Nos. 26-1114, 26-1768, 26-1769, 26-1864

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

SPECIALTYCARE, INC., et al.,
Plaintiffs-Appellants,
v.
AETNA, INC.,
Defendant-Appellee.

SPECIALTYCARE, INC., et al.,
Plaintiffs-Appellants,
v.
CIGNA HEALTHCARE, INC.,
Defendant-Appellee.

SPECIALTYCARE, INC., et al.
Plaintiffs-Appellants,
v.
UMR, INC.,
Defendant-Appellee.

SPECIALTYCARE, INC., et al.
Plaintiffs-Appellants,
v.
MERITAIN HEALTH, INC.,
Defendant-Appellee.

On Appeals from the United States District Court for the Middle District of Pennsylvania, No. 1:25-cv-224, and from the United States District Court for the District of Delaware, Nos. 1:24-cv-1378, 1:24-cv-1396, and 1:25-cv-198

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS, THE AMERICAN BENEFITS COUNCIL, AND THE ERISA INDUSTRY COMMITTEE AS AMICI CURIAE IN SUPPORT OF APPELLEES

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CORPORATE DISCLOSURE STATEMENT

Under Federal Rules of Appellate Procedure 26.1 and 29(a)(4)(A), America's Health Insurance Plans, Inc., the American Benefits Council, and the ERISA Industry Committee state that they have no parent corporations and that no publicly held corporation owns 10% or more of their stock.

s/Hyland Hunt
Hyland Hunt

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STATEMENT OF INTEREST OF AMICI CURIAE[1]

America's Health Insurance Plans, Inc. ("AHIP") is the national trade association representing the health insurance industry. AHIP is committed to market-based solutions and public-private partnerships that make high-quality coverage and care more affordable, accessible, and equitable for everyone. AHIP's members provide healthcare coverage, services, and solutions to more than 200 million Americans. That experience gives AHIP broad first-hand knowledge and a deep understanding of how the nation's healthcare and health insurance systems work.

The American Benefits Council (the "Council") is a Washington, D.C.–based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees, and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans. The Council regularly participates as amicus curiae in cases affecting employee benefit plans.

[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than amici, their members, or their counsel made a monetary contribution intended to fund the brief's preparation or submission. All parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a)(2), (4).

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.

Collectively amici's members include health insurers and employers that together offer or administer health coverage for most Americans covered under either employer-sponsored health plans or health insurance purchased in the individual market. As a result, amici have a particular interest in the No Surprises Act and its effects on the cost of providing health coverage.

Amici's members strive to reach agreements with healthcare providers to offer their health plan beneficiaries and enrollees affordable networks that provide choices in the delivery of quality medical care. When unable to secure network agreements before treatment is rendered, health plans seek to negotiate reasonable out-of-network payments to prevent surprise medical bills and reduce costs for patients. Before the No Surprises Act, some providers leveraged their refusal to

participate in networks to send patients excessive surprise bills and extract payments well above typical market rates.

Congress, after significant debate, ultimately arrived at a bipartisan solution in the No Surprises Act to protect healthcare consumers from out-of-network payment disputes and surprise bills. The Act does this by barring providers from billing patients for the balance of their out-of-network charges and encouraging health plans and out-of-network providers to resolve out-of-network payments through ex post negotiations. If disputes persist, Congress established Independent Dispute Resolution (IDR) as a streamlined final-offer dispute resolution process. Absent fraud or other grounds for vacatur, Congress intended IDR to conclusively resolve payment disputes when the parties do not agree on fair payment rates.

Congress intended for the agencies it charged with implementing IDR—not the courts—to sort through when IDR determinations require payment and when they don't, as part of their supervisory role for the IDR process. Amici write separately here to explain the negative consequences for patients, healthcare consumers, and employers if Congress's careful design for IDR as a low-cost dispute resolution mechanism is thwarted by the creation of a judicial remedy for nonpayment.

The unfortunate reality is that a few provider staffing firms and provider-contracted IDR middlemen are already abusing the IDR system at scale. If the

Federal Arbitration Act, No Surprises Act, or ERISA were interpreted to provide a cause of action for enforcing IDR payment determinations, IDR-exploiting firms would have even more incentive to overwhelm the IDR system, and then the courts, with disputes about bureaucratic errors that generated minor payment delays or claims that were never qualified for IDR in the first place. Far from serving the purposes of the No Surprises Act, the upshot would be to undermine the IDR system, waste scarce judicial resources, and ultimately escalate healthcare costs for all Americans.

