action.

PHI takes issue with Congress's choice and argues it does not equate to a true enforcement mechanism. It is not a court's role, however, to step in and create a private right of action simply because private enforcement may provide a more effective remedy than the mechanism Congress chose. *See Aland v. United States Dep't of the Interior*, No. 23-2415, 2024 WL 2036115, at *2 (7th Cir. May 8, 2024) ("[W]hen Congress does

not impliedly or expressly confer a cause of action to enforce a statute, courts may not create one even if . . . doing so would be desirable as a policy matter.").

In support of its argument, PHI points to three decisions in which courts held that the NSA implies a private right of action. *Guardian Flight LLC v. Aetna*, 789 F. Supp. 3d 214 (D. Conn. 2025); *PHI Health, LLC v. Optimum Choice, Inc.*, 826 F. Supp. 3d 654 (D. Md. 2026); *Shareef Jandali Plastic Surgery LLC v. Cigna Health and Life Ins. Co.*, No. 25 C 1168, 2026 WL 2098149, *8–9 (D. Conn. July 21, 2026). Two more courts have enforced or confirmed NSA awards without discussion of whether the statute creates a private right of action. *Worldwide Aircraft Servs. Inc. v. Worldwide Ins. Servs., LLC*, No. 24 C 840, 2024 WL 4226799, *4 (M.D. Fla. Sept. 18, 2024); *GPS of New Jersey M.D., P.C. v. Horizon Blue Cross & Blue Shield*, No. 22 C 6614, 2023 WL 5815821 (D. N.J. Sept. 8, 2023). And one court has held that a private right of action is not required for judicial confirmation of an NSA award. *Agag v. Cigna Health and Life Ins. Co.*, No. 25 C 498, 2026 WL 1021213 (D. Conn. March 15, 2026)

In *Guardian Flight*, the court concluded that the NSA uses "rights-creating language." *Guardian Flight*, 789 F. Supp. 3d at 226. The court went on to reason that

[b]y placing the "determination . . . shall be binding on the parties" language in a clause immediately preceding the clause barring judicial review—and by locating the two provisions in a paragraph entitled "Effects of determination,"—Congress indicated that the judiciary would play a role in ensuring IDR awards were "binding," and sought only to clarify that courts should not undermine the substance or finality of these awards.

Id. at 228 (internal citation omitted). In the court's view, "[a]ny other interpretation would render IDR awards meaningless except . . . in the rare instance in which an award was challenged unsuccessfully." *Id.* The court also noted that "[p]roviding a private right of action only in cases that fall under the exceptions in § 10(a) of the FAA would also

create strange asymmetries: in cases involving fraud, corruption, partiality, and other misconduct, courts could review and vacate IDR awards, or decline to vacate them, in which case they would have the same force as civil judgments." *Id.*

In *Agag*, the court based its decision that a private right of action was not required to confirm an NSA award on the premise that "[a] private right of action is only required when a party seeks to enforce *substantive* rights in federal court, or at least when the party seeks a determination of the merits of a particular claim." *Agag*, 2026 WL 1021213, at *9. Because the provider's motion to confirm asked the court to act "in a purely ministerial way and enter as a judgment an earlier binding determination," the court concluded that a private right of action was not necessary. *Id.* The court explained that the NSA's administrative enforcement scheme does not provide a provider with any right to be heard when an award remains unpaid. *Id.* The court also noted that it was "conceivable that a health insurance company could choose to pay the civil monetary penalty but not the IDR award, because a civil monetary penalty under the NSA is \$100 per day, whereas an IDR award . . . can be many times that amount." *Id.* at *13 (internal citation omitted).

Most recently, in *Jandali*, the court found that the NSA implied a private right of action. *Jandali*, 2026 WL 2098149, at *8–9. The court relied on a similar analysis as in *Guardian Flight*. *Id.* The court also relied on its view that the "inadequate nominal government enforcement mechanism" does not preclude a private right of action. *Jandali*, 2026 WL 2098149, at *9.

The Court does not find these decisions persuasive. First, in the Court's view, finding that the NSA does not create a private right of action does not render IDR

awards meaningless. As discussed, the NSA includes an enforcement mechanism that penalizes a provider who fails to pay an IDR award. Even if this method of enforcement is not the most effective, it is the method that Congress chose. Furthermore, PHI seeks to enforce a substantive right to payment of the NSA awards. The Court cannot avoid the private right of action question by reframing enforcement or confirmation of the NSA awards as a purely ministerial task.

The Court thus concludes that the NSA does not create an implied private right of action or otherwise permit judicial confirmation of NSA awards.

B. Federal Arbitration Act (Count 2) and Illinois Uniform Arbitration Act (Count 3)

PHI alternatively seeks to enforce the NSA awards through the FAA or the IUAA. HCSC argues that PHI cannot use the FAA or IUAA to confirm the NSA awards because the parties did not have a written agreement to arbitrate.

