UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

GS LABS, LLC, *a Nebraska limited liability company*, Plaintiff, v. MEDICA INSURANCE COMPANY, *a Minnesota insurance corporation*, Defendant.	Case No.: 21-cv-2400 (SRN/TNL) **PLAINTIFF'S MEMORANDUM IN OPPOSITION TO MEDICA INSURANCE COMPANY'S MOTION TO DISMISS**

This is an action seeking congressionally-mandated full reimbursement for the publicly-posted cash price of lifesaving COVID-19 diagnostic testing that Plaintiff GS Labs, LLC ("GS Labs") provided to over 16,000 insureds of Defendant Medica Insurance Company ("Medica"). Congress declared under § 3202(a) of the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") that insurers like Medica "shall reimburse the provider of the diagnostic testing." GS Labs provided diagnostic testing to urgently respond to the federally-established policy and law enacted by Congress to address the crippling worldwide COVID-19 pandemic, which has now claimed over 750,000 American lives. But Medica has refused to fully reimburse GS Labs for the life-saving services it has provided to Medica insureds, as plainly required by federal law—even in the midst of the largest infection surge to date. Medica is not above the law.

Medica admits that it has not fully reimbursed GS Labs. Yet, Medica moves to dismiss GS Labs' Complaint. Medica contends there is no way in which Medica can be

held accountable to its obligation under the federal mandate to reimburse GS Labs pursuant to the CARES Act. Medica further contends that there is no way to hold Medica liable under state law either. But Medica is not above the law.

Omicron and the recent surge highlight the importance of diagnostic testing, as well as reaffirm Congress's essential goal to increase access to testing by enacting a streamlined mechanism for payment to incumbent and startup testing providers. Even now, testing demand outpaces supply, due to recalcitrant insurers like Medica who refuse to do their part to bear the cost of rapidly increasing and vitally needed testing capacity—namely, to buildout testing facilities, develop testing protocols and procedures, source testing technologies and supplies, and staff professional teams in this high-demand environment. Medica's refusal to do its part has substantially crippled and undermined the purposes that Congress enacted § 3202(a) of the CARES Act to achieve. Congress provided that diagnostic testing providers are entitled to reimbursement from insurers, and this necessarily implies that providers may enforce that right. Medica is not above the law.

Medica insists on flouting the law passed by Congress and signed by the President. The Court cannot condone such conduct, particularly given the serious public health emergency the country continues to face. GS Labs is entitled to collect reimbursement from Medica. The Court should deny Medica's motion because Medica is not above the law.

BACKGROUND

In considering Medica's motion to dismiss, the Court must accept the facts alleged in GS Labs' Complaint as true. The Court must also disregard and reject Medica's allegations and accusations throughout its briefing, such as those regarding GS Labs' prices

and motivations and statements in pleadings in other cases and newspaper articles, which are not only untrue but are also entirely outside of the pleadings in this case and therefore improper and irrelevant.

I. GS Labs Has Made Substantial Investments to Rapidly Meet the Nation's Emerging Need for COVID-19 Diagnostic Testing.

GS Labs was formed in January 2020 as a clinical lab. (¶12.)[1] In response to the COVID-19 public health emergency in early 2020, GS Labs invested in and opened over 50 testing sites across the country (now over 60). (¶13.) A new entrant to the nascent diagnostic testing market, GS Labs had to make substantial investments to expeditiously develop infrastructure and assemble a team for delivering its testing services from the ground up in response to the fast-spreading pandemic. (¶14.)

Given the unusually high infection rate of COVID-19 and the need for rapid testing to prevent community spread, GS Labs' founders focused on maximizing appointment availability; providing safe and accessible drive-through testing administration; and, where possible, delivering same-day test-results. (¶15.) Additionally, to maximize testing capacity, GS Labs intended that the hours of operation for its sites would be seven days per week, twelve hours per day. (¶16.) GS Labs also assembled its own in-house support teams, including staffing and billing personnel, and committed to employing highly-credentialed test administrators such as registered nurses ("RNs") to be present on-site. (¶18.)