INTRODUCTION AND SUMMARY OF ARGUMENT

The No Surprises Act, and the IDR process it establishes, were designed to protect patients from crushing surprise bills from out-of-network providers in situations where they cannot choose their provider. And in one important way the Act has been a success; it has protected patients from millions of surprise medical bills. But provider staffing firms and other entities that generate revenue by filing disputes—IDR middlemen—have also abused the IDR process by deluging the system with ineligible claims to secure windfall profits. This abuse has added billions in costs already and has significantly compounded the healthcare affordability crisis impacting nearly every American.

This abuse has real and profound impacts, including on health plans actively trying to contain escalating healthcare costs in the face of both an extraordinary

volume of IDR claims and the need to navigate resource-intensive and time-consuming administrative procedures for correcting rampant IDR submission errors. Yet despite these challenges, health plans are meeting their statutory obligations to make timely payments on qualified IDR determinations.

In the rare instance when a nonpayment problem may arise on a qualified IDR determination, the governing agencies have established complaint procedures that allow them to ensure payment is made if warranted. Like every part of the IDR system, the complaint process has been hampered by an overwhelming volume of claims submitted to IDR. But although the complaint process may not be perfect, it has secured results for providers—meaning direct payments from health plans—when there have been cases of delayed payments for qualified IDR determinations. Creating a judicial remedy for nonpayment in lieu of the administrative system envisioned by Congress would impair the functioning of this administrative process and short-circuit crucial administrative supervision of IDR.

Opening the courthouse doors is thus unnecessary. It would also needlessly embroil the courts in hundreds or thousands of disputes regarding minor payment delays, administrative minutiae, or IDR eligibility each year. Worse yet, it would kick off a vicious cycle that would incentivize ever more IDR filings (eligible or not). Administrative costs that already number in the billions of dollars would explode, burdening Americans and their employers with more unnecessary and

wasteful administrative costs and further imperiling healthcare affordability for everyone.

ARGUMENT

I. Congress Intended Administrative Resolution of Any IDR Payment Issues.

A. Payment Processes Are Impaired by an IDR System Flooded with Ineligible Claims.

1. The Act intended low-cost, voluntary resolution of disputes.

Under the Act's dispute resolution process, the provider sends a bill and a patient's health plan makes an initial payment to the out-of-network provider, which is often based on the Qualifying Payment Amount (QPA).[2] The QPA is set to the health plan's median in-network contract rate for the same service in the same area.[3] If the provider is unsatisfied with the initial payment, the provider can then start an open negotiation period.[4] If negotiations fail, then either party may initiate IDR.[5]

The Act has worked to take patients out of the middle of provider-plan disputes. In 2024, the Act protected patients from nearly 20 million surprise bills. AHIP & Blue Cross Blue Shield Ass'n (BCBSA), *New AHIP/BCBSA Survey Finds Providers are Flooding IDR System with Ineligible Disputes*, at 3 (Oct. 2025), https://tinyurl.com/5hdb63te (AHIP/BCBSA Survey). Most providers are satisfied

[2] 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I), (b)(1)(C).
[3] *Id.* § 300gg-111(a)(1)(C)(iii), (a)(3)(E), (H), (b)(1)(B).
[4] *Id.* § 300gg-111(c)(1)(A).
[5] *Id.* § 300gg-111(c)(1)(B).

with initial payments from health plans under the Act, too. In 2024, only about 6% of out-of-network claims subject to the Act even entered IDR. *Id.* Although this is still far too many disputes for the system to handle, the IDR-filing rate underscores that just a few big firms—and not providers at large—have focused on IDR exploitation as a business strategy. *See infra* Section I.A.2.

For those claims that enter IDR, the No Surprises Act limited procedures to foster speed and efficiency. Each party must submit an offer within 10 days after an IDR entity is selected to decide the dispute.[6] Neither party sees or responds to the other party's offer.[7] The IDR entity must select one of the two offers within 30 days; it cannot set any other payment amount.[8] These limited "baseball-style" procedures are intended to encourage reasonable offers, foster settlement, and minimize administrative costs.[9] This process can result in quick resolutions for good-faith actors. But it lacks safeguards to protect against exploitation by providers or their IDR middlemen submitting ineligible disputes.

