

Nos. 26-2269, 26-2279, 26-2280, & 26-2401

**In the
United States Court of Appeals
for the Seventh Circuit**

SPECIALTY CARE, INC., *et al.*,

Plaintiffs-Appellants,

v.

HEALTH CARE SERVICE CORPORATION,

Defendant-Appellee.

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

**BRIEF OF *AMICI CURIAE* THE EMERGENCY DEPARTMENT PRACTICE
MANAGEMENT ASSOCIATION AND THE EMS AMBULANCE OPERATORS
STRATEGIC AND INNOVATION ALLIANCE IN SUPPORT OF PLAINTIFFS-
APPELLANTS**

Alexa R. Baltes
JONES DAY
110 N. Wacker Dr., Suite 4800
Chicago, IL 60606
(312) 269-4143
abaltes@jonesday.com

Charlotte H. Taylor
Counsel of Record
Hannah L. Templin
JONES DAY
51 Louisiana Avenue, N.W.
Washington, DC 20001
(202) 879-3872
ctaylor@jonesday.com

Counsel for Amici Curiae

APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 26-2269, 26-2279, 26-2280, & 26-2401Short Caption: SpecialtyCare, Inc., et al v. Health Care Service Corporation

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Attorney's Signature: /s/ Charlotte H. Taylor Date: 9/16/2026Attorney's Printed Name: Charlotte H. TaylorPlease indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d).

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☒

No

☐Address: 51 Louisiana Avenue, N.W.Washington, DC 20001Phone Number: (202) 879-3872Fax Number: (202) 626-1700E-Mail Address: ctaylor@jonesday.com

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Attorney's Signature: /s/ Alexa R. Baltes Date: 9/17/2026Attorney's Printed Name: Alexa R. BaltesPlease indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d).

Yes

☐

No

☐Address: 110 N. Wacker Dr., Suite 4800Chicago, IL 60606Phone Number: (312) 269-4143Fax Number: (312) 782-8585E-Mail Address: abaltes@jonesday.com

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Attorney's Signature: /s/ Hannah L. Templin Date: 9/17/2026Attorney's Printed Name: Hannah L. TemplinPlease indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d).

Yes

☐

No

☐Address: 51 Louisiana Avenue, N.W.Washington, DC 20001Phone Number: (202) 879-3417Fax Number: (202) 626-1700E-Mail Address: htemplin@jonesday.com

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INTEREST OF *AMICI CURIAE*¹

The Emergency Department Practice Management Association (EDPMA) is the nation's only professional physician trade association focused on the business and practice management functions associated with the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes and ownership models, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, EDPMA members each year see or support 60% of all emergency department visits in the country and provide direct patient care to 40% of all emergency department visits.

The EMS Ambulance Operators Strategic and Innovation Alliance (EMS Alliance) is an unincorporated association of a number of the nation's largest providers of emergency ambulance services.² The EMS Alliance's primary

¹ This brief was authored solely by *amici* and their undersigned counsel. No person, other than *amici*, made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a)(2).

² With respect to the EMS Alliance, this brief is submitted on behalf of members Air Methods LLC; Apollo MedFlight, LLC; Falck USA, Inc.; Global Medical Response, Inc.; and Life Flight Network, LLC. Plaintiff-Appellant in two of the consolidated appeals, PHI Air Medical, is an EMS Alliance member but, as a party to the case, does not join in this *amicus* brief. *See supra* n.1. PHI Air

purpose is to effect beneficial change in the laws affecting reimbursement of emergency medical transport. The EMS Alliance's member companies collectively perform hundreds of thousands of emergency air medical transports every year, using thousands of helicopters and planes stored at hundreds of bases around the country.

Amici's members depend upon the No Surprises Act (NSA) to obtain proper reimbursement, at fair rates, from commercial health insurers. Many of those insurers have terminated long-standing in-network contracts or refused to meaningfully negotiate network agreements with *amici's* members, thereby leaving *amici's* members with no alternative but the NSA's independent dispute resolution process, backed up by the NSA's shall-pay mandate. But many insurers refuse to pay, and the district courts' opinions deny *amici's* members the ability to enforce this vital source of payment.

INTRODUCTION AND SUMMARY OF ARGUMENT

The NSA is Congress's comprehensive solution to a difficult and important problem: how to take patients out of the middle of payment disputes over out-of-network emergency medical care. When a commercially insured patient receives *in-network* care (meaning care from a provider that has a

Medical participated in the filing of a similar brief in *SpecialtyCare, Inc. v. Cigna Healthcare, Inc.*, Nos. 26-1768 & 26-1769 (3d Cir.), where it is not a party.

contract with the patient's insurer), the provider accepts the contracted rate from the insurer; and the patient pays only the predetermined "patient responsibility" amount under her policy. But when a commercially insured patient receives *out-of-network* care—which often happens in emergencies—there is no agreed-upon rate between insurer and provider, and the patient is ultimately responsible for the balance the insurer does not cover. Before the NSA, that sometimes resulted in patients receiving significant and unexpected medical bills.

The NSA's solution to this problem is novel, but simple in concept. From the patient's perspective, treat the care as if it were in-network—including prohibiting balance billing. Then, to resolve payment disputes between insurers and providers, set up a streamlined, arbitration-like process. Implementing this novel solution within a complex healthcare regulatory scheme was, of course, no easy task. As Congress drafted, it drew upon settled background principles and harmonized the NSA system with existing law governing health plans, including the Employee Retirement Income Security Act (ERISA). The result is a statute that balances the interests of patients, providers, and insurers. But the district court opinions threaten to upend that carefully designed scheme.