[1] All citations to paragraphs are to the Complaint (Dkt.No.1), unless otherwise stated.

As a result of its extensive planning and substantial investments, GS Labs quickly established the capacity to administer tests to up to 1,000 patients per day at each of its testing sites—with nine such locations in Minnesota. (¶19.) Patients can now book appointments to occur as soon as within 15 minutes, and receive test results as soon as within 20 minutes. (¶20.)

GS Labs' planning and investments have enabled it to test more patients, and provide quicker results, as compared to incumbent testing providers such as retail pharmacies. (¶21.) GS Labs' testing capacity is several times greater than other COVID-19 diagnostic testing providers; and, therefore, GS Labs is a key player in the continued public health response to COVID-19 and in saving lives across the country. (¶22.)

II. GS Labs Has Administered COVID-19 Tests for Over 90,000 Minnesotans and over 16,000 Medica Insureds.

GS Labs is a leading provider of testing. (¶23.) In September 2021, GS Labs accounted for more than 22% of the rapid antigen COVID-19 tests conducted in Minnesota. (¶23.) Since March 2020, GS Labs has provided COVID-19 diagnostic tests to more than 90,000 Minnesotans. (¶24.) Of these, over 16,000 patients are Medica insureds. (¶25.)

Over 20% of these Medica insureds have requested and received COVID-19 diagnostic testing from GS Labs on more than one occasion, demonstrating both their reliance on GS Labs and their satisfaction with GS Labs' testing. (¶26.)

By administering this diagnostic testing, GS Labs has provided a vital and valuable community service to Minnesotans and to Medica and its insureds. (¶27.) In addition, GS Labs has supported and assisted the state's testing needs. (¶28.) Indeed, studies have shown

that increased availability of rapid COVID-19 testing, which is facilitated and made readily accessible by providers like GS Labs, dramatically improves patient health outcomes, reduces the spread of the virus, saves lives, and prevents and (consequently) reduces medical spend. (¶29.)

Put simply, GS Labs' testing has benefited Medica in multiple ways, by advancing Medica a prepayment credit and reducing overall costs of care by improving the health outcomes of Medica's insureds, all of which benefit Medica by reducing medical spend.

III. GS Labs Has Provided Three Different Types of COVID-19 Tests, All of Which are Approved for Diagnostic Testing.

GS Labs has provided three different types of COVID-19 tests to Minnesotans. (¶30.) The three tests are well-recognized in the medical community:

1. "Rapid Antigen" tests;
2. "Polymerase Chain Reaction" tests ("PCR test"); and
3. "Rapid Antibody" tests.

(¶¶30-35.) The CDC has determined all three of these tests are medically appropriate for COVID-19 diagnostic testing purposes. (¶31.) Medica has not disputed this fact.

IV. GS Labs Has Performed, and Continues to Perform, Thousands of Medically Necessary COVID-19 Diagnostic Tests for Medica's Insureds, but Medica Has Failed to Fully Reimburse GS Labs for That Testing.

Since March 2020, GS Labs has performed thousands of COVID-19 diagnostic tests for Medica's insureds without requiring any prepayment. (¶36.)

GS Labs has timely submitted requests for reimbursement to Medica and billed for the relevant testing services consistent with the applicable cash price that GS Labs has

publicly posted on its website, as expressly authorized by the CARES Act. (¶37.) GS Labs submitted its first request for reimbursement on October 21, 2020. (¶38.) GS Labs has submitted monthly requests for reimbursement every month since. (¶38.)

Medica has withheld full reimbursement and demanded that GS Labs provide voluminous medical records for each test performed for Medica's insureds. (¶39.) However, as explained below, federal law prohibits "pre-approval" and "medical necessity" reviews, as the CARES Act is designed to promote rapid accessibility to testing and results. (¶39.) Although the information Medica requested was not required, GS Labs nevertheless responded as quickly as it was able to do so. (¶40.) Yet, Medica has still refused to fully reimburse GS Labs for all tests provided to Medica's insureds. (¶40.)