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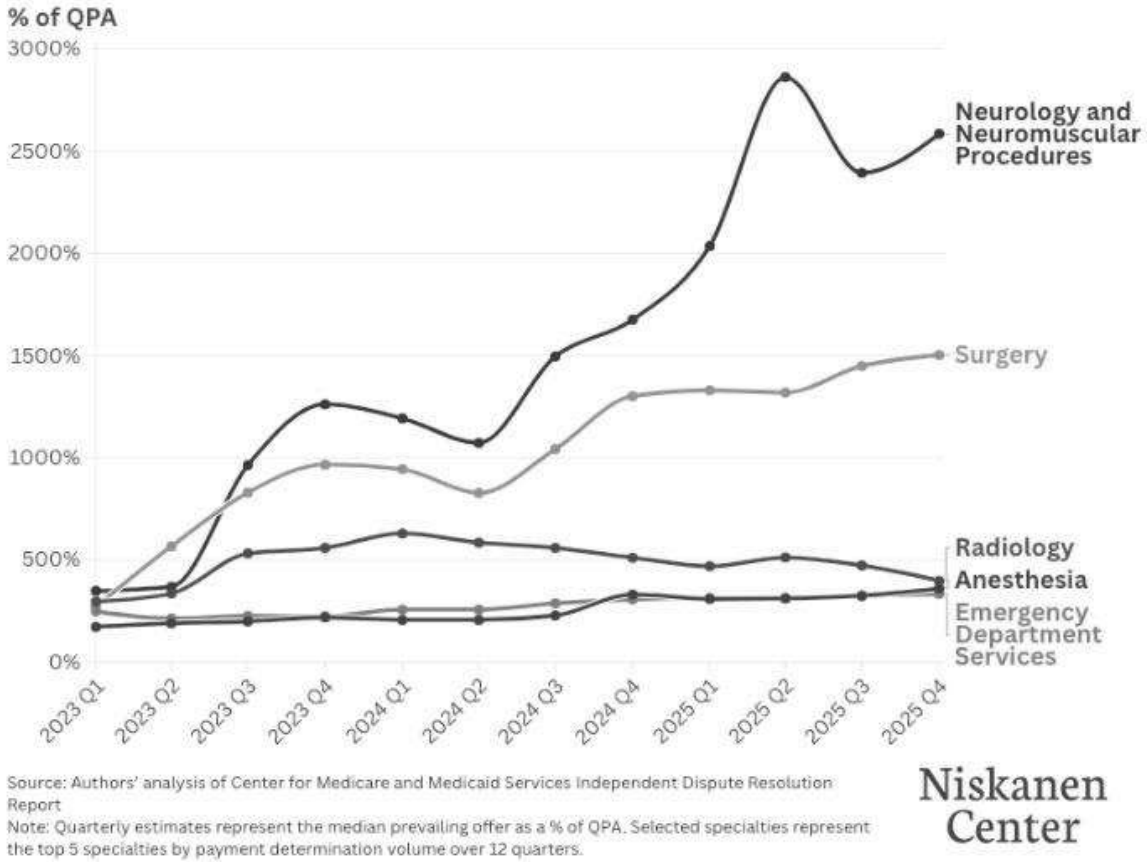
[6] 42 U.S.C. § 300gg-111(c)(5)(B).
[7] *Id.*; *see also* CMS, *Federal [IDR] Process Guidance for Disputing Parties*, at 18-19 (Dec. 2023), https://tinyurl.com/mr2xvdrk.
[8] 42 U.S.C. § 300gg-111(c)(5)(A)(i).
[9] *See Tex. Med. Ass'n v. U.S. HHS*, 110 F.4th 762, 768 n.8 (5th Cir. 2024); 42 U.S.C. § 300gg-111(c)(3)(A).

2. The IDR process has been hamstrung by abusive practices.

A few provider staffing firms and other intermediaries that generate revenue from filing providers' disputes have adopted IDR exploitation as a business strategy, flooding the system with ineligible claims to obtain windfall payments. In particular, just three entities—one intermediary that makes its profits by filing disputes and two provider staffing firms—generated 38% to 44% of all IDR disputes in 2025. CMS, *Supplemental Background on Federal [IDR] Public Use Files, July 1, 2025 – Dec. 31, 2025*, at 2 (July 22, 2026), https://tinyurl.com/y8sa4zf7 (2025 Second Half IDR Report); CMS, *Supplemental Background on Federal [IDR] Public Use Files, Jan. 1, 2025 – June 30, 2025*, at 2 (Jan. 21, 2026), https://tinyurl.com/yc35y54r.