Since the NSA took effect in 2022, providers' efforts to obtain fair reimbursement for their services have been frustrated by chronic insurer underpayment. As the Fifth Circuit recently explained, due in part to a federal regulation that improperly allowed insurers to artificially lower their median in-network rates—a key statistic for NSA reimbursement—providers have been forced to resort to the independent dispute resolution (IDR) process far more often than the government originally expected. *See Texas Med. Ass'n v. United States Dep't of Health & Hum. Servs.*, No. 23-40605, 2026 WL 2322331, at *3 (5th Cir. Aug. 11, 2026) (en banc) (per curiam). Independent IDR entities have overwhelmingly sided with providers in these disputes. *See id.* (“[P]roviders prevailed in over 80% of arbitrations[, and] arbitrators selected a reimbursement rate higher than the [insurer’s claimed median in-network rate] in a whopping 85% of arbitrations.”). The result has been hundreds of thousands of IDR awards payable to providers.

The NSA’s text is clear about the effects of these IDR awards: they are “*binding* upon the parties involved.” 42 U.S.C. § 300gg-111(c)(5)(E)(i) (emphasis added). The statute further directs that payments “*shall be made* directly to the nonparticipating provider ... not later than 30 days after the date on which such determination is made.” *Id.* § 300gg-111(c)(6) (emphasis added); *see also id.* § 300gg-112(a)(3) (“the group health plan or health

insurance issuer ... shall ... pay a total plan or coverage amount ... directly to [the] provider”).³

But disturbingly often, insurers are simply not paying the awards. At the end of last year, *amicus* EDPMA’s members reported \$245 million in unpaid IDR awards—a staggering eight-fold increase in unpaid IDR awards for EDPMA’s members from 2024. The members of *amicus* EMS Alliance also struggle to obtain payment. One EMS Alliance member reports a non-payment rate of IDR awards for transports from 2023 to the present of 11.8%, with an average time to payment of 285 days from issuance of the award. Another reports that 18% of its favorable IDR awards for 2025 transports remain unpaid, months after they were issued. Adding insult to injury, when the EMS Alliance’s members have filed complaints with the federal government, insurers have stonewalled that process too.

The appeals before this Court present what is by now a familiar story. Plaintiffs won millions of dollars in IDR awards against Defendant Health Care

³ The NSA is comprised of two parts, one applicable to emergency room facilities and providers and the other to air-ambulance providers. The two parts are substantially similar and cross-reference one another. *See* 42 U.S.C. §§ 300gg-111, 300gg-112. The relevant provisions of the NSA occur in triplicate in the U.S. Code, because the Act amended the Public Health Service Act (cited above and throughout), ERISA, and the Internal Revenue Code. *See* 29 U.S.C. §§ 1185e, 1185f (ERISA); 26 U.S.C. §§ 9816, 9817 (Internal Revenue Code).

Service Corporation (HCSC), but HCSC has refused to pay. To enforce the IDR awards, plaintiffs sued in federal court. For some awards, plaintiffs asserted an ERISA benefits claim as the assignee of a plan beneficiary; for all awards, plaintiffs asserted a cause of action directly under the NSA.

But the district courts held that plaintiffs have no path to court to obtain payment of their IDR awards. All of the opinions on review held that the NSA does not create a private right of action for providers to enforce their “binding” IDR awards directly. And the district court in three of the consolidated cases held that ERISA beneficiaries do not have standing to sue when insurers decline to pay an IDR award because that award depends on terms outside the plans themselves. As a result, it held, the plaintiffs lack derivative standing as the plain beneficiaries’ assignees. On both issues, the district courts got the analysis badly wrong, ignoring statutory text, settled precedent, and plain common sense.

The Court should reverse. Once insurers learn that federal courts will enforce the NSA’s mandate, they will start paying what they owe. But if federal courts shut their doors to these lawsuits, the temptation to ignore IDR awards may prove irresistible, leaving *amici*’s members with no recourse to obtain the money they are owed and undoing the carefully crafted legislative compromise that the NSA embodies.

ARGUMENT

I. This Case Is Very Important to Emergency Physicians and Air Ambulance Providers

A. Emergency physicians and air ambulances depend on the NSA's shall-pay mandate.

1. Every year, millions of Americans rely on emergency physicians to render life-saving care. According to a 2025 RAND study, hospital emergency departments (EDs) handle 120 to 140 million visits each year—a number that continues to climb.⁴ Emergency physicians are both ethically and legally required to treat all patients who present at the ED. *See* 42 U.S.C. § 1395dd. But most of the life-saving care provided is either uncompensated or undercompensated. The vast majority of patients who present to an emergency department are insured by Medicaid or Medicare—or perhaps not even insured at all.⁵ The only way that emergency physicians can *stay in business*—let alone earn a profit—is to obtain reasonable compensation from those ED patients who are covered by commercial health insurance.

⁴ Mashid Abir et al., STRATEGIES FOR SUSTAINING EMERGENCY CARE IN THE UNITED STATES 19 (Apr. 7, 2025), *available at* https://www.rand.org/content/dam/rand/pubs/research_reports/RR2900/RR2937-1/RAND_RRA2937-1.pdf (2025 RAND Report).

⁵ Jesse M. Pines et al., The Cost Shifting Economics of United States Emergency Department Professional Services (2016-2019), 82 ANN. EMERG. MED. 637 (2023), *available at* <https://perma.cc/ZG3K-TUCB>.

