No. 26-20170

In the United States Court of Appeals for the Fifth Circuit

ALLSTATE INSURANCE COMPANY, ALLSTATE INDEMNITY COMPANY, ALLSTATE PROPERTY & CASUALTY INSURANCE COMPANY, ALLSTATE FIRE & CASUALTY INSURANCE COMPANY, AND ALLSTATE COUNTY MUTUAL INSURANCE COMPANY,

Plaintiffs-Appellants,

v.

INNOVO MANAGEMENT, LLC, 59 PAIN & REHABILITATION CENTER, INC., 290 PAIN & REHABILITATION, INC., YOUNG AN, M.D., BREEZE MRI, LLC, CXR INVESTMENTS LLC, HETANSH INVESTMENTS, INC. D/B/A HRX INVESTMENTS, THAO T. HUYNH, D.C, INNOVO PHYSICIAN SERVICES, PLLC, LAURA TRAN LE, D.C., RAVI PATEL, DEEPAK SHARMA, AND ROBERT CASIMIR, D.O.,

Defendants-Appellees.

On Appeal from the United States District Court
for the Southern District of Texas, No. 4:25-CV-00368

BRIEF OF AMICI CURIAE THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AND THE AMERICAN TORT REFORM ASSOCIATION IN SUPPORT OF APPELLANTS

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CERTIFICATE OF INTERESTED PERSONS

No. 26-20170

Allstate Insurance Company, Allstate Indemnity Company, Allstate Property & Casualty Insurance Company, Allstate Fire & Casualty Insurance Company, and Allstate County Mutual Insurance Company,
Plaintiffs-Appellants,

v.

Innovo Management, LLC, 59 Pain & Rehabilitation Center, Inc., 290 Pain & Rehabilitation, Inc., Young An, M.D., Breeze MRI, LLC, CXR Investments, LLC, Hetansh Investments, Inc. d/b/a HRX Investments, Thao T. Huynh, D.C, Innovo Physician Services, PLLC, Laura Tran LE, D.C., Ravi Patel, and Deepak Sharma, and Robert Casimir, D.O.,
Defendants-Appellees.

The undersigned counsel of record certifies that, in addition to the persons and entities listed in Appellants' Certificate of Interested Persons, the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the Judges of this Court may evaluate possible disqualification or recusal.

Amici Curiae:

The Chamber of Commerce of the United States of America ("Chamber") states that it is a non-profit, tax-exempt organization incorporated in the District of Columbia. The Chamber has no parent corporation, and no publicly held company has 10% or greater ownership in the Chamber.

The American Tort Reform Association ("ATRA") states that it is a non-profit, tax-exempt organization incorporated in the District of Columbia.

ATRA has no parent corporation, and no publicly held company has 10% or greater ownership in the ATRA.

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INTEREST OF AMICI CURIAE

The Chamber of Commerce of the United States of America ("Chamber") is the world's largest business organization. As the nation's leading advocate for business, the Chamber represents companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files amicus curiae briefs in cases, like this one, that raise issues of concern to the nation's business community.[1]

The Chamber has a strong interest in the proper resolution of the questions presented in this appeal. Many of its members operate businesses that purchase liability insurance, self-insure risk, or otherwise bear the costs associated with civil litigation. They have a substantial interest in ensuring that federal law provides an effective means of addressing coordinated schemes that artificially inflate liability claims and settlement demands, thereby increasing the costs of litigation and insurance borne by businesses throughout the economy.

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[1] Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), no counsel for any party authored this brief in whole or in part, and no person or entity other than amici curiae, their members, or their counsel made any monetary contribution intended to fund the preparation or submission of this brief.

The American Tort Reform Association ("ATRA") is a broad-based coalition of businesses, corporations, municipalities, associations, and professional firms that have pooled their resources to promote reform of the civil justice system with the goal of ensuring fairness, balance, and predictability in civil litigation. For more than three decades, ATRA has filed amicus briefs in cases, like this one, involving important product liability and related issues.

ATRA has long advocated for reforms that deter abusive litigation practices and preserve the integrity of the civil justice system. It has a substantial interest in ensuring that legal doctrines do not impede civil remedies against alleged fraudulent schemes designed to manufacture unnecessary medical treatment and artificially inflate settlement demands.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

This appeal arises from allegations that a network of medical providers, management companies, and related entities orchestrated a referral-and-billing enterprise designed to inflate automobile-accident settlements. Appellants allege that the participants generated unnecessary treatment and inflated medical charges, then caused those charges to be presented to insurers through settlement demands. Appellants' Br. 3-4. The district court dismissed the complaint after concluding that Appellants' settlement decisions broke the chain of causation, notwithstanding this Court's intervening decision in *Allstate Indemnity Co. v. Bhagat*, which acknowledged that settlements are the intended goal of such schemes. 164 F.4th 426, 433 (5th Cir. 2026).