The doctors themselves are often uninvolved in these claims—and may not ultimately receive the IDR payments. One investigation found that "physicians who show up repeatedly" in the dispute files "were salaried workers and uninvolved in the claims filed under their names." Sarah Kliff & Margot Sanger-Katz, *Health Law Lets Doctors Cash In*, N.Y. Times, Apr. 26, 2026, at A1. The entities that have focused on exploiting IDR, on the other hand, often secure extraordinary payments of the type and nature the Act was intended to avoid. By the end of 2025, median IDR payment determinations for some specialties, like surgery and neurology, had skyrocketed to 10 to 25 times median in-network rates.



Lawson Mansell & Caitlin Rowley Gallamore, *New data, same problem: No Surprises Act arbitration abuse persists*, Niskanen Center, fig. 3 (July 30, 2026), https://tinyurl.com/ytycnujt.

The upward trend applies across other specialties, too. A recent analysis indicated that for emergency care in 2024—where mean in-network rates were already 174% of the Medicare rates that the Emergency Department Practice Management Association ("EDPMA") describes (Br. 7) as "break even"—mean IDR determinations were nearly five times Medicare rates. Loren Adler et al., *No Surprises Act arbitration databook*, Brookings, at fig. 2 (Apr. 20, 2026),

https://tinyurl.com/2m62e6jb. For imaging services, mean IDR determinations were nearly eight times Medicare rates. *Id.* In the aggregate, total payment amounts determined by IDR entities for services from 2023 to 2025 exceeded estimated in-network rates for the same services by $15.6 billion. Jack Hoadley & Kennah Watts, *Spending On IDR Process Pushes No Surprises Act Costs To More Than $22.4 Billion Over Just Four Years*, Health Affairs: Forefront (Aug. 26, 2026), https://tinyurl.com/ycxjy8mj. As a spokesperson for the Centers for Medicare and Medicaid Services (CMS) acknowledged in July of this year, "the system is being gamed." Anna Wilde Mathews & Tom McGinty, *Medical Billing Arbitration Paid Out $15 Billion to Providers in Surprise Bill Disputes*, Wall St. J., July 22, 2026, https://tinyurl.com/6zcf96ex.

3. A common IDR abuse strategy is to overwhelm the system with ineligible claims.

The Act makes the IDR process available for a limited set of disputes. Only certain services, covered by an eligible health plan, are governed by the Act. Even then, services subject to state surprise billing laws are not eligible for the federal IDR process.[10] Additionally, parties must adhere to tight statutory timeframes to invoke IDR.[11] And, of course, submissions must include key information, the provider must be out-of-network, the patient must be covered by the health plan, and

[10] 42 U.S.C. § 300gg-111(a)(3)(K).
[11] *Id.* § 300gg-111(c)(1)(B).

the submission cannot be a duplicate. If a dispute is ineligible, then the IDR entity is "statutorily prohibited from making [a] payment determination[]." 91 Fed. Reg. 33900, 33933 (June 4, 2026).

Yet about two-fifths of IDR disputes are filed for services that are not eligible for IDR. *See* AHIP/BCBSA Survey, *supra*, at 4 (39%); 2025 Second Half IDR Report, *supra*, at 3 (40-42% challenged as ineligible in 2025); CMS, *Supplemental Background on Federal [IDR] Public Use Files, July 1, 2024 – Dec. 31, 2024*, at 3 (May 28, 2025), https://tinyurl.com/yefd33j5 (43-45% challenged as ineligible in 2024). That adds up to more than a million ineligible disputes per year based on the latest IDR volume data.

The IDR process is vulnerable to this type of exploitation. Although IDR entities closed some disputes for ineligibility, 91 Fed. Reg. at 33942, there is no comprehensive system for screening out all unqualified disputes. *See id.* at 33943 (discussing training efforts to "improve consistency among ... certified IDR entities" on eligibility determinations); CMS, *Federal [IDR] Technical Assistance for Certified IDR Entities and Disputing Parties*, at 1 (June 2025), https://tinyurl.com/2ujrhaxu (noting that IDR entities may make "jurisdictional" errors that are "not identified until after a dispute is closed"). IDR entities also have little incentive to closely scrutinize dispute eligibility, and more than a little incentive to do the opposite, because they generally recover fees only when they

issue a final payment determination on the merits. CMS, *Calendar Year 2023 Fee Guidance for the Federal [IDR] Process under the No Surprises Act*, at 5-6 (Oct. 31, 2022), https://tinyurl.com/4r5w97p5.