Unfortunately for EDPMA’s members, the reimbursement they receive is steadily declining, most sharply from out-of-network commercial health insurers, whose payments are governed by the NSA. The 2025 RAND study shows that “allowed amounts” for emergency services fell 7.42% in real terms from just 2018 to 2022, and out-of-network insurers paid on average just 67% of the “allowed amounts” for the care provided to their beneficiaries.⁶ The study’s data set ended in 2022, just when the IDR process was beginning. But it contains anecdotal evidence from subsequent years demonstrating that commercial health insurers are leveraging the NSA to delay, complicate, or simply refuse payment to out-of-network providers. “One interviewee said that they have ‘claims that are as old as the beginning of the NSA and still outstanding.’”⁷

Moreover, though the majority of ED patients covered by commercial health insurers are (at present) treated by in-network emergency physicians who fall outside the NSA’s strictures,⁸ EDPMA’s members report that many large commercial health insurers are presenting them with a choice: accept

⁶ 2025 RAND Report 50, 54.

⁷ *Id.* at 33.

⁸ FAIRHealth, In-Network and Out-of-Network Utilization and Pricing: A Study of Private Healthcare Claims 9 (Feb. 20, 2024), <https://perma.cc/E2TF-9FLP>

drastically reduced reimbursement rates or else the insurer will cancel the in-network contract. Insurers are incentivized to do this because of decisions like those under review: they know that without an in-network contract, the provider's ability to recover payment is imperiled. The NSA's IDR process is in many cases the only cost-effective mechanism for out-of-network ED physicians to obtain payment, and if IDR awards are unenforceable in court, insurers do not have to pay. Reduced in-network reimbursement rates are better than no reimbursement at all.

2. Air-ambulance providers are facing a similar dilemma. Air ambulances are expensive to operate: The members of the EMS Alliance must have state-of-the-art aircraft on standby 24 hours a day, 7 days a week, 365 days a year. Each aircraft needs a base of operations and—at all times—an available pilot, flight nurse, flight paramedic, and aviation mechanic. Providers therefore incur high fixed costs that come due each month, including aircraft acquisition and leasing costs, salaries, jet fuel, and maintenance costs.

Air-ambulance companies are legally and ethically required to respond to all requests for emergency transport, without regard to the patient's ability to pay. Most of the patients they transport are covered by Medicare or Medicaid, which reimburse providers at rates that typically do not even cover EMS Alliance members' costs of providing the services, let alone allow them to

turn a profit. The EMS Alliance’s members are therefore critically dependent on the payments they receive from commercial health insurers. Many air-ambulance companies are out-of-network for many or all major commercial health insurers, which means that these providers are especially dependent on the NSA’s shall-pay mandate.

B. Insurers are flouting the NSA’s shall-pay mandate.

Yet as this case demonstrates, insurers like HCSC are routinely refusing to pay IDR awards—despite the NSA’s dictate that insurers “shall” pay. *Amicus* EDPMA conducts annual surveys to measure the impact of the NSA’s IDR process on its members. The results show that an increasing number of IDR disputes are initiated (and won) by EDPMA’s members: more than 659,000 IDR awards in 2025 alone. But members also reported that more than \$245 million of IDR awards have gone unpaid.

EDPMA began its surveys in 2022, when the IDR process took effect. Respondents to those surveys collectively served at least a quarter of all ED visits and initiated more than half of all IDR disputes that year. They reported

that a whopping 87% of insurers failed to fully pay the IDR awards within 30 days as required by the NSA.⁹

Things improved somewhat in 2023: respondents reported that just under a quarter of IDR awards were unpaid within 30 days.¹⁰ But that improvement was short-lived. The next year, the first district court held that the NSA does not give providers a private right of action to enforce IDR awards—and things began to go downhill. EDPMA’s 2024 survey, sent to eight large members representing hundreds of ED practices, indicated that:

- providers won 313,800 IDR awards;
- 186,900 (59.6%) of those awards were not paid within 30 days;
- of those that ultimately were paid, 33,300 (26.3%) were paid in the *wrong amount*; and
- \$29,099,100 worth of IDR awards were wholly *unpaid* as of December 31, 2024.¹¹

⁹ EDPMA, INDEPENDENT DISPUTE RESOLUTION IN THE NO SURPRISES ACT—DEFICIENCIES AND COMPLIANCE FAILURES 2 (July 2023), <https://perma.cc/263D-MD8T> (2022 EDPMA Survey).

¹⁰ EDPMA, NO SURPRISES ACT IMPLEMENTATION AND COMPLIANCE: DATA ANALYSIS 3 (Apr. 2024), <https://perma.cc/U5NB-67KB> (2023 EDPMA Survey).

¹¹ EDPMA, NO SURPRISES ACT UPDATE FULL-YEAR 2024 IDR METRICS 1 (May/June 2025), <https://perma.cc/FTB9-S4Z2> (2024 EDPMA Survey).

EDPMA's most recent survey, focused on services provided in 2025, confirmed that the problem is only getting worse. Nine large members representing hundreds of ED practices reported that:

- their providers won 659,600 IDR awards in 2025;
- 316,300 (48%) of those were not paid within 30 days; and
- \$245,040,100 worth of IDR awards were wholly unpaid as of December 31, 2025—an *eight-fold increase* over the previous year.¹²

Members of *amicus* EMS Alliance report a similar pattern. Global Medical Response, Inc., the largest provider of air-medical transportation services in the country, reviewed its records for all transports it has carried out since 2023. GMR received a favorable award in 95.9% of the cases it took through the IDR process. However, insurers failed to provide timely payment of amounts owed on over 58.6% of those awards—and 11.8% of GMR's favorable IDR awards remain unpaid as of the date of this filing. The average time it takes insurers to pay is 285 days, which is *255 days* past Congress's mandatory 30-day payment deadline.

