CASE NO. 26-2355

United States Court of Appeals

for the

Ninth Circuit

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, a California corporation; and BLUE CROSS OF CALIFORNIA DBA ANTHEM BLUE CROSS, a California corporation,

Plaintiffs-Appellants,

v.

HALOMD, LLC, et al.,

Defendants-Appellees.

On Appeal from the United States District Court for the Central District of California, No. 8:25-cv-1467, Magistrate Judge Karen E. Scott

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

Kara P. Wheatley
Ryan C. Temme
Seth T. Perretta
Elizabeth Loh
GROOM LAW GROUP, CHARTERED
1701 Pennsylvania Ave., N.W.
Washington, D.C. 20006
Tel: (202) 867-0620
Fax: (202) 659-4503

CORPORATE DISCLOSURE STATEMENT

Amici Curiae the American Benefits Council, the ERISA Industry Committee, and the Business Group on Health have no parent corporations. They have no stock, and therefore, no publicly held company owns 10% or more of their stock.

INTEREST OF THE AMICI CURIAE

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

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

administration.

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

Amici's members include thousands of employers that together offer or administer the health benefits of virtually all individuals covered under employer-sponsored plans. Because those plans bear the direct financial consequence of how the NSA functions in practice, *Amici* therefore have a direct and substantial interest in the No Surprises Act ("NSA")[1] and its effects on the cost of providing health coverage.

Amici previously submitted an amicus brief in the district court proceedings in this case, urging the court to recognize the structural fraud and abuse permeating

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

the NSA's independent dispute resolution ("IDR") process and the significant costs that abuse imposes on employer-sponsored plans and their enrollees. The district court dismissed all claims for want of subject matter jurisdiction. Because that ruling, if affirmed, would eliminate the only viable recourse available to plans and employers victimized by bad-faith IDR conduct, *Amici* write separately to describe, from the perspective of the plans and employers that bear these costs directly, what is at stake if the district court decision stands.

INTRODUCTION

The importance of this appeal transcends the interests of the parties. The district court read the NSA to foreclose judicial review of IDR eligibility determinations and to bar fraud-based claims whenever a payer identifies and challenges the alleged fraud during the IDR process. Taken together, the district court's holding would insulate from review the bad-faith conduct that Plaintiffs-Appellants allege. No subset of payers bears the cost of this bad-faith conduct more directly than self-insured group health plans sponsored by private employers and their employees, who absorb every inflated award through higher cost of coverage, reduced benefits, or both.[2]

The fraudulent behavior that Plaintiffs-Appellants challenge here is widespread and impacts virtually all private payers of health care services. These behaviors untenably increase the cost of health care for employers, employees, and the health care delivery system. *Amici* submit this brief to describe, from the vantage point of plans and employers that bear these costs, how the IDR process currently operates and what is at stake if the district court decision stands: the billions in excess costs imposed by a flood of ineligible and fraudulent IDR filings, the absence of any effective screening mechanism, the inflated awards that incentivize providers to remain out of network, and the unregulated intermediaries

[2] CMS, *Independent Dispute Resolution Reports,* Federal IDR Supplemental Tables for 2025, https://www.cms.gov/nosurprises/policies-and-resources/reports.

who have built entire business models out of exploiting these features.

I. CONGRESS ENACTED THE NSA TO PROTECT PATIENTS AND TO REIN IN OUT-OF-NETWORK COSTS.

Prior to the NSA, health plan enrollees had no systematic way to avoid surprise medical bills involving air ambulance services, emergency services, and non-emergency services provided by out-of-network professionals at in-network facilities. The financial burden imposed by surprise bills on employees and their families was, in many cases, extraordinary. After lengthy debate, Congress enacted the NSA with two objectives: to protect patients *and* to lower the cost of health care.

The Congressional Budget Office ("CBO") confirmed as much, determining that the dispute resolution process would generate $17 billion in budgetary savings and result in reductions of premium rates by 0.5 to 1 percent.[3] A central negotiator of the NSA emphasized that those very savings allowed Congress to fund other multi-year health priorities.[4]

To that end, Congress built the qualifying payment amount ("QPA"), the plan's median in-network reimbursement rate, into the statute and *mandated* that IDR entities consider it in evaluating the parties' offers, a mandate that does not

[3] *See CBO Estimate for Divisions O through FF, H.R. 133, Consolidated Appropriations Act, 2021* (Jan. 14, 2021), https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf.
[4] 166 Cong. Rec. H7301-02, H7305 (Dec. 21, 2020) (House floor debate on H.R. 133, the Consolidated Appropriations Act, 2021, as amended).