As a result, many ineligible disputes still make it through the process and become (non-qualified) IDR determinations—15% of all disputes. AHIP/BCBSA Survey, *supra*, at 4. This means that several hundred thousand payment determinations are issued annually for ineligible disputes. This is a widespread problem. *See, e.g.*, Kliff & Sanger-Katz, *supra*, at A1 ("Many claims that shouldn't be eligible for arbitration … move through the system anyway."); AHIP, *Comment Letter on Proposed Rule: Federal [IDR] Operations*, at 13 (Jan. 2, 2024), https://tinyurl.com/488wkans (describing "numerous ineligible claims entering the IDR process" leading to "payment determinations without basis in the letter or spirit of the No Surprises Act").

4. Health plans are promptly paying qualified claims despite the obstacles created by abuse of the IDR system.

The IDR-abuse strategy adopted by a few large entities—some of which provide no medical services at all but generate all of their revenue from filing disputes—affects payments in two ways.

First, it has caused the volume of IDR disputes to skyrocket far beyond what Congress intended or the system can handle. More than 2.5 million IDR disputes were filed in 2025 alone, roughly 115 times the anticipated annual volume. 2025

Second Half IDR Report, *supra*, at 2; 86 Fed. Reg. 55980, 56056-57 & nn.187, 199 (Oct. 7, 2021). IDR volume is still climbing. Filings in 2026 are on track to hit 3.4 million and, given "the dramatic increase in utilization of the Federal IDR process," the government expects a further 30% increase because it recently reduced the administrative fee. CMS, *Federal IDR bi-monthly reports* (May 31, 2026), https://tinyurl.com/3rv425es; 91 Fed. Reg. at 33969 n.128, 33971 n.142. From the outset, this overwhelming volume caused numerous processing issues that can contribute to payment delays. For example, claims are submitted with incomplete or incorrect information or directed to the wrong plan; duplicate claims are filed; and providers or IDR entities sometimes fail to communicate when an IDR determination has been rendered. *See* 91 Fed. Reg. at 33935, 33993 (describing problems with "misdirected disputes," "miscommunication," "incomplete information," and "duplicate submissions").

Second, the flood of ineligible disputes requires health plans to sort through which IDR determinations relate to "qualified IDR item[s] or service[s]" and which don't.[12] Under the Act, only determinations on qualified services are "binding" and require payment.[13] The provision making IDR determinations "binding" applies only to a "determination … under subparagraph (A)," which is limited to a "determination

[12] 42 U.S.C. § 300gg-111(c)(5)(A).
[13] *Id.* § 300gg-111(c)(5)(E)(i)(I).

for a qualified IDR item or service."[14] This echoes the limitations in the payment provision, which requires the "total plan or coverage payment" to be made within 30 days only "with respect to a *qualified* IDR item or service."[15]

The governing agencies have implemented an administrative reopening process that allows correction of "clerical, jurisdictional, and procedural" errors after an IDR determination has wrongly been issued. CMS, *IDR Technical Assistance*, *supra*, at 5-6. The guidance specifies how the payment deadline applies in case of errors and reopenings. *Id.* at 6. Faced with a torrent of ineligible disputes, health plans must, at considerable time and expense, navigate these rules to complete payments.

Despite these challenges, plans are meeting their obligation to make timely payments. However, plans cannot make payments when, among other things, notices are "misdirected" or when IDR determinations "lacked essential information needed to process payment." AHIP/BCBSA Survey, *supra*, at 5. For example, because IDR initiation notices sometimes include incorrect contact information for the health plan, plans may entirely lack notice of the IDR process until "they receive a complaint from regulators that a payment has not been made within the required 30

[14] *Id*. § 300gg-111(c)(5)(A), (c)(5)(E)(i)(I).
[15] *Id*. § 300gg-111(c)(6) (emphasis added); *see also id.* § 300gg-112(b)(6) (same for air ambulances). A "qualified" service is one that is eligible under the Act and for which a timely IDR notice has been filed. *See id.* § 300gg-111(c)(1), (2)(A).

days." BCBSA, *Comment Letter: Federal [IDR] Operations Proposed Rule*, at 16 (Jan. 2, 2024), https://tinyurl.com/me3e8cmx.