After five months of Medica refusing to provide full reimbursement, GS Labs engaged counsel and has sought to work through Medica's demands to pay less than the publicly-posted cash price for the COVID-19 diagnostic testing performed by GS Labs. (¶41.) Even after several months of discussions spanning March 2021 through the present, Medica continued to refuse to fully reimburse GS Labs unless GS Labs agreed to accept the prices unilaterally dictated by Medica. (¶42.) Consequently, having exhausted its efforts to resolve the dispute with Medica, GS Labs was forced to pursue litigation. (¶43.)

V. Medica's Actions Illegally Countermand Congress's Directive to Insurers to Reimburse COVID-19 Diagnostic Testing Providers.

In response to the COVID-19 national health and financial crisis, Congress enacted the CARES Act, which clearly and unequivocally directs that "a health insurance issuer . . . *shall reimburse the provider of the diagnostic testing* as follows:"

> (1) If the health plan or issuer has a negotiated rate with such provider in effect before the public health emergency declared under section 319 of the Public Health Service Act (42 U.S.C. § 247d), such negotiated rate shall apply throughout the period of such declaration.
>
> (2) *If the health plan or issuer does not have a negotiated rate with such provider, such plan or issuer shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website*, or such plan or issuer may negotiate a rate with such provider for less than such cash price.

CARES Act § 3202(a) (emphasis added).

Through its enactment of the CARES Act, Congress required that health insurers "shall reimburse" COVID-19 diagnostic testing providers directly for testing that the providers have stepped-up to deliver to those insurers' insureds. The CARES Act plainly states if the health insurer had previously negotiated rates with the provider, the insurer shall pay the negotiated rates. But if the insurer has not negotiated rates—which Medica has failed to do here (¶56)—then the insurer shall pay "the cash price for such service as listed by the provider on a public internet website."

In sum, the insurer may choose to negotiate a different price, but otherwise it "shall reimburse" the provider in the amount of the publicly-posted cash price.

The CARES Act does not condition reimbursement on any insurance company's unilateral determinations of "medical necessity" or "medical appropriateness." On the contrary, federal guidance regarding the CARES Act states that plans and issuers cannot "use medical screening criteria to deny (or impose cost sharing on) a claim for COVID-19 diagnostic testing" for asymptomatic patients, and they "***cannot*** require the presence of

symptoms or a recent known or suspected exposure, or otherwise impose medical screening criteria on coverage of tests." FAQs, Part 44 Q1 (Feb. 26, 2021) (emphasis added).[2]

There can be no reasonable dispute as to "medical necessity" for the COVID-19 diagnostic testing at issue in this lawsuit. All of GS Labs' tests are ordered by a licensed medical professional and therefore are, by definition, medically necessary. (¶50.)

VI. Medica Illegally Refuses to Fully Reimburse GS Labs, Even When Insurers Across the Country Have Done so.

GS Labs has repeatedly requested reimbursement from Medica for COVID-19 diagnostic tests provided to Medica's insureds without prepayment. (¶51) Medica has refused to pay the full publicly-posted cash price for GS Labs' tests, preferring instead to attempt to unilaterally dictate and impose a lower price. (¶52.)

GS Labs has endeavored to negotiate with Medica in good faith. (¶53.) GS Labs has devoted considerable time and resources in responding to Medica's requests for information. (¶53.) In contrast, Medica has not negotiated in good faith and instead cynically used its requests for information as a delay tactic. (¶54.) Specifically, Medica's requests for medical documentation as a ground for evaluating GS Labs' request for reimbursement were illusory. Medical appropriateness or necessity is not a ground to deny reimbursement. And, regardless, GS Labs provided voluminous information on medical appropriateness and necessity, but Medica still refuses to fully reimburse. (¶55.)

[2] *Available at* https://www.cms.gov/files/document/faqs-part-44.pdf (emphasis added).

Medica and GS Labs have not agreed upon a different negotiated cash price, and their discussions have broken down and are at an impasse. (¶56.) Therefore, GS Labs was forced to sue Medica to obtain reimbursement and other damages resulting from Medica's brazen refusals to reimburse GS Labs in violation of the federal CARES Act, as well as in contravention to state law. (¶58.)