This case is not an isolated dispute. Courts in this Circuit increasingly have confronted "intricate" referral-and-billing enterprises that depend on personal-injury attorneys and medical providers "to identify car-accident victims, prescribe unnecessary medical treatment, and fraudulently bill" insurers to pressure them into inflated settlements. *Id.*[2] Many of these

[2] *See also, e.g.*, *United States v. Graham*, 648 F. App'x 421, 422 (5th Cir. 2016) (describing conspiracy in which law firm sent recruited clients to chiropractic clinics for treatment and "much more treatment was billed than was given"); *Allstate Ins. Co. v. Plambeck*, 802 F.3d 665, 671 (5th Cir. 2015) (describing "scheme to defraud insurance companies such as Allstate" by identifying individuals involved in automobile accidents, convincing them to undergo "unnecessary chiropractic services," and encouraging them to file third-party insurance claims against the at-fault party's insurer); *State*

enterprises also rely on third-party funders that finance medical treatment and secure repayment through liens on future settlements or judgments. *What You Need to Know About Third Party Litigation Funding*, U.S. Chamber of Com. Inst. for Legal Reform (June 7, 2024), https://perma.cc/C4WG-2Q5F. These enterprises are designed to maximize profits for their participants rather than to advance the interests of the injured claimants they purport to serve.

The district court's reasoning rests on assumptions that do not reflect how referral-and-billing enterprises actually operate. The Chamber respectfully submits this brief to describe the broader landscape and correct those assumptions. It proceeds in two parts.

Farm Mut. Auto. Ins. Co. v. Misra, 658 F. Supp. 3d 362, 368 (W.D. Tex. 2023) (describing alleged scheme where doctor inflated medical bills and "submit[ted] the medical bills and records to his patients' personal injury attorneys to submit demands to [insurance companies] to settle the patients' claims"); *State Farm Mut. Auto. Ins. Co. v. Punjwani*, 2019 WL 7372215, at *2 (S.D. Tex. Dec. 31, 2019) (allegations of scheme to inflate medical bills personal-injury attorneys used to settle insurance claims); *Allstate Ins. Co. v. Benhamou*, 190 F. Supp. 3d 631, 663 (S.D. Tex. 2016) (unnecessary medical charges "were sent to attorneys for forwarding to and payment by Allstate"); *In re ArthroCare Corp. Secs. Litig.*, 726 F. Supp. 2d 696, 702-03 (W.D. Tex. 2010) (allegations of scheme in which personal-injury attorneys referred clients to physicians for procedures; physicians supplied medical records and inflated bills for settlement demands to casualty insurers; and lawyers, physicians, medical-device manufacturer, and distributor were paid from the settlement proceeds).

Part I explains that referral-and-billing schemes generally involve at least three sets of actors: attorneys who refer claimants to selected providers and shape the treatment those claimants receive; providers who generate inflated, often unnecessary medical charges; and funders who finance the medical treatment in exchange for a future portion of the settlement or damages. The shared end goal is to convert the entire arrangement into profit while insulating it from the scrutiny of discovery and trial, often through settlement.

Part II explains that the effects of this model extend well beyond the parties in any single case. Insurers contend with inflated claims and the higher reserves they require; claimants see much of their recovery consumed by legal fees, medical expenses, and financing charges before they ever receive it; and ordinary policyholders bear the cost through higher premiums. And all of these economic consequences come at a time when costs are rising for consumers in nearly every area. Referral-and-billing schemes also compromise the medical care claimants receive because they promote treatment driven by billing potential rather than clinical need. Finally, referral-and-billing schemes jeopardize principles of truth and fairness in the adversarial system by distorting claims presented and relied on in legal judgments and settlement.

ARGUMENT

I. The District Court's Opinion Fundamentally Misunderstands the Nature of the Fraudulent Referral-and-Billing Scheme at Issue.

The district court fundamentally misunderstood the referral-and-billing scheme at issue, particularly as to the role of attorneys and the ultimate goal of settlement. Referral-and-billing enterprises are generally effected through the coordination of three actors: (1) the attorney directs clients and shapes the case with an eye toward inflated settlement; (2) the medical provider generates inflated charges to drive up potential liability and force settlement; and (3) the third-party funder purchases an interest in the settlement proceeds. These actors work together in pursuit of profit via inflated settlement demands, as in this litigation.

A. Referral-and-Billing Schemes Depend on Coordination Among Attorneys, Medical Providers, and Litigation Funders.

1. Lawyers direct claimants through a referral network that converts medical treatment into litigation leverage.

Personal-injury attorneys play a critical role in many fraudulent referral-and-billing schemes, including the one in this case. *See* Appellant's Br. 10. They identify and recruit claimants, connect patients with selected medical providers,[3] control the claims, and supply the settlement leverage that makes

[3] The term "medical providers" in this brief refers generally to locations that operate as or hold themselves out as medical facilities and provide healthcare services to patient-claimants. While some of the individuals

the scheme profitable. *See Bhagat*, 164 F.4th at 431 (personal-injury attorneys referred clients to a specific emergency center, received the medical bills from the center, and "present[ed] the bills to Allstate as part of settlement demands"). Simply put, attorneys function as indispensable "quarterbacks" rather than outside decisionmakers. Daniel Fisher & John O'Brien, *Hush Money: Secrets of Georgia's Injury Lawyers Coming to Light*, Legal Newsline (May 29, 2026), https://perma.cc/53ML-SYJL.