Life Flight Network, a mid-size air-ambulance company, conducted a review of its payment records for transports it carried out in 2025. Life Flight

¹² EDPMA, NO SURPRISES ACT UPDATE – FULL YEAR 2025 IDR PAYMENT COMPLIANCE (Apr. 2026), <https://perma.cc/WG3Y-UFZJ> (2025 EDPMA Survey).

has also prevailed in the overwhelming majority of the IDRs in which it has participated, but 29% of those awards were not paid by the 30-day deadline, and 18.5% remain unpaid as of this filing. Similar to the experience of EDPMA's members, that represents an uptick in delinquency from transports performed in 2023 and 2024, when Life Flight (in a comparable review) found a non-payment rate of approximately 14%.

Another mid-size EMS Alliance member conducted a review of its payment records from 2023, 2024, and 2025. Of the 2,260 transports covered by the NSA, this member took 1,722 to IDR and received decisions from arbitrators for 1,517 of these submissions. Arbitrators from the IDR entities awarded additional payments to this member in 1,400 of those determinations (about 92%). Of those victories, 177 of those binding awards (about 13%) remain unpaid as of September 2026; the average length of delay for those holdouts was about 192 days.

This pattern of delayed and non-payment is not due to inadvertence on the part of insurers. Because of court decisions like those on appeal here, insurers believe there are no consequences for ignoring the mandatory 30-day payment deadline. Indeed, it is the avowed policy of at least one major third-party administrator of employee healthcare plans to refuse payment of IDR awards when it believes the underlying dispute was not eligible for IDR under

the NSA—even when it raised this argument in IDR and the IDR entity rejected it.¹³ A recent complaint filed by Plaintiff-Appellant PHI Air Medical indicates that PHI is owed over \$30 million on over 1,000 unpaid IDR awards under plans insured or administered by the same company.¹⁴

C. Insurers’ failure to pay has dire consequences.

Without receiving reimbursement from insurers, ED physicians and air-ambulance providers face dire financial consequences—including bankruptcy. That is not a mere hypothetical. In 2022, Air Methods, a member of the EMS Alliance, announced the closure of air bases across the country, in part “due to the tremendous pressures from the No Surprises Act.”¹⁵ Two years later, Air Methods declared bankruptcy, attributing its financial woes to the IDR process. As it told the bankruptcy court, it “has been highly successful in winning

¹³ Unison Risk Advisors, NO SURPRISES ACT – ANTHEM’S PROCESS FOR INDEPENDENT DISPUTE RESOLUTION (IDR) at 2 (2026), *available at* <https://tinyurl.com/3ceyk7b8> (“TPAs may challenge whether a claim is eligible for the federal IDR process. The arbitrator must decide that threshold issue. However, claims frequently proceed through IDR [when] the arbitrator rejects the challenge.... According to Anthem, its historical practice has been to decline payment of IDR awards when it continues to believe that the underlying dispute was not eligible for federal IDR.”).

¹⁴ See ECF 1, at 25 ¶ 77, *PHI Health, LLC v. Anthem Ins. Cos.*, No. 3:26-cv-00636-GNS (W.D. Ky. Aug. 17, 2026).

¹⁵ Z. Briggs, Air Methods Closes Bases in Kerrville and Pleasanton over Financial Pressures, *Kens 5 News* (Sept. 16, 2022), <https://perma.cc/BJ63-9ZYE>.

disputes during the IDR process,” but faced “significant delays ... caus[ing] an unprecedented increase in the time to collect.”¹⁶

Likewise, in 2023, American Physician Partners—a company that had staffed EDs in more than 100 hospitals and treated more than 4 million patients each year in the midwestern and southwestern United States—filed for bankruptcy. The company told the court that the NSA was a contributing factor to its bankruptcy by “enabling [insurers] to significantly delay and unilaterally reduce or deny payments.”¹⁷ Indeed, “[o]f the eligible claims the Company submitted through the [IDR] process, only a small portion has been resolved, and of those that were resolved, many remain unpaid by health insurers.”¹⁸

II. Plaintiffs May Sue to Enforce Their Right to Payment from HCSC Under the NSA.

This state of affairs is not what Congress intended. Instead, the statute Congress enacted gives providers like plaintiffs a cause of action to enforce their NSA awards.

¹⁶ Declaration of Jason Kahn ¶ 45, ECF 5, *In re Air Methods Corp.*, No. 23-90886 (Bankr. S.D. Tex. Oct. 24, 2024).

¹⁷ Declaration of John C. DiDonato ¶ 35, ECF 18, *In re American Physician Partners, LLC*, No. 23-11469 (Bankr. D. Del. Sept. 19, 2023).