apply to any of the other factors that the IDR *may* consider. The House Report accompanying the NSA praised "the opportunity to tether payment rates for surprise out-of-network bills directly to market-based prices, curbing cost growth relative to the status quo."[5]

The framework has not functioned as designed. The IDR process has been captured by high-volume, bad-faith actors who treat it not as a last resort but as a profit center. When intermediaries like HaloMD advertise their ability to obtain IDR awards of at least five times the QPA[6] and when CMS data confirms median awards reaching multiples of that benchmark across specialties and service categories, the mechanism designed to moderate out-of-network costs is instead driving them dramatically upward. The costs flow directly to employer-sponsored plans, and from those plans to employees through higher premiums and reduced benefits.

The district court's ruling creates an impossible bind for employer plans. Plans that identify and object to ineligible or fraudulent IDR filings—as the NSA's process requires—are left without judicial recourse on those very same grounds. The party best positioned to catch and document fraud is thus the one left without a remedy. Notably, these are not challenges to the IDR entities' ultimate

[5] H.R. Rep. No. 116-615 (2020).
[6] *See HaloMD,* https://halomd.com/ (last visited Aug. 11, 2026) (touting $2 billion annual in IDR awards and awards of 5 times or more than the QPA).

determinations, but to the jurisdictional authority of the IDR entities to issue a determination.

II. THE DISTRICT COURT'S RULING ELIMINATES THE ONLY PRACTICAL CHECK ON IDR ABUSE, AT MASSIVE COST TO PLANS AND ENROLLEES.

The existing data, much from Centers for Medicare and Medicaid Services' ("CMS's") own reporting, shows how far the IDR process has strayed from its intended role, and why foreclosing judicial recourse would be consequential for employer-sponsored plans and their enrollees. The four dimensions of that harm are discussed as follows: the direct cost burden imposed by excessive IDR filings and awards; the structural absence of any effective eligibility check; the perverse incentives that drive providers to remain out of network; and the unregulated intermediaries who built business models around exploiting these failures.

A. Misuse of the IDR Process Sharply Increases Costs for Employer Plans.

CMS estimated that the NSA would generate 17,000 disputes to be decided through IDR per year.[7] The reality today is starkly different: initiating parties, virtually all of whom are providers (over 99%), filed more than 2.5 *million* disputes in 2025 alone,[8] bringing the total disputes to roughly 6 million to date.[9]

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[7] Requirements Related to Surprise Billing; Part II; 86 Fed. Reg. 55,980, 56,066 (Oct. 7, 2021).
[8] *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.
[9] CMS, *Independent Dispute Resolution Reports,* Federal IDR Supplemental Tables for 2025, https://www.cms.gov/nosurprises/policies-and-resources/reports.

Rather than a backstop, the IDR process has become a vehicle for high-volume, high-dollar claims that generate billions of dollars in plan and employer payments far exceeding the market-based rate.

Because the losing party in IDR must bear the full cost of the IDR entity fee[10] and because providers prevailed in 85% of IDR cases in the second half of 2025,[11] these fees fall predominately on payers. Additionally, because IDR entity fees are assessed on a claim-by-claim basis, the surge in filings yields no efficiencies, only recurring costs. Neither Congress nor CMS anticipated this level of financial burden when the NSA was adopted and implemented, and the existing statutory framework provides no mechanism to cap or moderate it.

Federal agencies estimated plans' and providers' internal costs to submit IDR materials would be $857 per dispute.[12] On that basis, researchers concluded internal administrative costs reached roughly $1.9 billion from 2022 through 2024.[13] Recent data shows that in the second half of 2025 alone, administrative fees and IDR entity fees totaled over $932,712,931.00 accounting for 1,372,563 initiated disputes.[14] This roughly equates to $680 per dispute. These estimates do

[10] 29 U.S. Code § 1185e(c)(5)(F)(i).
[11] *Supra* note 8.
[12] 86 Fed. Reg. 55,980.
[13] Jack Hoadley & Kennah Watts, *The Substantial Costs Of The No Surprises Act Arbitration Process*, Ctr. On Health Ins. Reforms (Sept. 24, 2025), https://chir.georgetown.edu/the-substantial-costs-of-the-no-surprises-act-arbitration-process/.
[14] *Federal Independent Dispute Resolution Public Use Files, July 1, 2025 —December 31, 2025*, https://www.cms.gov/nosurprises/policies-and-resources/reports.

not fully capture other financial and administrative burdens associated within ongoing IDR participation, including vendor support and responses to procedural challenges—costs that *Amici's* members bear directly as necessary administrative expenses that do not contribute to high-value, high-quality health coverage for employees.