Section 9 of the FAA states that if the parties "in their agreement have agreed that a judgment of the court shall be entered upon the award made pursuant to the arbitration," a party to the arbitration may apply to the court to confirm the award. 9 U.S.C. § 9. The court must confirm the award unless the award is vacated, modified, or corrected as laid out in sections 10 and 11 of the Act. *Id.* The IUAA states, "Upon application of a party, the court shall confirm an award, unless within the time limits hereinafter imposed grounds are urged for vacating or modifying or correcting the award" 710 ILCS 5/11.

The FAA and IUAA require written arbitration agreements. *Gupta v. Morgan Stanley Smith Barney, LLC*, 934 F.3d 705, 710 (7th Cir. 2019) ("Although [the FAA] requires arbitration agreements to be in writing, it does not require them to be signed.");

Chi. Southshore & S. Bend R.R. v. N. Ind. Commuter Transp. Dist., 184 Ill. 2d 151, 155, 703 N.E.2d 7, 9 (1998) (The IUAA "provides that a *written* agreement to submit any existing or future controversy to arbitration is valid and enforceable.").

PHI does not argue that a written agreement exists. Instead, it argues that HCSC agreed to arbitrate by participating in the NSA dispute resolution process. Rejecting this argument, courts have uniformly held that a party cannot use the FAA to enforce an award entered pursuant to the NSA when the parties did not have a written agreement to arbitrate. *PHI Healthcare*, 2026 WL 1802985, at *4–5; *SpecialtyCare*, 2026 WL 1556442, at *3–4; *Agag*, 2026 WL 1021213, at *8–9. In the Court's view, PHI provides no good reason to depart from those decisions.

The Court concludes that PHI cannot state a claim under the FAA to enforce the NSA awards because no written agreement to arbitrate exists.

C. Employee Retirement Income Security Act (Count 5)

1. Standing

HCSC argues that PHI lacks standing to bring ERISA claims because the plan beneficiaries who allegedly assigned their rights to PHI have not sustained, and cannot sustain, any concrete injury based on HCSC's alleged non-payment or untimely payment of IDR payment determinations. PHI responds that it has standing because it "alleges a concrete injury-in-fact—HCSC's refusal to pay amounts owed—and that a favorable judgment will compel payment." Pl.'s Resp. at 23. It is undisputed that the patients who received air transport services from PHI signed agreements that assigned their insurance benefits to PHI.

"[I]n order to claim the interests of others, the litigants themselves still must have

suffered an injury in fact, thus giving them a sufficiently concrete interest in the outcome of the issue in dispute." *Thole v. U. S. Bank N.A.*, 590 U.S. 538, 543 (2020) (internal citations omitted). "[A]n assignment puts the assignee into the shoes of the assignor." *Milam v. Selene Fin., LP*, 163 F.4th 416, 420 (7th Cir. 2025). "An assignee cannot have greater rights than the assignor possessed[.]" *Decatur Mem'l Hosp. v. Conn. Gen. Life Ins. Co.*, 990 F.2d 925, 927 (7th Cir. 1993).

In *Guardian Flight*, the court found that a provider had standing to bring an ERISA claim—after assignment—because the claim was based on the insurance companies' "improper denial of payment and benefits" for out of network services. *Guardian Flight*, 789 F. Supp. 3d at 232. The court reasoned that "the patient-assignors were still owed these benefits under the plans for which they contracted" so "their denial remains a concrete injury." *Id.*

Judge Shah also addressed a similar question in *SpecialtyCare*. He held that the case did not present a question of standing but instead a question of whether the claim for payment fell within ERISA's "zone of interests." *SpecialtyCare*, 2026 WL 1556442, at *2. "The Supreme Court stressed in *Lexmark International, Inc. v. Static Control Components, Inc.*, 572 U.S. 118 (2014), the importance of keeping standing distinct from statutory coverage." *Penn. Chiropractic Ass'n v. Indep. Hosp. Indem. Plan, Inc.*, 802 F.3d 926, 928 (7th Cir. 2015). Under ERISA, "[a] civil action may be brought by a participant or beneficiary [of an ERISA plan] to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). The question therefore is "whether plaintiffs are participants or beneficiaries as ERISA uses those

words—both of which are defined terms." *Penn. Chiropractic*, 802 F.3d at 328. A beneficiary is "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8).

The issue in this case is not whether PHI has standing to bring an ERISA claim but instead is whether PHI's claim falls within ERISA's "zone of interests." *SpecialtyCare*, 2026 WL 1556442, at *2–3. PHI alleges that patients have assigned it their benefits under the HCSC plans and thus it is a "beneficiary." But PHI is not asserting assigned claims while standing in the shoes of patients. Instead, PHI's claim is based on HCSC's alleged failure to pay IDR awards owed to PHI itself. The patients could not bring a claim to enforce the awards, and thus the patients have no claim to assign to PHI. The Court thus concludes that PHI cannot bring a claim to enforce the NSA awards under ERISA because the claim does not fall within the Act's zone of interests.