¹⁸ *Id.*

When Congress crafts a statutory alternative-dispute resolution process that results in a binding award, that award is enforceable in court. Indeed, *amici* are aware of *no statute* in which Congress has created a scheme where such an award is *not* enforceable in court. *See, e.g., Cheminova A/S v. Griffin L.L.C.*, 182 F. Supp. 2d 68, 73-74 (D.D.C. 2002) (explaining that “absent a plain indication to the contrary” courts “must assume” that Congress intends a statutory scheme “to fit within existing arbitration law” that says “use of ... terms” like “binding” makes awards enforceable). IDR determinations should be treated no differently. IDR entities do not undertake the work of determining the appropriate “out-of-network rate” as an abstract academic exercise. The sole purpose of the IDR process is to determine the payment owed to providers; it is streamlined and fast to make sure that insurers pay promptly.

The Court’s analysis could end there, but multiple textual and contextual clues confirm that Congress gave providers a right of action to enforce IDR awards under the NSA. A private right of action exists where there are both “a private right” and “a private remedy.” *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). As the district courts recognized, the NSA checks the first box: it “confers a right for providers to payment.” *SpecialtyCare Inc. v. Health Care Service Corporation*, No. 25 CV 12935, 2026 WL 1556442, at *5 (N.D. Ill. June 2, 2026); *accord PHI Health, LLC v. Health Care Serv. Corp.*, No. 25 C 12406, 2026

WL 1802985, at *4 (N.D. Ill. June 23, 2026). However, they wrongly concluded that Congress “chose agency enforcement as the tool for enforcing IDR awards, not litigation.” *Id.*; *see also SpecialtyCare*, 2026 WL 1556442, at *5. Not so. The NSA’s text and structure confirm that Congress gave *providers* (like plaintiffs) the ability to enforce their rights in court. This remedy is especially critical because agency enforcement mechanisms are inapposite and ineffectual.

A. The text and structure of the NSA evince Congress’s intent for providers to be able to enforce their right to payment in court.

Several aspects of the NSA make clear that Congress intended providers to be able to enforce their right to payment from insurers in court.

First, the NSA “explicitly confer[s] a right directly on a class of persons”—the providers who seek to enforce that right here. *Cannon v. Univ. of Chicago*, 441 U.S. 677, 690 n.13 (1979). One of the district courts read the NSA as focused solely on benefitting *patients*, not *providers*. *SpecialtyCare*, 2026 WL 1556442, at *5. But that is mistaken; the text safeguards providers and patients equally. The NSA guarantees that payment “shall be made directly *to the nonparticipating provider* not later than 30 days after the date on which such determination is made.” 42 U.S.C. § 300gg-112(b)(6) (emphasis added); *see also* § 300gg-111(c)(6). Courts have recognized that language establishing entitlement to payment is “rights-creating because it is mandatory and has a

clear focus on the benefitted” providers. *Legacy Cmty. Health Servs., Inc. v. Smith*, 881 F.3d 358, 371-72 (5th Cir. 2018) (citation modified); accord *Bowen v. Massachusetts*, 487 U.S. 879, 923 (1988) (Scalia, J., dissenting) (explaining that “a statute commanding the payment of a specified amount of money by the United States impliedly authorizes (absent other indication) a claim for damages in the defaulted amount” and collecting cases); *Pee Dee Health Care, P.A. v. Sanford*, 509 F.3d 204, 212 (4th Cir. 2007). While the existence of a private right does not necessarily dictate the existence of a remedy, it is nevertheless “critical” to the overall inquiry and should dispel any reluctance to finding a private right of action where there is other textual and structural evidence of congressional intent to create one. *Sandoval*, 532 U.S. at 288.

Second, the NSA speaks of providers’ right to payment in mandatory terms: it states that payment “shall be made [by insurers] directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.” See 42 U.S.C. § 300gg-112(b)(6); see also § 300gg-111(c)(6). To say that an insurer “shall” be liable for costs to a provider is “the express creation of a right of action.” *Key Tronic Corp. v. United States*, 511 U.S. 809, 818 n.11 (1994); accord *id.* at 822 (Scalia, J., dissenting). Unsurprisingly, the Supreme Court has repeatedly held that “shall pay” (and similar mandatory words) “often reflects congressional intent ‘to create both a right

and a remedy.” *Maine Cmty. Health Options v. United States*, 590 U.S. 296, 324-25 (2020); *see also Federal Communications Commission v. AT&T*, 608 U.S. 531, 544 n.3 (2026) (the phrase “shall be liable” expressly created a cause of action enabling “the victim [to] sue the perpetrator”); *Sandoval*, 532 U.S. at 279-80, 288-89 (explaining that Section 601 of Title VI of the Civil Rights Act and Title IX of the Education Amendments of 1972—both using “shall” language—confer private rights of action).

Third, the NSA makes IDR awards “binding upon the parties involved.” 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I); *see also* § 300gg-112(b)(5)(D). By making the effect of an IDR award “binding,” Congress plainly intended to render payment required by IDR awards enforceable in court. “Binding” means “having legal force to impose an obligation” or “requiring obedience.” *Binding*, *Black’s Law Dictionary* (11th ed. 2019). If an award is not enforceable in court, it is not binding on the parties.

That plain meaning comes imbued with a long history of courts enforcing binding awards. Before enactment of the Federal Arbitration Act (FAA), parties that concluded an arbitration pursuant to a contract routinely came to court to enforce awards. The agreement to arbitrate rendered any resulting arbitration award binding; in turn, the fact that the award was binding made it enforceable in court. *See* 21 Williston on Contracts § 57:2, *Arbitration Agreements at*

Common Law (4th ed.) (“[O]nce an arbitration award was made ... [a]n award was binding on both parties and was enforced by the courts.”); *Red Cross Line v. Atl. Fruit Co.*, 264 U.S. 109, 121 (1924) (“[I]f [an agreement to arbitrate is] executed—that is, if the award has been made—effect will be given to the award in any appropriate proceeding at law, or in equity.”). So strong is the relationship between the binding nature of an award and its consequent enforceability that this Court has long concluded that “[t]o agree to binding arbitration *is to agree* that if your opponent wins the arbitration he can obtain judicial relief if you refuse to comply with the arbitrator’s award.” *Lander Co. v. MMP Invs., Inc.*, 107 F.3d 476, 480 (7th Cir. 1997) (emphasis added).