Even more consequential are the payment determinations reached by the IDR entities, which continue to drive payments far above the market rates (and even in excess of the providers' original billed charges). The prevailing offer was higher than the QPA in approximately 85% of payment determinations made in the second half of 2025,[15] and IDR awards added $2.24 billion in payments to out-of-network providers for disputes resolved in 2023 and 2024.[16]

Taken together, these figures reflect at least an additional $5 billion in administrative and claims expenses, costs that do not buy a dollar of additional care, and that are ultimately borne by employees through higher premiums and reduced benefits.[17]

Finally, the IDR fee structure compounds the injury for employer-sponsored plans. Because plans must contest each claim individually and pay the entire IDR entity fee when they lose—which is over 85% of the time—every good-faith

[15] S*upra* note 8.
[16] Hoadley & Watts, *supra* note 13.
[17] *Id.*

attempt to push back against a fraudulent or inflated claim carries a guaranteed financial penalty. Because of the unwillingness or inability of IDR entities to effectively police eligibility at the front end, plans are forced to either accept a default judgment by not engaging in the IDR process or expend resources to engage in the IDR process and still likely face the provider's offer being accepted regardless of the reasonableness of the amount. The district court's ruling adds a third consequence: by objecting, plans also forfeit the right to judicial relief. That is not a dispute resolution system. It is a process that leaves plans without recourse at every turn.

B. The NSA Contains No Internal Mechanism to Deter Fraud and Eligibility Screening Is Ineffective.

The NSA supplies no functional anti-abuse regime and no robust federal enforcement targeted at mass submission of ineligible disputes, mischaracterization of services to fit eligibility rules, strategic "refiling," or gamesmanship around claim batching. The burden of policing eligibility falls on payers, one claim at a time, inside a process where the economics cut against them: IDR entities are paid only if they reach a payment determination, so dismissing an ineligible claim results in $0 of payments to the IDR entity, even if it takes the entity significant time and effort to arrive at this conclusion. This incentive structure systematically rewards the filing of ineligible claims and imposes the cost of challenging them entirely on the payer.

The incentive to file ineligible disputes is particularly acute in states like California, where a state surprise billing law governs many out-of-network payments, paying providers the higher of the average contracted rate or 125% of the Medicare rate, and those claims are not eligible for federal IDR.[18] With federal IDR awards averaging many multiples of that rate, providers have a particularly strong financial incentive to submit California claims to the federal IDR process despite knowing they do not qualify.

The available data confirms this is happening and has been going on since the inception of the Federal IDR process. According to the Departments, from April 15, 2022 to December 31, 2024, non-initiating parties challenged the eligibility of 976,721 disputes for the Federal IDR process, and certified IDR entities found 355,804 disputes ineligible.[19] In 2024 alone, plans identified as much as 39% of disputes as ineligible, citing improper jurisdiction (subject to state law, not federal law), duplication/refiling, claims for in-network providers, or claims paid by Medicaid or Medicare.[20] Additionally, recent IDR data shows that non-initiating parties challenged 42% of disputes as ineligible in the second half of

[18] AHIP, *New AHIP/BCBSA Survey Finds Providers are Flooding IDR System with Ineligible Disputes* (Oct. 2025), https://ahiporg-production.s3.amazonaws.com/documents/202510_AHIP_IB_No_Surprises_Act_Survey51.pdf.
[19] Federal Independent Dispute Resolution Operations, 91 Fed. Reg. 33900, 33902 (June 4, 2026).
[20] *New AHIP/BCBSA Survey Finds Providers are Flooding IDR System with Ineligible Disputes, supra* note 18.

2025.[21] Yet IDR entities dismissed only 19% of cases as ineligible in the second half of 2025.[22] The Departments have repeatedly acknowledged that initiating parties are submitting a large number of ineligible disputes, leading to both a high volume of dispute submissions and slow processing of disputes.[23] More troubling still, approximately 15% of all disputes reach a final award despite being ineligible.[24] These numbers continue to rise as more initiating parties see the benefits from participating in the process without much risk for submitting knowingly ineligible claims. The gap between the rate at which plans identify ineligible disputes and the rate at which IDR entities dismiss them has a direct dollar cost that employers and employees ultimately pay.