The scheme often begins with an attorney's referral. Personal-injury attorneys direct their clients to specific medical providers. *See Graham*, 648 F. App'x at 422 (describing conspiracy to recruit individuals with claims against automobile insurers as law firm clients and to refer them to four chiropractic clinics); *State Farm Mut. Auto. Ins. Co. v. Kugler*, No. 11-80051, 2011 WL 4389915, at *2 (S.D. Fla. Sep. 21, 2011) (personal-injury attorneys provided "ongoing patient referrals" to non-attorney defendants, who in turn supplied providers with those referrals).

The volume of such referrals may be substantial. In *Bhagat*, for example, this Court noted that, after personal-injury attorneys entered an agreement to refer clients to a specific medical center, visits by car accident patients doubled. 164 F.4th at 431. Some patients "traveled from as far away as 92

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employed at these providers are actual medical professionals, such as doctors, nurses, and radiologists, others are not.

miles, bypassing other medical centers to reach this inconspicuous facility in a modest shopping center far from any major thoroughfares." *Id.*[4]

Recent cases show that such "referrals" are often a tool to drive up costs: Personal-injury attorneys in Louisiana, for example, were recently convicted of spearheading "a long-running scheme to defraud insurance companies and commercial trucking companies by staging and litigating fraudulent automobile collisions to collect insurance company payouts," including by "encouraging those passengers to seek medically unnecessary neck and back surgeries to incur medical costs and increase the size of future insurance company settlements." *See* Press Release, U.S. Att'ys Off., E.D. La., *Federal Trial Jury Convicts New Orleans Personal Injury Attorneys in Staged Collision Scheme* (Mar. 20, 2026), https://perma.cc/6YW8-FPAE ("Including this jury trial, sixty-three (63) defendants have been charged in the federal probe into the staging of automobile collisions with other vehicles in the New Orleans metropolitan area."); *see also State Farm Mut. Auto. Ins. Co. v. Giventer*, 212 F. Supp. 2d 639, 641 (N.D. Tex. 2002) (describing alleged conspiracy in which

[4] *See* Nora Freeman Engstrom, *Shining a Light on Shady Personal-Injury Claims*, 2 J. Ins. Fraud in Am. at 13, 15 (2011) (attorneys advised almost one third of surveyed represented claimants "on which medical care providers to visit" (citation modified)); Daniel Fisher, *Ga. Doctors Face Scrutiny as They Cozy Up to Injury Lawyers*, Legal Newsline (June 3, 2026), https://perma.cc/5SB2-XGS8 (reporting that a single law firm "sent 752 referrals" to a specific orthopedic clinic over a two-year period).

law firms and chiropractic clinics "submitted fraudulent insurance claims" for "at least 153 deliberately caused automobile collisions").

After referring clients to selected providers, attorneys often use their relationships with those providers to shape the medical evidence that drives up claim value. Attorneys may discuss patient care with their client's physicians or even direct treatment. *See, e.g.*, First Am. Compl. ¶¶ 163-67, *Allstate Fire & Cas. Ins. Co. v. Found. Physicians Grp.*, No. 3:25-cv-02984-K-BT (N.D. Tex. Mar. 23, 2026), ECF No. 30 (alleging personal-injury attorneys "selected the procedures to be done based on personal injury claim considerations" and that some procedures, including steroid injections, were not performed without attorney approval); *see also* Nat'l Ins. Crime Bureau, *NICB Medical Fraud Scheme Guide* 2, 9-11 (Version 1.0, Nov. 2016), https://perma.cc/MUJ9-EHCS (describing "attorney directed care," in which lawyers may order tests and treatment (citation modified)); Tez Romero, *Allstate Blasts Texas Clinics, Claims $5.2 Million Auto Fraud Scheme*, Ins. Bus. Am. (Nov. 7, 2025), https://perma.cc/43AA-LSZB (noting deposition testimony that personal-injury attorneys "had to approve injection procedures before they were performed"). As a result of this dynamic, attorney-represented claimants receive more chiropractic treatment, physical therapy, magnetic resonance imaging ("MRIs"), and computed tomography ("CT") scans when compared to other claimants with similar injuries. Ins. Rsch. Council, *Countrywide Patterns in Auto Injury Insurance Claims: 2018 Edition* at 3 (2018), https://perma.cc/N6H9-VFUV.

Attorneys also play a key role at the back end of the scheme. Once a client-claimant receives medical care, attorneys lead the effort to recoup payment from insurers for that care, often through settlement demands. *See infra* Part I.B.