Indeed, that stands true even with respect to the FAA, which by its terms states that judicial confirmation of an arbitration award via Section 9’s procedures is appropriate only “[i]f the parties ... have *agreed* that a judgment of the court shall be entered upon the award made pursuant to the arbitration.” 9 U.S.C. § 9 (emphases added). Despite the express condition, courts do not require magic words about “judicial confirmation” to be included in an arbitration agreement before allowing court enforcement. Rather, a “provision in [an] agreement that the arbitrator’s determination would be *final and binding*, along with [a party’s] full participation in the arbitration process, is sufficient ... to confer authority on the district court to confirm the award.”

Booth v. Hume Publ'g, Inc., 902 F.2d 925, 930 (11th Cir. 1990) (emphases added).

Here, by expressly making IDR determinations “binding” under the NSA, Congress drew on this baseline understanding of the term and demonstrated clear intent for those awards to be enforceable in court. *See Transamerica Mortg. Advisors, Inc. v. Lewis*, 444 U.S. 11, 19 (1979) (holding that when Congress uses a particular term, “it intend[s] that the customary legal incidents” of that term follow).

Fourth, the IDR process is in fact *modeled* on the FAA’s arbitration process, reinforcing that the award is judicially enforceable.¹⁹ The NSA, like the FAA, provides that the merits of the adjudicator’s determination “shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a)” of the FAA, the provision addressing limited circumstances in which awards can be vacated. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). In permitting limited vacatur, Congress confirmed that the award must otherwise be judicially enforceable; there would be no reason to describe the circumstances in which an IDR award could be *disturbed* if the award could not be *enforced* in the first place. Indeed, if judicial enforcement

¹⁹ Alternatively, as Plaintiffs-Appellants argue, they have a cause of action under FAA Section 9 itself. *See* Opening Br. 47-55.

were unavailable, the party dissatisfied with the award could simply decline to pay without demonstrating to a court that it met any of the enumerated grounds for vacatur (as indeed at least one payor is already deliberately doing, *see supra* Section I.B.). That would turn the NSA’s careful limitation of the circumstances in which an IDR award can be vacated into a nullity.

Fifth, if providers have no means of enforcing their right to payment, not only would the purpose of the NSA be frustrated, but its very structure would collapse. *See Turkiye Halk Bankasi A.S. v. United States*, 598 U.S. 264, 275 (2023) (statutory provisions must be read “with a view to their place in the overall statutory scheme”). The NSA channels disputes over payments into mandatory IDR—providers cannot seek payment from patients or go outside the system. 42 U.S.C. §§ 300gg-131, 300gg-135. If providers cannot compel insurers to comply with the resulting IDR awards, the IDR process would be pointless.

B. Congress did not vest enforcement of the “shall pay” mandate in agencies.

Further reinforcing the case for a private right of action is the fact that the NSA provides no other enforcement mechanism to ensure payors pay providers what they are due. As *Sandoval* explains, “elaborate” agency enforcement mechanisms “tend to contradict a congressional intent to create privately enforceable rights.” 532 U.S. at 290. The provision at issue there, for

example, tasked agencies with “advis[ing] the appropriate person or persons of the failure to comply” with the authorized regulations and attempting to secure “compliance ... by voluntary means” before taking specified enforcement actions. *Id.* at 289 (quoting 42 U.S.C. § 2000d-1). That weighed against private enforcement. *Id.*

In contrast, the NSA makes “binding” the “determination *of a certified IDR entity*” itself. 42 U.S.C. § 300gg-111(c)(5)(E) (referring to the determination made “under subparagraph (A)”); *see also id.* § 300gg-112(b)(5)(D). The IDR entity’s determination does not trigger further administrative enforcement action; nor is there an administrative mechanism comparable to that in *Sandoval*. The NSA contemplates that the IDR determination will be directly *judicially* reviewable under certain circumstances. *Id.*

The district courts reached the opposite conclusion based on generic provisions that vest the Department of Health and Human Services (HHS) and the Department of Treasury to impose a civil penalty of \$100 a day on insurers that fail to comply with an IDR determination. 42 U.S.C. § 300gg-22(b)(2) (HHS); 26 U.S.C. § 4980D(b)(1) (Treasury); *see SpecialtyCare*, 2026 WL 1556442, at *5; *PHI Health*, 2026 WL 1802985, at *4. But there are numerous problems with that conclusion.

To start, providers' efforts to seek agency assistance in enforcing IDR awards have gone nowhere. One EMS Alliance member, for example, has submitted 109 complaints reporting non-payment and other payor misconduct—but it is unaware of any agency taking any action to compel an insurer to pay. Along the same lines, EDPMA surveys its members about agencies' responses to their complaints (including complaints about issues other than nonpayment). These surveys consistently reveal that agencies provide little to no help:

- In 2022, “[r]espondents reported that CMS had only responded to approximately 14% of their complaints.”²⁰
- In 2023, “respondents alone submitted 19,047 complaints” to HHS, Treasury, and Labor, but “report[ed] that only 1.3% of these complaints ha[d] been resolved.”²¹
- In 2024, respondents reported that “[t]he lack of enforcement by regulatory agencies has perpetuated massive payment non-compliance by health plans into the 3rd year of the NSA program.”²²

²⁰ 2022 EDPMA Survey 2.