The eligibility failures described above are only part of the picture. Even where claims are eligible, the awards themselves often bear no rational relationship to the value of services rendered, even when the process is working exactly as designed. In one case presented in the record below, an assistant surgeon performing a total disc arthroplasty received an IDR award of $128,000. The applicable CMS rate for an assistant surgeon for that procedure is $207 – meaning the IDR award equaled approximately 617 times the Medicare benchmark rate for

[21] *Federal Independent Dispute Resolution Public Use Files, July 1, 2025 —December 31, 2025*, https://www.cms.gov/nosurprises/policies-and-resources/reports.
[22] *Id.*
[23] 91 Fed. Reg. at 33902.
[24] *See supra* note 20.

that role, and more than 19 times what the in-network primary surgeon was paid for the same procedure. In another, a neuromonitoring provider received a total IDR award of $26,800 on a submitted offer of $4,049.75, with individual service codes awarded at between 1876% and 5175% of the Medicare rate. These are not isolated incidents attributable to clerical error. Rather, they reflect the routine operation of a process that selects provider offers without meaningful scrutiny of whether those offers bear any relationship to prevailing market rates, the value of the services rendered, or any objective payment benchmark.

In an effort to address the ongoing challenge with ineligible disputes receiving payment determination awards, the Departments published Technical Assistance to allow parties to identify errors, including eligibility errors, after dispute closure.[25] While this process is available, it has been widely unsuccessful.

Per the Technical Assistance, IDR entities remain the gatekeepers for reopening closed disputes, and any correction that reverses a finding of eligibility requires the IDR entity to refund its already-collected fee. The Technical Assistance thus suffers from the same misaligned financial incentives as the original eligibility decision; IDR entities must voluntarily spend uncompensated

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

time and resources to investigate a closed dispute, and payors only prevail if the IDR entity agrees to reach a conclusion requiring the IDR entity to refund its fees.

The *Amici* note that this process has been fraught with delays and often receive no response from the Departments.

Furthermore, the Departments recently issued a new Final Rule to help address the submission of ineligible disputes, yet the Final Rule is effective prospectively, once in effect, and provide no relief for non-initiating parties retrospectively.[26] The Final Rule is designed to reduce certain types of ineligible dispute submissions, but not all. Providers still attest to the eligibility of disputes, and IDR entities still review eligibility, despite having a direct financial interest in finding that disputes are eligible. The Final Rule still does not prevent fraud. As such, neither the Technical Assistance nor the Final Rule present any real opportunity for recourse or appeal. This further demonstrates the need for the Court to recognize the structural fraud and abuse permeating the NSA's IDR process and the significant costs that abuse imposes on employer-sponsored plans and their enrollees.

For employer-sponsored plans, objecting through the IDR portal is the only lever available against an ineligible or fraudulent filing, and it is one they must pull dispute by dispute at a real and recurring expense. If pulling that lever also

[26] 91 Fed. Reg. 33900.

extinguishes any recourse in court, plans are left worse off than if they had stayed silent. *Amici* note only that payers must be able to utilize all available tools, including actions like the case before the Court, to protect their ability to offer high-quality, high-value health coverage to their enrollees.

C. Fraudulent Use of the IDR Process Increases Plan Costs and Encourages Providers to Remain Out-of-Network.

Fraudulent use of the IDR process creates significant incentives for providers to leave, or otherwise remain out of, plan networks. When IDR awards systematically exceed in-network payment rates (as represented by the QPA), the calculus for providers is straightforward: remaining out of network and pursuing IDR is more lucrative than joining a network. One study determined that in 2023 median Federal IDR payment determinations were 372% of the QPA.[27] This dynamic has persisted with median payment determinations in 2024 equaling 445% of the QPA.[28] Of particular relevance here, in disputes filed by HaloMD, the median award amount was 934% of the QPA.[29] At these levels, the financial incentive to remain out-of-network is significant.

These figures are not statistical anomalies. Recent CMS data shows that for items and services under $100, the median prevailing offer relative to the QPA was

[27] Benjamin Ukert & Aliza S. Gordon, *Arbitration Outcomes for Out-of-Network Medical Bills Under the No Surprises Act*, https://pmc.ncbi.nlm.nih.gov/articles/PMC12698988/ (last visited Aug. 11, 2026).
[28] *See* Hoadley & Watts, *supra* note 13.
[29] *Id.*

591% in the first half of 2025.[30] For neurology and neuromuscular procedures-with 52,641 claims in the second quarter of 2025 alone—the median prevailing offer equated to 2862% of the QPA. Across service categories, the pattern is the same: IDR awards bear no relationship to the market-based rates the NSA was designed to produce.