2. Medical providers generate inflated charges.

The second component of the scheme involves medical treatment and inflated billing. When treating patient-claimants, providers may administer "several expensive diagnostic tests," including CT scans. *Bhagat*, 164 F.4th at 431. At times, the providers will order these tests "without properly documenting the need, only to discharge [the patient-claimants] without further treatment." *Id.*

Often providers will submit claims for services and treatments that were "not actually performed" or "not medically necessary." *Allstate Ins. Co. v. Exec. Ambulatory Surgical Ctr., LLC*, No. 22-11263, 2022 WL 16636927, at *1 (E.D. Mich. Nov. 2, 2022); *see also Plambeck*, 802 F.3d at 671-72 (describing prescribed chiropractic services as "unnecessary" and x-rays as often "useless"); *Kugler*, 2011 WL 4389915, at *1 (providers "perform[ed] medically unnecessary diagnostic tests and surgical procedures" on automobile accident victims). Or, as alleged in this case, "in billing for the services provided," providers may use billing "codes that fail[ ] to truthfully describe the services purportedly performed." Appellants' Br. 7. Treating physicians in other, similar cases have prescribed drugs like ibuprofen and charged services "to standard medical billing codes reserved for severe and life-

threatening emergencies." *Bhagat*, 164 F.4th at 431; *see also* Daniel Fisher, *Jurors Reject the Georgia Lawsuit Factory in Symbolic Case*, Legal Newsline (June 4, 2026), https://perma.cc/SL7J-E5JW (describing a rear-end collision claimant whose X-rays showed no acute injury, who received Motrin, and whose emergency-room bill totaled $3,800).

This manner of treatment routinely generates inflated medical bills. That is because, in addition to unnecessary treatments, providers involved in referral-and-billing schemes often charge patients far more than conventional insurers or government programs would pay, sometimes up to *three times* the normal cost of a given treatment. *See, e.g.*, *Bhagat*, 164 F.4th at 431 (provider "charged the referred patients using emergency billing codes, sometimes at rates nearly triple those normally charged"); *Kugler*, 2011 WL 4389915, at *1 (explaining providers used "false billing codes"); Appellants' Br. 9 (describing "unbundling" billing codes to bill more "for the component parts of a procedure").

Rather than ask the patient for upfront payment, physicians and medical centers involved in fraudulent referral-and-billing schemes regularly work with third-party litigation funders who pay the provider a discounted amount and acquire the right to collect from any resulting settlement or judgment. *See infra* Part I.A.3. This business model distorts providers' economic incentives. Under ordinary insurance billing, a provider's stated charge has little effect on what the provider actually collects, because insurers pay a fixed negotiated rate regardless of the amount billed.

Litigation funding removes that ceiling, because personal-injury damages are calculated in part from the patient's medical bills, and juries may see the full billed amount rather than the lower amount an insurer would have paid. Providers therefore have an incentive to maximize the face amount of medical charges because those amounts will be covered by third-party litigation funders and ultimately become part of the damages presentation in litigation (and a data point to be leveraged in settlement negotiations). *See How Third-Party Medical Financing and Phantom Damages Drive Rising Liability Costs*, The Hartford (May 19, 2026), https://perma.cc/M34D-U8W4. Higher bills represent a potential for higher awards or pay-outs.

3. Litigation funders finance medical treatment at a discount and profit from the patient-claimant's recovery in court.

The third piece of the referral-and-billing scheme involves financing. Instead of requiring the patient to pay medical costs upfront, a third-party funding company may finance the medical treatment "in exchange for a percentage of any settlement or judgment." *What You Need to Know About Third Party Litigation Funding*, *supra*.[5] In exchange for a reduced payment to the provider, the funder gains the right to be reimbursed from any court

[5] The role of litigation funders can be contemporaneous with other actors in referral-and-billing schemes. Litigation funders may be present at the onset of the matter but help inflate settlement demands all the same. To more closely align with the facts of the underlying case, this brief describes the role of litigation funders as the third phase of referral-and-billing schemes.

settlement or award the patient-claimant receives.[6] Cara Scheibling & John Schneider, *The New Era of Personal Injury Lawsuits: The Rise of Lien-Doctors and Medical Financing Companies*, Fed'n of Def. & Corp. Couns. Issue Brief (2023), https://perma.cc/973F-5CF4. The funder's profit is the gap between its purchase price (*i.e.*, what it paid in medical costs) and the amount claimed in court. *See id.*

Litigation funders may realize significant profits. For example, although litigation funders "operate[] largely in secret without any meaningful oversight," recent reporting explains that "investors typically seek returns of *three to four times their investment* for a single lawsuit, or around 18% when they invest in a portfolio of lawsuits." John H. Beisner, Jordan M. Schwartz & Alexander J. Kasparie, U.S. Chamber of Com. Inst. for Legal Reform, *Grim Realities: Debunking Myths in Third-Party Litigation Funding* 2, 19 (2024), https://perma.cc/45EB-R3Z2 (emphasis added) (citing Robert Freedman, *Litigation Funding Seen as Strategic Tool for Pursuing Lawsuits*, Legal Dive (July 1, 2022), https://perma.cc/5UXW-GEHQ)). Those profits are only realized

[6] The amount the funder pays the medical provider, while discounted, is still inflated. *See Bhagat*, 164 F.4th at 431 (provider "charged the referred patients using emergency billing codes, sometimes at rates nearly triple those normally charged"). So the provider still benefits from both the inflated charge and the scheme's "steady stream of patients." Fisher, *Ga. Doctors Face Scrutiny*, *supra* note 4.

when the claim produces a settlement or judgment, making settlement the final step—and ultimate target—of referral-and-billing schemes.