B. Providers Have Administrative Remedies to Address Payment Issues.

Should a payment issue arise, the governing agencies have established an administrative process to resolve it. Providers can file a complaint with CMS regarding nonpayment by either calling the No Surprises Help Desk or filling out a web form. *See* CMS, *Providers: submit a billing complaint*, https://tinyurl.com/46xehyda; *see also* 91 Fed. Reg. at 33943 (encouraging "parties to contact the No Surprises Help Desk to file a complaint" if they believe "an error or violation has occurred" in the IDR process). CMS transfers the complaint to the appropriate agency if the health plan does not fall within CMS jurisdiction (*e.g.*, to the Department of Labor for health plans governed by the Employee Retirement Income Security Act). U.S. Gov't Accountability Office, *Private Health Insurance: Roll Out of [IDR] Process for Out-of-Network Claims Has Been Challenging*, at 34 (Dec. 2023), https://tinyurl.com/mrsvxbdr (GAO Report).

If the complaint falls within CMS jurisdiction, CMS "work[s] to establish the factual accuracy of the complaint," and if substantiated, directs corrective actions. *Id.* at 34-35. Corrective action can include "requir[ing] the issuer to pay the provider the determined award amount." *Id.* at 35. The complaint process is backed up by

CMS's civil penalty authority. *See Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 277 (5th Cir. 2025); 42 U.S.C. § 300gg-22(b)(2)(A).[16]

The Department of Labor has a similar process through which it reviews complaints and works to obtain "voluntary compliance" with payment obligations "[w]hen warranted by the evidence." GAO Report, *supra*, at 36-37. Voluntary compliance is a formal tool that the Department of Labor uses "to pursue corrective action" by health plans. *See* Employee Benefits Security Admin., *Enforcement Manual: Health Plan Investigations*, para. 19 (Feb. 2025), https://tinyurl.com/4cxdfxf9. After the Department issues a Voluntary Compliance Notice Letter, if "there is only partial or no compliance," the case can be referred for further enforcement. *Id.* para. 20.f; *see* 29 U.S.C. § 1132(a)(5).

Providers' amici report that the agencies are slow to respond to complaints. EDPMA Br. 23-24. The delays are unsurprising; the abuse of IDR by a few has resulted in IDR volume that has swamped every process associated with the system. But the data show that valid complaints do get results, *contra* EDPMA Br. 23-26. From the start of IDR in 2022 through the end of 2025, CMS secured over $30

[16] EDPMA contends (Br. 21) that the civil penalty provision says nothing about Congress's intent for the No Surprises Act because it was first enacted in 1996. But Congress added the language that included the No Surprises Act within this enforcement authority ("or part D") when it enacted the No Surprises Act (which, as to the provisions governing health plans under CMS jurisdiction, was created as a new part D of Title XXVII of the Public Health Service Act). *See* Pub. L. No. 116–260, div. BB, title I, § 102(a)(1), (a)(3)(C), 134 Stat. 2759, 2772 (2020).

million "in direct monetary relief to consumers and providers," largely related to No Surprises Act complaints. CMS, *CMS Complaint Data and Enforcement Report on Health Insurance Market Reforms* (Dec. 2025), https://tinyurl.com/3f93kkjh. For its part, the Department of Labor closed over 27,000 No Surprises Act complaints in fiscal year 2025, worth $67 million. Employee Benefits Security Admin., *EBSA Restores $1.4 Billion to Employee Benefit Plans, Participants, and Beneficiaries*, https://tinyurl.com/yc7bvr3u. These amounts include millions that plans were ordered to pay providers on IDR determinations. *See* GAO Report, *supra*, at 35.

There is no dispute here that the administrative complaint process could be improved, like every administrative process related to the IDR system. But Congress assigned the agencies a supervisory role over IDR because the governing agencies are well-equipped to sort through case-specific, in-the-weeds complexities, like whether an IDR determination should be reopened or modified because it contains jurisdictional or procedural errors, or whether the determination was simply directed to the wrong plan. *See, e.g.*, 42 U.S.C. § 300gg-111(c)(2)(A), (4)(C)-(D) (establishment of IDR process and supervision of IDR entities).

The administrative complaint process also enables the Departments to gather information about issues plaguing the IDR system and develop comprehensive regulatory solutions. Thanks in part to the insights gained through addressing complaints, the governing agencies have recently adopted reforms to mitigate some

of the miscommunication that can make timely payments more difficult. For example, health plans will now be issued a unique IDR "registration number" and be listed in a centralized registry so that providers can "accurately identify plans … as well as their contact information" during the IDR process. 91 Fed. Reg. at 33993-94. This change and others may further reduce miscommunications and help streamline payment of qualified claims. *See id.* at 33935 (describing other rule changes designed "to improve efficiency and reduce miscommunication between the parties").