The practical effect on employer-sponsored plans is significant. When out-of-network payments exceed in-network rates at this scale, providers in high-demand specialties have every financial reason to remain outside of plan networks. The result is the erosion of provider networks that employers rely upon to deliver higher quality, coordinated care to their employees.[31] Employees who lose access to in-network specialists face higher out-of-pocket costs, more limited care options, and the very balance billing exposures the NSA was designed to eliminate. The harm then loops back to the employers, who must either absorb the increasing IDR costs or narrow the scope of covered benefits—neither of which improves health outcomes or reduce costs for the employees those plans are meant to serve.

III. Unregulated Intermediaries Should Not Be Permitted to Manipulate the IDR Process with Impunity.

[30] *See supra* note 13.
[31] Olena Mazurenko et al., *The Impact of Narrow and Tiered Networks on Costs, Access, Quality, and Patient Steering: A Systematic Review*, 79 Med. Care Rsch. & Rev. (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9817087/.

Provider intermediaries, such as Defendant-Appellee HaloMD, are alone as essentially unregulated entities in the health care delivery system. Clinical providers are licensed at the state level, and subject to a host of fraud, waste, and abuse rules at the federal level, particularly when participating in government funded health care programs. Insurers are subject to extensive state and federal regulation, and self-insured plans and their service providers are subject to both substantive benefit requirements and fiduciary obligations under ERISA and the Affordable Care Act. Provider intermediaries face no such regulation, let alone one that would govern their conduct with respect to the IDR process. The concentration of IDR submissions among a very small number of initiating parties—with the top three initiating parties (HaloMD, Team Health, and SCP Health) accounting for approximately 38% to 44% of all disputes initiated in 2025 make the consequences of that regulatory gap clear.[32]

This lack of regulation does not, however, create an inference that they can act with impunity for behavior that amounts to federal or state civil fraud. To the contrary, the lack of regulation heightens the need for the courts to hold them accountable for the significant damage they cause to employers and employees by

[32] *Federal Independent Dispute Resolution Public Use Files, July 1, 2025 —December 31, 2025*, https://www.cms.gov/nosurprises/policies-and-resources/reports.

manipulating the IDR process. The district court decision would foreclose that accountability.

IV. Conclusion

As *Amici*'s members and the hundreds of millions of Americans who receive health coverage from them continue to face the challenges of ever-rising health care costs, the negative influences of a small subset of bad actors must not go unchecked. The inflationary effects of the fraud and abuse alleged by Plaintiffs-Appellants are common across all payers subject to the NSA, most acutely employer-sponsored plans. The lack of regulation of intermediaries like HaloMD under federal or state health regulatory structures does not give them a free pass to extract massive financial windfalls from a currently dysfunctional IDR process through fraudulent or otherwise improper behavior.

Amici submit this brief to ensure the Court has a full picture of what is at stake. Employer-sponsored plans bear billions of dollars in excess costs that drive up premiums and reduce benefits for the very employees these plans exist to serve. The employer plans and the hundreds of millions of Americans who depend on them simply cannot afford that outcome.

Dated: August 12, 2026

Respectfully submitted,

s/ Kara P. Wheatley
Kara P. Wheatley
Ryan C. Temme (admission forthcoming)
Seth T. Perretta (admission forthcoming)

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

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

CERTIFICATE OF COMPLIANCE

The undersigned, counsel of record for the American Benefits Council, Business Group on Health, and the ERISA Industry Committee certifies that this brief contains 3,830 words. The brief's type size and typeface comply with FRAP 32(a)(5) and (6). I certify that this brief is an amicus brief and complies with the word limit of FRAP 29(a)(5), Cir. R. 29-2(c)(2), or Cir. R. 29-2(c)(3).

s/ Kara P. Wheatley
Kara P. Wheatley

F.R.A.P. 29 DISCLOSURE

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

s/ Kara P. Wheatley
Kara P. Wheatley

CERTIFICATE OF SERVICE

I hereby certify that on August 12, 2026, a copy of the foregoing document was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the court's CM/ECF system.

s/ Kara P. Wheatley
Kara P. Wheatley