B. Settlements Monetize the Inflated Claims and Shield Referral-and-Billing Schemes from Scrutiny in Court.

Settlement is not merely one possible outcome of referral-and-billing schemes; it is the primary mechanism through which the enterprise realizes its profits. *See Bhagat*, 164 F.4th at 431 (agreements between personal-injury attorneys and emergency centers guarantee "payment from future insurance settlements"); Nat'l Ins. Crime Bureau, *NICB Medical Fraud Scheme Guide*, *supra*, at 9 ("The medical expenses are . . . used to increase settlements in bodily injury lawsuits."); Appellants' Br. 10 ("Defendants knew that personal-injury attorneys would use the bills and records to extract settlement payments from Allstate."). Attorneys receive contingency fees only upon recovery. *See, e.g.*, *Hernandez v. Hill Country Tel. Co-op., Inc.*, 849 F.2d 139, 144 (5th Cir. 1988). And litigation funders profit only if the eventual recovery exceeds the amount they paid to the medical providers. *See What You Need to Know About Third Party Litigation Funding*, *supra* (explaining funders only benefit if the plaintiff succeeds).

A referral-and-billing scheme's structure incentivizes attorneys and providers to increase claimed damages in order to pressure defendants and their insurers to settle. Attorneys and providers work together to craft medical treatment, additional medical records, procedures, and charges to increase the claimed damages. Those expanding damages raise litigation

reserves, increase perceived verdict exposure, and make continued litigation prohibitively expensive for insurers like Appellants. *See infra* Part II.

Such schemes thereby force insurers to choose between paying a large settlement or incurring substantial discovery and trial costs to thwart referral-and-billing arrangements. *See How Third-Party Medical Financing and Phantom Damages Drive Rising Liability Costs*, *supra*. For example, in a case filed last year in the Northern District of Texas, insurers alleged that scheme participants performed unnecessary procedures solely to inflate settlement value, placing insurers in the position of choosing between policy-limit settlements and the risk of substantially greater liability exposure. First Am. Compl. ¶¶ 244-48, *Found. Physicians Grp.*, No. 3:25-cv-02984-K-BT, ECF 30.

Even when an insurer suspects that a claim has been artificially inflated, refusing settlement often remains untenable. *See* Martin Boerlin et al., *Litigation Costs Drive Claims Inflation: Indexing Liability Loss Trends* 28, Swiss Re Inst., Sigma No. 4/2024 (2024), https://perma.cc/3KKX-TXAY (discovery process in bodily injury cases is "in-depth," "onerous," "time-consuming," and "expensive"). Challenging every medical claim, no matter how meritless, through expert discovery, depositions, medical review, dispositive motions, and trial imposes substantial costs independent of the merits. *See What You Need to Know About Third Party Litigation Funding*, *supra* ("Businesses often settle cases rather than engage in protracted and costly litigation, regardless of whether the [legal] claims are legitimate."); *see also Bhagat*, 164 F.4th at 431 (describing litigation pressure resulting in "Allstate

settl[ing] with 635 claimants" "[b]etween August 2018 and November 2022"). Insurers like Appellants are often better off taking the earliest off-ramp from litigation they can find.

In the rare instance that a challenge to inflated claims prevails and a court orders disclosure of referral records, funding contracts, or actual payments, the billing-and-referral network is quick to settle or dismiss their claims. Fisher & O'Brien, *Hush Money*, *supra* (attorneys urge clients to quickly settle or dismiss their case "to keep prying eyes out of their business"); *see also* Beisner et al., *Grim Realities*, *supra*, at 2-3 (noting litigation-funding arrangements often remain strategically and intentionally undisclosed). As a result, the economics of referral-and-billing schemes remain largely hidden from courts, opposing parties, and the general public. Beisner et al., *Grim Realities*, *supra*, at 2-3, 6-9. This outcome is preferable for the personal-injury attorneys, providers, and litigation funders involved, because insight into the referral volume, provider discounts, and attorney involvement in treatment decisions may lead astute jurors to reject the claimed damages entirely.

C. The District Court's Order Failed to Account for the Role of Attorneys and the Settlement Goal of Referral-and-Billing Schemes.

The district court misconstrued the scheme pleaded by Appellants in at least two respects, and those misconceptions colored its decision.

First, the court incorrectly treated the claimants' attorneys as operating "outside the medical providers' structure" because the attorneys were not employed by the medical defendants, were not situated directly within their corporate structure, and did not "supervise[] the medical teams." ROA.6790. That unduly formal test finds no support in this Court's precedent. In *Bhagat*, this Court held that proximate cause turned on whether the defendants' conduct was a substantial and foreseeable cause of the insurer's payment—not on the attorney's formal affiliation with the medical provider. 164 F.4th at 433-34. The same was true in *Plambeck*. 802 F.3d at 676. Regardless of formal affiliation, the scheme's structure depends heavily on the attorney's role as quarterback. *See supra* Part I.A.1.