2. Failure to state a claim

HCSC also argues that PHI has not stated a viable claim under sections 502(a)(1)(B) or 502(a)(3) of ERISA. PHI contends that it has stated a claim under section 502(a)(1)(B) for underpayment of benefits. PHI also responds that its section 502(a)(3) claim is distinct from its section 502(a)(1) claim for payment. According to PHI, its section 502(a)(1) claim "seeks equitable relief to force compliance with the NSA provisions of ERISA and related regulations. In other words, PHI seeks an injunction compelling HCSC to pay IDR awards within 30 days of issuance." Pl.'s Resp. at 24-25.

Section 1132(a)(1)(B) states: "A civil action may be brought—(1) by a participant

or beneficiary . . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan" 29 U.S.C. § 1132(a)(1)(B). Section 1132(a)(3) provides that a civil action may be brought "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) 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). This equitable relief "is available only when Congress did not provide relief elsewhere." *Griffin v. TeamCare*, 909 F.3d 842, 846 (7th Cir. 2018).

As discussed, PHI does not allege that it is a participant, beneficiary, or fiduciary under ERISA. This is a requirement to state a claim under section 1132(a)(1)(B) or 1132(a)(3) of ERISA. Thus the Court concludes that PHI has failed to state a claim under these provisions.

D. Illinois Consumer Fraud and Deceptive Business Practices Act (Count 6)

HCSC argues that PHI cannot state a claim under the Illinois Consumer Fraud and Deceptive Business Practices Act because it is not a consumer and cannot satisfy the "consumer nexus" test. HCSC also argues that the failure to pay the NSA awards lacks any sufficient connection with Illinois. Finally, HCSC argues that PHI fails to allege facts that plausibly show a violation of the Act.

PHI concedes that it is not a consumer and thus recognizes that it can state an unfair conduct claim only if it alleges facts to establish standing under the "consumer

nexus" test.¹ PHI argues that its allegations satisfy the "consumer nexus" test because it alleges that Illinois consumers purchase HCSC products with the expectation of compliance with federal law and that HCSC's refusal to pay binding IDR awards undermines the value of its products and threatens access to care. PHI further contends that the claim is sufficiently connected to Illinois because it alleges that HCSC is headquartered in Illinois and directs its claims administration, payment processing, and payment policies from Illinois. Finally, PHI responds that it has stated a claim because it alleges that HCSC maintains a pattern and practice of refusing to pay IDR awards which harms providers, restricts access to care, and undermines statutory protections.

A plaintiff who asserts an unfair conduct claim under the Illinois Consumer Fraud and Deceptive Practices Act must allege: (1) a practice offends public policy, (2) is immoral, unethical, oppressive, or unscrupulous, and (3) causes substantial injury to consumers. *Benson v. Fannie May Confections Brands, Inc.*, 944 F.3d 639, 647 (7th Cir. 2019). A business may maintain a claim under the Consumer Fraud and Deceptive Practices Act only if "the alleged conduct involves trade practices addressed to the market generally or otherwise implicates consumer protection concerns." *Kim v. State Farm Mut. Auto. Ins. Co.*, 2021 IL App (1st) 200135, ¶ 46, 199 N.E.3d 737, 752. A plaintiff must also sufficiently allege that "the circumstances that relate to the disputed

¹ The Illinois Supreme Court addressed the "consumer nexus" test in the context of a deceptive practices claim. *Tri-Plex Tech. Servs., Ltd. v. Jon-Don, LLC*, 2024 IL 129183, ¶¶ 30–38, 241 N.E.3d 454, 463–66. The court held that there is no "consumer nexus" exemption that relieves a business plaintiff from alleging facts in support of the element of proximate cause." *Id.* at ¶ 38, 241 N.E.3d at 465. Because PHI asserts an unfair conduct claim as opposed to a deceptive practices claim, *Tri-Plex* does not impact the Court's analysis.

transaction occur primarily and substantially in Illinois." *Avery v. State Farm Mut. Auto. Ins. Co.*, 216 Ill. 2d 100, 187, 835 N.E.2d 801, 853–54 (2005). "[T]here is no single formula or bright-line test for determining whether a transaction occurs within the state. Rather, each case must be decided on its own facts." *Id.*

Judge Kocoras recently rejected PHI's argument that similar allegations were sufficient to establish "a sufficient nexus to Illinois." *PHI Health*, 2026 WL 1802985, at *8. He based this on the fact that the services giving rise to the payment dispute were not rendered in Illinois and the individuals who received the services that ultimately led to the NSA awards were not Illinois residents. *Id.* Additionally, PHI did not allege that it dealt with any representatives of the defendant insurance company in Illinois or suffered damage in Illinois. *Id.* Instead, the "only reason Illinois is impacted is because BCBSTX is a division of a company headquartered in Illinois." *Id.* The court concluded this was insufficient, given the totality of PHI's allegations, to find that "the circumstances that relate to the disputed transaction occur[ed] primarily and substantially in Illinois." *Id.* (quoting *Robinson v. DeVry Educ. Grp., Inc.*, No. 16 C 7447, 2018 WL 828050, *4 (N.D. Ill. Feb. 12, 2018)).

