March 10, 2026

Anthem Sues HaloMD over Alleged No Surprises Act Arbitration Abuse

This Briefing is brought to you by AHLA's Payers, Plans, and Managed Care Practice Group.

March 10, 2026

Raja Sekaran, Epstein Becker & Green PC | **Jeremy A. Avila**, Epstein Becker & Green PC | **Alexis Boaz**, Epstein Becker & Green PC | **Jean-Claude Velasquez**, Epstein Becker & Green PC

On July 7, 2025, Anthem Blue Cross Life and Health Insurance Company and Anthem Blue Cross (collectively, Anthem) sued HaloMD (Halo), Sound Physician Enterprises (SPE), and their related entities in the U.S. District Court for the Central District of California (*Anthem* Litigation). Anthem has sued Halo in federal districts in various regions of the country.[1] This Briefing focuses on the California case.

Anthem asserted violations under the Racketeer Influenced and Corruption Organizations Act (RICO), the Employee Retirement Income Security Act (ERISA), negligent and fraudulent misrepresentation and related state law claims arising from defendants' alleged exploitation of the federal Independent Dispute Resolution (IDR) arbitration process under the federal No Surprises Act (NSA). Anthem seeks damages, injunctive relief, and vacatur of the arbitration awards. As of this writing, briefing on defendants' motion to dismiss is ongoing, and several organizations including the California Medical Association have filed amicus curiae briefs expressing their views and interest in the dispute.

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

Overview of the No Surprises Act and the IDR Process

Genesis of the NSA and IDR Process

Congress enacted the federal NSA in December 2020, to prohibit certain out-of-network providers and emergency facilities from "balance billing" patients—i.e., charging for outstanding amounts after reimbursement—for certain services and to create a payment framework for these out-of-network services. Prior to the NSA, several states had already implemented state-level balance billing protection laws. However, such state laws varied significantly in scope and typically applied only to group and individual health insurance issued by health insurance issuers subject to state-level regulation, and therefore excluding the substantial population of individuals with employer-sponsored group plan coverage. This landscape prompted stakeholder engagement and efforts to implement a comprehensive, nationwide framework of balance-billing protections. This led to the NSA and its protections, which are triggered whenever the items and services at issue, the patient's type of coverage, and the applicable care setting and/or provider satisfy the statute's threshold criteria.

Specifically, the NSA prohibits emergency providers, emergency facilities (including hospital-based and free-standing emergency departments), and air ambulance services providers from balance billing patients covered by group or individual health insurance or a group health plan for emergency services and post-stabilization services. The NSA further prohibits out-of-network providers from "surprise billing" such patients for out-of-network services furnished in connection with the patient's visit for non-emergency services at an in-network hospital, hospital outpatient department, ambulatory surgical center, or critical access hospital unless the patient properly waived their protections under the NSA's notice-and-consent requirements. In such circumstances, the NSA effectively holds such patients harmless for amounts above the patient's applicable in-network cost-sharing amount—leaving the insurer and out-of-network provider or emergency facility to handle the remaining unpaid amounts.

Establishing an out-of-network payment mechanism—a key point of contention that nearly led to the failure of Congress' legislative efforts—became and remains one of the more controversial aspects of the IDR process. While the aforementioned state-level surprise billing laws implemented various mechanisms to determine the correct out-of-network payment amount (such as benchmarking, arbitration, and other methods or combinations thereof), Congress ultimately compromised by agreeing to establish a two-part solution: an out-of-network payment process that involved an initial payment and IDR process.

In theory, under the NSA's out-of-network payment mechanism, once the out-of-network provider or emergency facility (collectively, the provider) submits a claim subject to the NSA, the insurer then issues an initial payment to the provider. While the NSA does not specify a minimum initial payment amount, the law allows out-of-network providers who disagree with the initial payment amount to initiate negotiations with the insurer to attempt to agree upon the amount. If the 30-day negotiation period ends without settlement and the claims are in fact eligible for IDR, either party can initiate the IDR process whereby a neutral entity selected by both parties determines which of the parties' offered payment amounts constitutes the correct out-of-network payment for the items and services provided. The IDR entity must make this determination based on factors enumerated in the NSA and information

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

obtained from both parties through the IDR process. Thus, under Congress' intended out-of-network payment mechanism, the final out-of-network payment amount for claims subject to the NSA would be either the amount agreed upon by both parties or the amount determined through the IDR process.