Second, the district court's conclusion that settlement "interrupt[ed] the alleged fraud," ROA.6791, misapprehends the relationship between settlement and the scheme described above. The court's analysis rests on the mistaken idea that settlement is an independent business decision by the insurer. But as this Court acknowledged in *Bhagat*, the very goal of the referrals, inflated medical charges, and litigation financing that make up a referral-and-billing scheme is to alter the insurer's settlement calculus by increasing the expected costs and risks of continued litigation. 164 F.4th at 433-34; *see also Misra*, 658 F. Supp. 3d at 374 (plaintiffs' claims not too attenuated where defendants inflated medical bills "to maximize" reimbursement during settlement); *Benhamou*, 190 F. Supp. 3d at 645, 647 (allegations sufficiently "connect[ed] the alleged fraud to the alleged harm"

where insurer's overpayment of claims "by settlement checks" "would not have occurred if Defendants had not submitted fraudulent records, reports, billings, and other documents . . . substantiating the unnecessary and inflated services'"); *Kugler*, 2011 WL 4389915, at *7-8 (stating insurer "is entitled to recover to the extent its settlement decision making was influenced and distorted by false billings generated by the defendants").

In other words, settlement is not an intervening decision that interrupts the fraud—it is the whole point of the scheme, as Appellants here alleged. Appellants' Br. 10; ROA.2005. Every preceding step, from referral to inflated medical charges, to financing arrangements, to settlement demands, is designed to increase the probability of reaching settlement and the value of that settlement. Requiring an insurer to forgo settlement and incur the cost, delay, and risk of full-blown litigation on every claim merely to preserve a RICO remedy would convert the very injury the scheme is designed to produce into a bar to recovery.

II. Referral-and-Billing Schemes Cause Widespread and Substantial Harm.

The negative consequences of referral-and-billing schemes extend far beyond inflated individual settlements. These schemes impose economic and legal harms on insurers, claimants, and ordinary consumers alike. They also inflict medical harm on claimants by prioritizing profit over treatment and undermine fundamental fairness in legal proceedings.

A. Referral-and-Billing Schemes Inflict Economic Harm on Insurers, Claimants, and Consumers.

Referral-and-billing schemes harm insurers through inflated and improper claims; reduce claimants' recoveries through legal fees, medical expenses, and financing charges; and burden consumers with higher premiums.

1. Insurance companies occupy a unique position among businesses: their structure requires them to maintain substantial cash reserves. *See generally* Ins. Info. Inst., *Background on: Insurance Accounting*, https://perma.cc/A9PQ-9EHF. These reserves guarantee that insurers can meet claims as they come due, and as a result, they constitute an insurer's largest liability. *Id*. Actuaries calculate the required reserve amounts in advance, drawing on claim trends to inform their projections. *Id*. Consequently, as claims rise in both frequency and payout, insurers must adjust their reserves in kind. *Id.*

When claims surge unexpectedly, insurers absorb the loss of having priced premiums too low for the actual risk. *Id*. To offset this shortfall, insurers face difficult business decisions, including raising rates for consumers. Daniel Fisher & John O'Brien, *Georgia's Hidden Money Machine: Car-Wreck Lawsuits*, Legal Newsline (June 1, 2026), https://perma.cc/Y2B9-GHYG. As one source puts it, the "result [of higher medical claims] is higher costs that ripple through the system and show up as higher insurance premiums, medical bills, and everyday prices for everyone." *Id*. (quoting Stef

Zielezienski, Chief Legal Officer, American Property Casualty Insurance Association).

Referral-and-billing schemes exacerbate the strain on insurer reserves. In this case alone, Appellants paid "in excess of $4,108,426.52" for Appellees' fraudulent claims. ROA.132. The scale of this harm is not unique. *See Punjwani*, 2019 WL 7372215, at *1 ("State Farm alleges it paid hundreds of allegedly fraudulent claims for medical services."); *Exec. Ambulatory Surgical Ctr., LLC*, 2022 WL 16636927, at *1 ("Allstate alleges that it paid Defendants more than $2,000,000 in false claims."); *Kugler*, 2011 WL 4389915 at *2 ("Relying on the defendants' bills and documentation submitted through this conduit, State Farm alleges it was fraudulently induced to pay over $13 million."). And when multiplied by the increasing number of referral-and-billing schemes courts are encountering, that scale has an obvious and significant effect on insurer reserves.

2. Insurers are not the only ones harmed by these fraudulent schemes. Claimants, too, bear the costs. Much of the recovery never reaches the claimant-patient at all: legal fees, medical expenses, and financing charges consume the settlement before distribution, often leaving the claimant with only a fraction of the total amount. *See* Countrywide Patterns in Auto Injury Insurance Claims, *supra*, at 4 (attorney involvement correlates with lower net recovery for claimant after expenses and legal fees); *What You Need to Know About Third Party Litigation Funding*, *supra* ("In many known instances, when the plaintiff wins a funded case, the funder will first take its cut of the

winnings before the plaintiff is paid—often 20-40% of the proceeds of the case, or even more."); *Plambeck*, 802 F.3d at 672 ("Often the accident victim received less than one-third of the funds.").