Two of the NSA awards at issue in this case relate to services provided to participants of group health plans administered by Blue Cross Blue Shield of Illinois. HCSC noted at oral argument, however, that PHI does not provide services within Illinois. Thus, even though these individuals were covered by Illinois plans, the patients could not have been in Illinois when they received PHI's air ambulance services.

The fact that PHI does not render services in Illinois creates a larger problem for its Consumer Fraud and Deceptive Business Practices Act claim. PHI's primary

"consumer nexus" argument is that HCSC's refusal to pay IDR awards harms providers and restricts access to care. At oral argument, PHI emphasized that consumers would be impacted by HCSC's refusal to pay IDR awards because, if it goes unpaid, PHI ultimately would go out of business and would no longer be available to provide services to consumers. The problem, however, is that PHI does not allege or argue that it regularly provides services to *Illinois* consumers. Without this information, any potential impact on Illinois consumers is remote and speculative.

PHI also argues that it adequately alleges conduct occurring substantially and primarily in Illinois because "HCSC is headquartered in Illinois and directs claims administration, payment processing, and payment policies from Illinois, including decisions regarding (non-)compliance with IDR awards." Pl.'s Resp. at 26. These contentions do not support PHI's claim because they do not relate to HCSC's conduct towards the market and consumers.

At oral argument, PHI pointed the Court to *Guardian Flight*, 789 F. Supp. 3d at 238, arguing that the court in that case concluded that the plaintiff stated a claim for unfair and deceptive practices. This case provides no support for PHI's position, however, because the court did not address whether the plaintiff sufficiently alleged a nexus between the alleged conduct and Connecticut.

The Court concludes that PHI has not stated pled a viable claim under the Illinois Consumer Fraud and Deceptive Business Practices Act because the allegedly illegal conduct did not occur primarily and substantially in Illinois.

E. Declaratory and injunctive relief (Count 4)

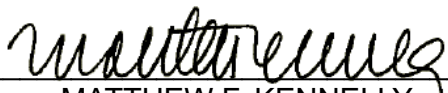
"A justiciable actual controversy exists only when a private right of action is available." *Mellott v. Sprague*, 334 F. Supp. 3d 916, 922–23 (C.D. Ill. 2017) (citing

Schilling v. Rogers, 363 U.S. 666, 677 (1960) ("the Declaratory Judgments Act is not an independent source of federal jurisdiction, the availability of such relief presupposes the existence of a judicially remedial right"). PHI's declaratory judgment and injunctive relief claim thus cannot survive without any underlying claim.

Conclusion

For the reasons stated above, the Court grants defendant's motion to dismiss plaintiff's first amended complaint [dkt. no. 28]. Unless PHI files, by August 26, 2026, a motion to amend attaching a proposed second amended complaint including at least one viable claim over which the Court has jurisdiction, the Court will enter judgment against it. The case is set for a telephonic status hearing on September 2, 2026 at 9:00 a.m., using call-in number 650-479-3207, access code 2305-915-8729.

Date: August 5, 2026


MATTHEW F. KENNELLY
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE
NORTHERN DISTRICT OF ILLINOIS

Plaintiff(s),

v.

Defendant(s).

Case No.
Judge Matthew F. Kennelly

JUDGMENT IN A CIVIL CASE

Judgment is hereby entered (check appropriate box):

in favor of plaintiff(s)
and against defendant(s)
in the amount of \$

which ☐ includes pre-judgment interest.
☐ does not include pre-judgment interest.

Post-judgment interest accrues on that amount at the rate provided by law from the date of this judgment.

Plaintiff(s) shall recover costs from defendant(s).

☐ in favor of defendant(s)
and against plaintiff(s)

Defendant(s) shall recover costs from plaintiff(s).

☒ other: Plaintiff's claims are dismissed.

This action was (*check one*):

☐ tried by a jury with Judge
☐ tried by Judge
☒ decided by Judge Matthew F. Kennelly

presiding, and the jury has rendered a verdict.
without a jury and the above decision was reached.
on a motion .

Date: 8/18/2026

Thomas G. Bruton, Clerk of Court

Melissa Astell, Deputy Clerk

APPX381