However, changing administrative processing requirements for good-faith, qualified claims will do nothing to mitigate IDR abuse by entities that are flooding the system with ineligible claims. Nonetheless, the governing agencies are well situated to address such issues through systemwide regulatory changes, rather than case-by-case adjudication. And the administrative complaint process both assists the agencies in fulfilling that supervisory function and allows the agencies to sort through which determinations are qualified and require payment and which are infected with errors, including jurisdictional errors, that require reopening.

Opening the door to nonpayment lawsuits as soon as an IDR determination ages past 30 days would short-circuit these administrative correction efforts and risk overtaxing the courts with matters of administrative minutiae. Congress sensibly chose to direct such matters to administrative resolution rather than litigation, as the

text of the No Surprises Act confirms. UMR Response Br. 15-38; Aetna/Meritain Response Br. 20-41; Cigna Response Br. 22-48; *Guardian Flight*, 140 F.4th at 277; *see also Alexander v. Sandoval*, 532 U.S. 275, 290 (2001) (availability of administrative remedies is strong evidence that Congress did not intend to create a judicial remedy). As Appellees explain, providers cannot use the Federal Arbitration Act or ERISA as an end run around Congress's decision not to include a cause of action in the No Surprises Act, either. *See* UMR Response Br. 38-51; Cigna Response Br. 18-22, 48-54. The complaint resolution program, imperfect though it may be, provides a direct means of remedying any nonpayment, backed up by the governing agencies' full set of enforcement tools, and has in fact yielded agency orders to plans to pay IDR determinations when appropriate. GAO Report, *supra*, at 35.

II. Creating a Nonpayment Cause of Action Would Reduce Healthcare Affordability for All Americans.

1. Creating a nonpayment cause of action would magnify the incentives to abuse the IDR system and drive up administrative costs.

As described above, some entities are already exploiting the IDR system by flooding the system with ineligible claims in the hopes of securing windfall revenues. Right now, if a plan recognizes that a determination was issued on an ineligible claim, and the provider files a complaint for nonpayment, the relevant agency and the parties can work through the process of reopening and correcting that

determination. But if providers could sue for nonpayment of any IDR determination—eligible or not—without engaging in that administrative process, it would only encourage the submission of even more duplicative, incorrect, or unqualified disputes, in hopes of receiving an IDR determination that can be taken to court the second the clock passes day 30.

The more ineligible claims that are submitted, the more likely that the system is further overwhelmed, that administrative errors frustrate timely resolution and payment, and that unqualified or duplicative determinations sneak through. This would create additional burdens on health plans as they seek to issue timely payments following IDR determinations, as well as a vicious circle of perverse incentives that would abrogate the careful constraints on the IDR system that Congress intended.

As it is, IDR has generated billions in new administrative costs. Both parties must pay an administrative fee, and the losing party must pay IDR fees that can reach nearly $1,200 or more for a batched claim with many items. 88 Fed. Reg. 88494, 88523 (Dec. 21, 2023). There are also hefty IDR-related staffing and technology expenses which are increased by the need to rapidly sort through a torrent of ineligible claims. Using just the agencies' 2021 per-dispute estimate for such costs, which is a substantial understatement, administrative costs alone totaled more than $6.8 billion over a four-year period (2022-2025) for all IDR parties. Hoadley &

Watts, *supra*. Every year, those costs climb even higher. Total IDR costs in 2025 (including both administrative costs and payments exceeding in-network rates) were nearly three and a half times total IDR costs in 2024. *Id*.

Glutting the system with hundreds of thousands of ineligible disputes has impaired IDR's efficiency and magnified administrative costs. *See* 91 Fed. Reg. at 33902 (noting ineligible claims "slow processing of disputes"). Adding a litigation stage would only make things magnitudes worse. The number of ineligible disputes annually is nearing seven figures. If litigation is integrated into provider-staffing firms' IDR exploitation strategies, court dockets could spike just as IDR dockets have. Courts would be drawn into an ever-expanding number of cases about whether an IDR dispute is duplicative, identifies the right plan, qualifies for IDR, or a host of other issues plaguing the IDR system.

Although providers' amici discount the concern (EDPMA Br. 5), the floodgates have already been opened. In the District of New Jersey alone, hundreds of IDR enforcement actions have been filed, requiring the court to develop special case management procedures to handle them all. Order Staying and Administratively Terminating Lead NSA Case, *East Coast Plastic Surgery PLLC PA v. Aetna Life Ins. Co*., No. 25-15052-BRM-LDW (D.N.J. June 15, 2026), Dkt. No. 40. Bypassing administrative remedies in favor of an atextual judicial remedy would potentially embroil the courts in thousands of disputes that Congress never intended for judicial

resolution. With litigation costs dwarfing already-high IDR costs, administrative costs would explode.