The NSA Becomes Law & Early Challenges

The NSA's balance-billing prohibitions and out-of-network payment mechanism went into effect on January 1, 2022, but soon faced litigation challenging the factors used to make an IDR determination, among other issues. This immediately gave the implementation and operation of the IDR process a rocky start and delayed the IDR process' official kick-off.

Further complicating matters and contributing to the delay were questions relating to eligibility determinations that stumped providers, facilities, plans, and IDR entities. In addition to challenges parties and the IDR entities faced in obtaining and communicating information, difficult questions of preemption became a key complication in eligibility determinations. While the NSA generally preempts state-based laws that operate in the same realm, the NSA specifically defers to state-level balance-billing laws to determine the out-of-network payment amount and to calculate a patient's cost-sharing. Therefore, if an out-of-network provider furnished NSA-covered emergency services to a patient covered by a plan subject to both a state-level law and the NSA with respect to the items and services at issue, the type of coverage, and applicable care setting and provider, then the state's approach would determine the out-of-network payment and the patient's cost-sharing amounts. Such claims, however, would then be ineligible for the federal IDR process. Further, because not all state-level surprise billing laws shared the same scope as the NSA, different payment mechanisms might apply to different claims within the same encounter, sometimes splitting the claims between eligibility for the state-level payment mechanism and the NSA's process. As such, the NSA's deference to state-established out-of-network payment mechanisms in certain instances often requires specific information and the performance of a careful and nuanced service-specific preemption analysis to determine whether a claim for out-of-network services would even be eligible for the NSA's out-of-network payment mechanism.

Altogether, a proverbial *perfect storm* of circumstances came together to make ripe the allegations in the *Anthem* Litigation:

1. Complicated preemption analyses required to determine the application of the state-level surprise billing laws, the application of the NSA, and the overall eligibility of the claim (based on other factors, such as patient consent to waive balance-billing protections);
2. Operational issues causing communication gaps among parties and IDR entities seeking information to validate eligibility or avoid a default determination;
3. A continuous stream of litigation involving the IDR administrative fee, bundled claims, and other issues that resulted in frequent updates to regulations and guidance; and
4. Notable differences and imbalances in the sophistication and preparedness of the various stakeholders navigating the IDR.

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

Anthem's Allegations Against Defendants

Anthem's lawsuit alleges defendants engaged in a scheme to exploit the IDR process to fraudulently maximize revenue. Specifically, Anthem alleges that SPE used Halo, an IDR technology services company, to submit illegitimate out-of-network claims to Anthem. According to Anthem, the defendants pursued this scheme through a coordinated enterprise that relied on false eligibility representations, mass filings, and inflated payment demands to extract reimbursement from Anthem and the plans it administers. Anthem alleges the following: a substantial portion of the defendants' disputes failed federal eligibility requirements; most of the IDR payment determinations involved services categorically ineligible for federal arbitration, including claims subject to state-level surprise billing laws' out-of-network payment processes; failure to initiate mandatory open negotiations; claims involving noncovered items and services; and time-barred filings. Anthem alleges that, despite these defects, defendants certified each submission as a "qualified IDR item or service," thereby *forcing* ineligible claims into the federal IDR process.

Anthem further alleges that Halo—acting on behalf of SPE's affiliated providers—served as the operational engine for mass fraudulent IDR submissions by deploying automated and artificial intelligence-enabled workflows to initiate IDR disputes on an industrial scale. Anthem alleges defendants clustered hundreds of filings on the same days, including initiating 129 separate IDR proceedings against Anthem on a *single day* in January 2024. As a result, Anthem represents it was inundated with claims, which affected its ability to contest eligibility.

Anthem also alleges defendants *continued* to make IDR submissions to Anthem even after Anthem notified defendants that many of the submitted claims were ineligible for the federal IDR process. In addition, the complaint argues that defendants inflated payment demands to distort the outcome of the IDR process and submitted offers that exceeded competitive rates and, in some cases, even exceeded the defendants' own billed charges. In effect, Anthem alleges the defendants leveraged extreme claim amounts to pump up arbitration awards in their favor. In one example noted by Anthem, the defendants allegedly claimed an IDR offer amount of 8,609% more than Anthem's "qualifying payment amount," which is generally the median contracted amount for that item or service in that region. Altogether, Anthem alleges this scheme resulted in IDR determinations exceeding billed charges by over $2.5 million.

In short, Anthem alleges defendants acted in a way that transformed the IDR process from a consumer-protection mechanism into a vehicle for large-scale fraudulent reimbursement extraction from Anthem.