²¹ 2023 EDPMA Survey 4.

²² 2024 EDPMA Survey 1.

- And last year, respondents described that agencies “notified repeatedly about ... payment noncompliance ... have yet to engage in meaningful enforcement,” resulting in “an unacceptably high percentage of non-compliance by health plans with impunity.”²³

This is not a system indicative of congressional intent to use “agency enforcement as the tool for enforcing IDR awards, not litigation.” *PHI Health*, 2026 WL 1802985, at *4.

Beyond the practical reality that complaints about non-payment have not been properly or timely addressed, as a legal matter, the enforcement provisions on which the district courts relied do not cover the waterfront.²⁴ Many IDR determinations concern ERISA plans, and the Department of Labor—not HHS or Treasury—has general supervisory authority over those. Indeed, a GAO report on the practical challenges of implementing the IDR process noted that, by the end of 2023, agencies had “received 3,400 complaints regarding late payment issues and 3,200 of those complaints were referred to the Department of Labor.”²⁵ But there is *no penalty provision* for the Department of Labor

²³ 2025 EDPMA Survey 1-2.

²⁴ That is unsurprising: they were enacted in 1996—decades before the NSA.

²⁵ 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

comparable to those applicable to HHS and Treasury. All the GAO report contemplates for awards subject to ERISA is that a Labor “benefits advisor” *might* “work[] with the group health plan to get voluntary compliance.”²⁶

Experience has since shown that group health plans are stymying Labor’s efforts to obtain compliance. Earlier this year, for example, GMR subsidiary Guardian Flight sought Labor’s assistance to compel Cigna to pay ten IDR awards. The agency responded that, because Cigna stonewalled its inquiries, there was nothing it could do:

[T]he carrier has not provided confirmation that payment has been issued nor any documentation demonstrating compliance with the IDR determination. We have therefore exhausted all avenues for informal resolution. Because our ability to move forward is limited by the lack of response and information from the insurer, we must close our review at this time. This closure does not suggest that your complaint lacks merit, nor does it prevent you from pursuing other available options or legal remedies.²⁷

Other providers have received similar responses. That means that for the large portion of IDR awards for healthcare services covered by ERISA-governed plans, there is effectively no enforcement. If Congress had really intended to

CHALLENGING 34-35 n.59 (Dec. 2023), <https://www.gao.gov/assets/d24106335.pdf> (emphasis added).

²⁶ *Id.* at 36.

²⁷ ECF 388-1, at 5, *Guardian Flight LLC v. Aetna Life Ins. Co.*, No. 3:24-cv-680-MPS (D. Conn. June 3, 2026).

leave enforcement of IDR awards up to the agencies, it would not have made such a glaring omission.

More fundamentally, the civil-penalty provisions do nothing to ensure that the insurer actually pays the provider what is owed. If they are assessed at all, they are paid to the *government* (based on the duration of noncompliance) rather than to the relevant *provider*. To put the point simply, an award of an amount due to a provider is not “binding” if there is no way for the provider to get paid the specified sum. As the federal government has emphasized, any “enforcement” by the agencies under the relevant provisions “would not ensure that [IDR] decisions are binding on the parties.” *Amicus Br. of United States 13, Guardian Flight v. Health Care Service Corp.*, No. 24-10561 (5th Cir.). Private enforcement is the *only* mechanism that can ensure IDR awards are paid *to providers*. The Court should hold that providers have a private right of action to give force to Congress’s directives that IDR awards are “binding” and that payors “shall” pay.

III. Plaintiffs Have Derivative Standing to Assert an ERISA Claim for Improper Denial of Benefits.

Alternatively, plaintiffs do have standing under ERISA to seek the payments wrongly withheld. Indeed, ERISA standing is especially critical here

where the Department of Labor has thus far been entirely unable to enforce IDR awards related to ERISA plans. *See supra* Section II.B.

ERISA health plan beneficiaries have a right to sue the plan administrator (here, HCSC) when they have been improperly denied plan benefits. *See* 29 U.S.C. § 1132(a)(1)(B). Beneficiaries may also assign that right to a third party, like a provider, and the assignee may bring ERISA suits standing in the shoes of the beneficiaries, including for standing purposes. *See Griffin v. TeamCare*, 909 F.3d 842 (7th Cir. 2018) (per curiam). Here, the HCSC beneficiaries validly assigned their rights to the plaintiffs. The question for standing purposes is whether the beneficiaries would have standing to bring an improper-denial-of-benefits claim under ERISA; if they would, then the plaintiffs have standing to assert that claim in this case.

The district court concluded that the HCSC beneficiaries would not have standing because the right to payment “depends on terms outside the plans themselves (here, the independent dispute resolution process).” *SpecialtyCare*, 2026 WL 1556442, at *2. The beneficiaries “were not parties to the independent dispute resolution process,” so the court reasoned “they could not bring a suit for underpayment.” *Id.* That is wrong; the NSA IDR process is not separate from the plans but an integral plan benefit.