The record in this case reflects the reality for claimants. Appellants have explained how one attorney at the center of the scheme "skimmed" claimants' awards to fund kickbacks to Appellees. ROA.6815-16. When each claimant finally received what was left of their award, they were unaware that it had first funded Appellees' personal expenses. *See id*. That is because a referral-and-billing scheme, by its very design, serves the interests of those who run it—not the claimants it ostensibly exists to help.

3. At the end of the day, the negative effects of referral-and-billing schemes are felt by all consumers. "[A]s much as 14 percent of *all* personal auto premiums" are the result of insurers having to cover fraudulently increased claims. Ins. Info. Inst., *Background on: Insurance Fraud*, https://perma.cc/53VX-K26S. That's a roughly $900 annual increase in premium cost for the average American policyholder. Nat'l Ins. Crime Bureau, *NICB Warns Consumers Nationwide: Insurance Fraud Is Coming for Your Pocketbook* (Nov. 5, 2025), https://tinyurl.com/5e7ez8sb; *see also* Thomas Holzheu et al., *US Litigation Funding and Social Inflation: The Rising Costs of Legal Liability*, Swiss Re Inst. (Dec. 9, 2021), https://tinyurl.com/yc28zuw4 (stating "[h]igher claims costs drive up insurance premiums," and resulting costs "are ultimately paid by consumers").

"Insurers have responded to the financial pressures" of litigation-driven claim costs "by raising rates." Jim Lynch et al., *Increasing Inflation on Auto Liability Insurance—Impact as of Year-End 2023* at 2, 19 (Cas. Actuarial Soc'y & Ins. Info. Inst. 2024), https://tinyurl.com/2ejuf7dy; *see What You Need to Know About Third Party Litigation Funding*, *supra* ("When companies face higher litigation costs, they are often forced to raise prices for consumers."). Texas automobile insurance rates, for example, increased by an average of 25.5% in 2023 alone. Tex. Dep't of Ins., *2024 Biennial Report* 6 (2024), https://perma.cc/459F-2EEQ. And the Texas Department of Insurance identified padded automobile-accident claims as a contributing factor, explaining that "fraudulent insurance claims drive premium costs up" because insurers spread claim costs among policyholders. Tex. Dep't of Ins., *Insurance Fraud Guide* (June 16, 2026), https://perma.cc/2M8U-XGV7.

Texas is not alone in this predicament. Louisiana tells a similar story. As of 2022, its bodily-injury claim frequency was nearly double the national average, with roughly 49% of vehicle accidents resulting in a bodily-injury claim compared to about 25% nationwide. Ins. Rsch. Council, *Personal Insurance Affordability in Louisiana*, https://perma.cc/Q7YJ-WBCB. Louisiana's litigation rate compounds the problem: claims in the state are more than twice as likely to involve a lawsuit as the national average, trailing only Florida. *Id*. The result is the least affordable auto insurance in the country—Louisiana's insurance expenditures consume roughly 2.7% of median household income, nearly double the 1.5% national figure. Ins. Rsch.

Council, *Louisiana Remains the Least Affordable State in the Country for Personal Auto Insurance, According to New IRC Study* (Oct. 14, 2024), https://perma.cc/85W2-LGQB.

These rising insurance costs certainly "do[] not help address persistent affordability challenges" across nearly every other area of life. U.S. Bureau of Lab. Stats., *Consumer Price Index Summary* (July 14, 2026), https://perma.cc/YX33-FS5Y (showing a 3.5% rise in the "all items index" for the past year, including a 15.7% increase in energy and a 3% increase in food); *see* Milliman, *2026 Milliman Medical Index* (May 20, 2026), https://perma.cc/E4SW-WA29 (estimating a 7.9% increase in healthcare costs for the average individual between 2025 and 2026, "the highest increase" in "more than a decade"). Insurance costs driven by referral-and-billing fraud are just another expense coming out of consumers' already strained pocketbooks.

B. Referral-and-Billing Schemes Compromise the Medical Care of the Very Claimants They Purport to Serve.

Referral-and-billing schemes also compromise claimants' medical care. When "the primary objective" is "to maximize profits," medical treatment is "not for the benefit of patients." ROA.37.

In this case, for example, the medical providers Appellees used operated under "predetermined treatment protocol[s]," using "template[s]" "indiscriminately" for cases referred under the scheme. ROA.66, 68; *see also* ROA.6786. The protocol was "not tailored to the specific patients' needs"

and did not account for actual injuries, severity, prior medical history, or other pertinent circumstances. *Id.* As Appellants' brief explains, Appellees routinely instructed claimant patients to undergo repeat diagnostic testing, MRIs, or needless epidural steroid injections. Appellants' Br. 8, 9. In some instances, the providers even misrepresented who was making medical decisions, allowing "unlicensed laypersons" to "dictate[] the healthcare services provided to the claimants." Appellants' Br. 3. The goal? "[T]o bill for as much treatment and testing as possible, regardless of whether such treatment and testing was reasonably necessary to patients' care, recovery, [and/or] rehabilitation." ROA.65.