2. Employers, healthcare consumers, and taxpayers will bear the burden of skyrocketing IDR costs.

When Congress enacted the No Surprises Act, the Congressional Budget Office projected that it would improve healthcare affordability because the additional administrative costs generated by IDR would be offset by premium reductions, on the expectation that out-of-network payments would move closer to lower negotiated rates. *See* Cong. Budget Off.*, Estimate for Divisions O Through FF, H.R. 133*, at 2-3 (Jan. 14, 2021), https://tinyurl.com/3eec2a4n. But—as the Office's analysts drily put it—"[e]merging evidence suggests that the law might not have the effects that CBO anticipated." Jessica Hale et al., *A Call for New Research on the No Surprises Act*, Cong. Budget Off. Blog (June 15, 2026), https://tinyurl.com/54r6b5w6.

Despite some studies showing price decreases for some services affected by the Act, *see, e.g.*, EDPMA Br. 8—which the budget analysts discount because they use early data from right after the Act's passage and do not reliably "isolat[e] the law's effects"—IDR-related evidence "suggests that the law could cause premiums to increase." Hale, *supra*. This is both because the "number of IDR cases has far exceeded projections," and because "awarded payments are often much higher than anticipated" and "much larger than the typical prices for health care services." *Id.*

IDR payment determinations are often "hundreds of times higher than what [providers] could negotiate with insurers directly or what they could have earned from patients before the law passed." Kliff & Sanger-Katz, *supra*, at A1. Some health plans have already been forced to increase premiums to cover inflated IDR-related costs. *Id*. New York State has identified hundreds of millions of dollars in additional out-of-network payments "stemming from [IDR] abuse" as the "primary contributor" to a nearly 10% premium increase this year for one of its health plans for employees and retirees. *FY 2027 New York State Executive Budget: Public Protection & General Government Article VII Legislation—Memorandum in Support*, at 26, https://tinyurl.com/54fp97pz. And as premiums or the costs of providing coverage increase, individuals and employers will face difficult decisions regarding the scope and structure of their benefits.

Adding a litigation stage to the IDR process will only drive up the costs of an IDR system that is already prone to abuse. All Americans—patients, people who purchase health insurance, and employers providing coverage to their employees—would pay the costs of providers filing lawsuits instead of using the administrative remedies that Congress has already made available under the Act. This wasteful spending—not contemplated (much less authorized) by Congress—would directly harm both consumers who purchase insurance or receive it from their employer and the employers providing such benefits. The wasteful costs also indirectly harm

taxpayers by increasing expenditures for premium tax credits. *See* 86 Fed. Reg. at 56059. Such an outcome cannot be squared with either the Act's purpose to protect consumers from high out-of-network costs while lowering overall healthcare costs, or the broader legal, commercial, and regulatory imperatives for health plans to limit the amount spent on administrative costs. *See, e.g.*, 42 U.S.C. § 300gg-18(b).

* * * * *

Permitting IDR payment disputes to proceed in court is contrary to Congress's design. Judicial remedies are not necessary to redress any issues with payment of IDR determinations, because providers have an administrative remedy. And regulatory improvements already underway will begin to help fix the root causes of any payment issues. By contrast, flooding the courts with payment disputes would only drive up administrative costs (including for potentially thousands of new court cases per year). This outcome makes no sense for an Act designed to protect patients from out-of-control medical costs, and it would upend, not reinforce, the system that Congress designed.

CONCLUSION

The district court's judgments should be affirmed.

September 4, 2026

Respectfully submitted,

s/Hyland Hunt

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COMBINED CERTIFICATE OF COMPLIANCE

I hereby certify that:

1. My name appears on this brief and I am a member of the bar of this Court. *See* L.A.R. 46.1.

2. The foregoing brief is in 14-point Times New Roman proportional font and contains 5,256 words, and thus complies with the type-volume limitation set forth in Rules 29(a)(5) and 32(a)(7)(B) of the Federal Rules of Appellate Procedure.

3. On September 4, 2026, I served the foregoing brief upon all counsel of record by filing a copy of the document with the Clerk through the Court's electronic docketing system.

4. The electronic and paper versions of the foregoing brief are identical.

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s/Hyland Hunt
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