The NSA requires health plans to cover beneficiaries for care received from out-of-network emergency providers (including air-ambulance providers) the same way they would for in-network providers, paid at a rate ultimately determined by an IDR award:

[T]he plan or issuer *shall cover* emergency services ... in a manner so that ... the group health plan or health insurance issuer ... pays a total plan or coverage amount directly to such provider or facility ... equal to ...the *out-of-network rate* [minus the patient cost-sharing amount]....

42 U.S.C. § 300gg-111(a)(1) (emphases added); *see also id.* § 300gg-112(a) (air ambulances). The IDR entity, where necessary, determines the “out-of-network rate.” *Id.* §§ 300gg-111(a)(3)(K), 300gg-112(b). And the NSA is directly incorporated into ERISA itself. *See* 29 U.S.C. §§ 1185e(a)(1), (a)(3)(K), 1185f(a). That means the coverage mandate in the NSA is an *ERISA* coverage mandate. It is thus “a global directive that regulates the substantive content of [health] plans,” and as such, it “adds a mandatory term” to all plans that provide coverage for in-network emergency services. *See Cent. Laborers’ Pension Fund v. Heinz*, 541 U.S. 739, 750 (2004).

Like all coverage provisions, the fact that health plans must cover out-of-network emergency care—that is, pay providers for patient care at the IDR-determined rate—is one of the bargained-for benefits of HCSC’s health plans. HCSC’s failure to cover that care by paying the providers the total plan or

coverage amount (ultimately determined by the IDR entity) denies the beneficiaries a plan benefit to which they are contractually entitled. The beneficiaries have thus suffered an injury traceable to HCSC's conduct and redressable by an order to pay the IDR awards. *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016). In short, the beneficiaries have standing; therefore, so too do the plaintiffs.

CONCLUSION

The Court should reverse and permit plaintiffs' suits to proceed under the NSA and ERISA.

September 16, 2026

Respectfully submitted,

/s/ Charlotte H. Taylor

Charlotte H. Taylor

Counsel of Record

Hannah L. Templin

JONES DAY

51 Louisiana Avenue, N.W.

Washington, DC 20001

(202) 879-3872

ctaylor@jonesday.com

Alexa R. Baltes

JONES DAY

110 N. Wacker Dr., Suite 4800

Chicago, IL 60606

(312) 269-4143

abaltes@jonesday.com

Counsel for Amici Curiae Emergency

Department Practice Management

Association and Ambulance Operators

Strategic and Innovation Alliance

CERTIFICATE OF COMPLIANCE

This document complies with the type-volume limitations of Seventh Circuit Rule 29 because, excluding the parts of the document exempted by Federal Rule of Appellate Procedure 32(f), this document contains 6,422 words.

This document complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type-style requirements of Federal Rule of Appellate Procedure 32(a)(6) because this document has been prepared in a proportionally spaced typeface using Microsoft Word for Office 365 in 14-point Century Schoolbook Std.

/s/ Charlotte H. Taylor
Charlotte H. Taylor

CERTIFICATE OF SERVICE

I certify that on September 16, 2026, I electronically filed the foregoing document with the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

/s/ Charlotte H. Taylor
Charlotte H. Taylor

EXHIBIT A

An appearance is hereby filed by the above named attorney for:

1. The Emergency Department Practice Management Association
(EDPMA)
2. EMS Ambulance Operators Strategic and Innovation Alliance
members:
 - a. Apollo MedFlight, LLC
 - b. Falck USA, Inc.
 - c. Global Medical Response, Inc.
 - d. Life Flight Network, LLC
 - e. Air Methods, LLC

Disclosure Statement

Pursuant to Fed. R. App. P. 26.1 and Cir. R. 26.1, the undersigned counsel provides the following statements to the best of my knowledge and belief:

1. The Emergency Department Practice Management

Association (EDPMA): EDPMA is a not-for-profit national trade association organized as a Section 501(c)(6) corporation. EDPMA has no parent corporation and no publicly held company has an ownership interest in EDPMA.

2. EMS Ambulance Operators Strategic and Innovation

Alliance (EMS Alliance): EMS Alliance is an unincorporated association. The EMS Alliance members participating in this amicus brief are listed below.

3. Apollo MedFlight, LLC: Apollo MedFlight, LLC is a wholly owned subsidiary of ITA Holdings Group, LLC, a privately held limited liability company.

4. Falck USA, Inc.: Falck USA, Inc. is a wholly owned subsidiary of Falck A/S, a privately held Danish corporation.

5. Global Medical Response, Inc.: Global Medical Response, Inc.

is an indirect subsidiary of GMR Solutions Inc., a publicly traded corporation (symbol: “GMRS”). Pegasus Aggregator Holdco LLC owns 10 percent or more of GMR Solutions Inc.’s common stock. Pegasus Aggregator Holdco LLC is ultimately owned by KKR & Co. Inc., a publicly traded company (symbol: “KKR”). KKR & Co. Inc. has no parent corporation, and no publicly held company owns 10 percent or more of its common stock.

6. Life Flight Network, LLC: Life Flight Network, LLC is an

Oregon limited liability company. The members of Life Flight Network, LLC are non-profit hospital systems and public corporations. Life Flight Network operates the air medical program on a not-for-profit basis. No publicly held company has an ownership interest in Life Flight Network, LLC.

7. Air Methods, LLC: Air Methods, LLC is a wholly owned

subsidiary of ASP AMC Intermediate Holdings, LLC, which is a wholly owned subsidiary of CHPPR AcquisitionCo Inc.

/s/ Charlotte H. Taylor
Charlotte H. Taylor