This pattern is not unique to the underlying litigation. Other tools in personal-injury attorneys' referral-and-billing "playbook" include encouraging claimant-plaintiffs "to avoid going to their own doctors or using their own insurance" and directing medical personnel to perform "MRIs on ALL injured body parts." Fisher & O'Brien, *Hush Money*, *supra*. Providers participating in such schemes often convince accident victims to undergo unnecessary medical services. *Plambeck*, 802 F.3d at 671 (providers "almost always prescribed the same treatment" regardless of need: "hot and cold packs, electrical stimulation, massages, and other passive modalities"). In one extreme case, an attorney even "convince[d]" a claimant "to undergo neck surgery to receive more money through the lawsuit." Nat'l Ins. Crime Bureau, *No Accident: An Inside Look at a New Orleans Organized Crime Ring*, https://tinyurl.com/2ecdabu9.

Claimants seeking medical treatment "rely[] on the judgment and accuracy of the medical professionals involved." *State Farm Mut. Auto. Ins. Co. v. Complete Pain Sols., LLC*, 2024 WL 3488256, at *6 (S.D. Tex. July 18, 2024). They trust medical professionals to treat them "in a professional and accurate manner"—and not for self-motivated reasons. *Id.* Referral-and-billing schemes take advantage of this trust, while disregarding medical providers' ethical obligations to do no harm.

C. Referral-and-Billing Schemes Undermine Fairness in Legal Proceedings and Compromise Legal Ethics.

Referral-and-billing schemes also strike at the core of fair adjudication and the ethical duties that govern legal proceedings. When an attorney, medical provider, or litigation funder inflates medical claims and billing, the scheme corrupts the very facts on which a court, jury, or settling party must rely.

The facts of this case show that principle in action. Settlement payments between Appellants and Appellees rested on inflated medical bills. *See* ROA.65 (alleging "Defendants regularly submitted bills" for unnecessary and unreasonable "treatment and services"). And Appellees primarily aimed "to extract settlement payments" based on these "manufactured claims." ROA.6816. Had Appellants known of this arrangement sooner, they would have recognized the scheme for what it was and refused to pay the inflated settlement amounts. ROA.132-33. Instead, Appellants fell victim to this improper valuation, to the tune of $4.1 million. ROA.132.

Recent state legislation addressing these issues reflects a growing concern with referral-and-billing schemes and their hallmark practices. In 2025, Georgia revised the rules governing proof of medical expenses by allowing parties to present evidence of amounts charged, amounts paid, and related payment agreements. O.C.G.A. § 51-12-1.1 (2025). In 2026, New York enacted broader litigation-funding regulations requiring contract disclosures and prohibiting funders from paying or receiving referral fees involving attorneys and medical providers and referring consumers to specific attorneys or providers. N.Y. Fin. Serv. Law §§ 1001–11 (2026). California, likewise, targeted relationships between attorneys and litigation funders directly this year, prohibiting certain referrals, referral fees, fee-sharing, and funders' control over decisions in any underlying litigation or settlement. Cal. Bus. & Prof. Code §§ 6155.156 (2026).

* * *

The harms described above illustrate why the district court's order does not reflect how these schemes actually operate. The district court's suggestion that Appellants "freely chose to settle the underlying claims" and thus could not "rethink or recalculate" those settlements misses the forest for the trees. *See* Appellants' Br. 9 (discussing ROA.6791). As numerous courts have recognized, fraud of this kind may only become apparent in the aggregate and after the fact. *See State Farm Mut. Auto. Ins. Co. v. Parisien*, 352 F. Supp. 3d 215, 229 (E.D.N.Y. 2018); *State Farm Mut. Auto. Ins. Co. v. Physiomatrix, Inc.*, 2013 WL 10936871, at *7 (E.D. Mich. Nov. 26, 2013).

A pleading standard like the district court's that requires a claimant-by-claimant medical rebuttal at the motion-to-dismiss stage—and forces insurers to choose between settling claims and seeking justice—would immunize referral-and-billing schemes from detection because those schemes depend on volume and repetition to succeed. This is the same dynamic that makes referral-and-billing fraud so difficult for insurers, regulators, and courts to detect and remedy in the first place.

CONCLUSION

This Court should reverse the district court's judgment.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on July 29, 2026, this brief was served via CM/ECF on all registered counsel and transmitted to the Clerk of the Court. Counsel further certifies that: (1) any required privacy redactions have been made in compliance with Fifth Circuit Rule 25.2.13; and (2) the document has been scanned with the most recent version of a commercial virus scanning program and is free of viruses.

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CERTIFICATES OF COMPLIANCE

This brief complies with: (1) the type-volume limitation of Federal Rules of Appellate Procedure 29(a)(5) and 32(a)(7)(B)(i) because it contains 5,902 words, excluding the parts of the brief exempted by Rule 32(f); and (2) the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface (14-point Palatino Linotype) using Microsoft Word (the same program used to calculate the word count).

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