Concluding Thoughts: Notable Implications for the Future of Payer–Provider Conduct and Disputes Under the NSA

One of the more striking aspects of the *Anthem* Litigation is its inclusion of a civil RICO claim. RICO is not a routine feature of reimbursement disputes. Traditionally, payer–provider conflicts over billing and payment are litigated as breach of contract, ERISA benefits disputes, or state-law fraud claims. By invoking RICO, Anthem is framing the alleged misuse of the NSA's IDR process not as an isolated billing disagreement, but as a coordinated, enterprise-level scheme involving repeated predicate acts (e.g., alleged wire fraud through electronic IDR submissions).

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

This shift in framing is legally and strategically consequential. Civil RICO violations carry the possibility of treble damages, attorneys' fees, and significant reputational consequences. It also allows a plaintiff to tell a broader "pattern and practice" story rather than litigating claim-by-claim over individual arbitration awards. If courts permit RICO theories to proceed in the IDR context, disputes over NSA eligibility and attestations could escalate from administrative skirmishes into high-exposure federal fraud litigation. That prospect alone may alter how aggressively both sides approach the IDR process.

More broadly, the inclusion of a RICO count signals an inflection point in payer litigation strategy. Rather than challenging individual arbitration outcomes or seeking regulatory clarification from the Department of Health and Human Services, Anthem appears to be attempting to use federal fraud statutes to police alleged systemic abuse of a congressionally created dispute-resolution mechanism. Whether that theory survives dispositive motions will matter far beyond this case, because it tests whether participation in the NSA's IDR process can itself form the basis of racketeering liability when the plaintiff adequately pleads intentional misuse.

Regardless of the ultimate outcome, this litigation is likely to influence behavior on both sides of the payer–provider divide, such as the following:

First, providers and revenue-cycle vendors may become significantly more conservative in how they certify IDR eligibility. The NSA requires parties initiating the IDR process to attest that a dispute "qualifies for" federal IDR and is not governed by state law or otherwise excluded. If those attestations later could be characterized as *predicate acts* supporting RICO or fraud claims, compliance functions will likely re-evaluate their use. This could involve more internal documentation, legal review of eligibility determinations, and potentially fewer high-volume batching strategies designed to maximize leverage through arbitration. Changes made to the IDR process by the long-awaited Independent Dispute Resolution Operations final rule, currently under final review by the Office of Management and Budget, will further alter how stakeholders manage and strategize their use of the IDR process.

Second, payers may feel emboldened to bring similar actions against other providers. If Anthem's theory gains traction, such as a favorable ruling by the court on the pending motion to dismiss, insurers could pursue similar actions when they believe the IDR system is being "gamed," particularly where disputes involve large volumes or significant aggregate exposure. That could shift the dynamic from a post-offer arbitration model back to the days of litigation-driven deterrence.

Third, this case has the potential to influence negotiations outside the arbitration forum. The NSA was intended to remove patients from the middle of surprise billing disputes and encourage market-based resolution through structured negotiation, with IDR as a backstop. If participation in IDR becomes coupled with the threat of federal fraud liability, both payers and providers may have stronger incentives to resolve disputes earlier—either through contract renegotiation or more disciplined open negotiation—rather than risk becoming the next test case in a high-profile federal lawsuit.

In short, the RICO dimension elevates the stakes of what otherwise might have been "just another payer-provider dispute" or technical fight over statutory eligibility under the NSA. Instead, this litigation could become a defining case about the boundaries of lawful conduct within the IDR system—and how far federal courts are willing to go in policing alleged strategic behavior in health care reimbursement disputes. For that reason, these Halo cases should be followed by counsel for providers and payers alike.

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

[1] As of this writing, Anthem has also filed actions against HaloMD in the Northern District of Georgia (*Blue Cross Blue Shield Healthcare Plan of Ga., Inc. v. HaloMD, LLC et al.*, No. 1:25-cv-02919), the Southern District of Ohio (*Cmty. Ins. Co. v. HaloMD, LLC et al.*, No. 1:25-cv-00388), and the Eastern District of Texas (*Blue Cross Blue Shield of Tex. v. HaloMD LLC*, 5:25-cv-00132).

ARTICLE TAGS

Payers, Plans, and Managed Care Practice Group Health Insurance

1099 14th Street NW, Suite 925, Washington, DC 20005 | P. 202-833-1100
For payments, please mail to P.O. Box 79340, Baltimore, MD 21279-0340
© 2026 American Health Law Association. All rights reserved.
American Health Law Association is a 501(c)3 and donations are tax-deductible to the extent allowed by law. EIN: 23-7333380

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.