STANDARD FOR REVIEW

A complaint is only required to contain "a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). A complaint must include "sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citation omitted). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* A complaint states a claim if it "raise[s] a reasonable expectation that discovery will reveal evidence" in support of the claim. *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007).

ARGUMENT

Medica's motion to dismiss fails for lack of legal authority.

Medica attacks GS Labs' leading federal claims against Medica under the CARES Act based on a handful of district court cases that have analyzed entirely unrelated parts of the 335+ page CARES Act. But these cases are inapposite to establish that the particular statutory provision at issue in this case—§ 3202(a)—does not support an implied private cause of action. Instead, the only court that has actually analyzed the availability of a private cause of action under the relevant part of the CARES Act, § 3202(a), has held that

there is an implied private cause of action for violations of this provision (*see infra* Part I)—and so ruled based on the very same reasons that GS Labs has set forth in its memorandum in support of its motion for partial summary judgment. (*See* Dkt.No.10.)

As to the state law claims GS Labs has pled in the alternative, Medica's motion to dismiss all of these claims actually serves to reinforce finding an implied cause of action exists under the CARES Act (per the second *Cort* factor, *see infra* Part I.B) because, if Medica were correct, GS Labs would be left wholly without any remedy whatsoever. And in any event, Medica's attacks on GS Labs' state law claims are based on inapposite cases that do not support the bright-line rules that Medica advocates in its briefing.

Accordingly, the Court should deny Medica's motion to dismiss in all respects.

I. The CARES Act Requires Medica to Fully Reimburse GS Labs at the Publicly-posted Cash Price for COVID-19 Diagnostic Testing.

Section 3202(a) of the CARES Act requires Medica to fully reimburse GS Labs at the cash price listed on GS Labs' public internet site for the COVID-19 diagnostic testing that GS Labs has provided to over 16,000 of Medica's insureds:

> (a) REIMBURSEMENT RATES.—A group health plan or a health insurance issuer . . . **shall reimburse the provider of the diagnostic testing as follows**:
>
> . . .
>
> (2) If the health plan or issuer does not have a negotiated rate with such provider, such plan or issuer **shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website**, or such plan or issuer may negotiate a rate with such provider for less than such cash price.

CARES Act § 3202(a) (emphasis added).

Medica argues that GS Labs cannot bring an implied private cause of action under § 3202(a). To determine whether an implied private remedy exists under a statute, the Court must "interpret the statute Congress . . . passed to determine whether it displays an intent to create . . . a private remedy." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). In evaluating congressional intent, the Court considers four factors identified in *Cort v. Ash*, 422 U.S. 66 (1975), i.e., the "*Cort* factors": (1) whether the plaintiff is a member of the class of persons for whose benefit the statute was enacted; (2) whether the legislature has implicitly or explicitly manifested any intent to create or deny such a remedy; (3) whether it is consistent with the underlying purpose of the legislative scheme to imply such a remedy; and (4) whether the cause of action is traditionally a creature of state law such that inferring a cause of action based solely on federal law would be inappropriate. *Id.* at 78.

Here, each of the four *Cort* factors demonstrates Congress intended that diagnostic testing providers like GS Labs have an implied private cause of action for violations of § 3202(a): (1) Congress enacted this section to benefit diagnostic testing providers by specifying their right to reimbursement from insurers; (2) Congress implicitly manifested an intent to create such a private right because Congress did not establish *any* alternative form of relief through which providers could otherwise enforce Congress's mandate; (3) a private cause of action is consistent with the purpose of the CARES Act, which was to mobilize private industry to rapidly expand testing resources and capacity so as to save American lives; and (4) pandemic response and establishment of fundamental insurance standards are traditionally creatures of federal law.

The only court to have considered this question has held that § 3202(a) supports an implied private cause of action. *Diagnostic Affiliates of Northeast Hou, LLC v. United Healthcare Services, Inc.*, No. 2:21-CV-00131, 2022 WL 214101 (S.D. Tex. Jan. 19, 2022). Proceeding through the *Cort* factors, the *Diagnostic Affiliates* court found each favors finding a private cause of action. *Id.* at *4-9. This Court should hold the same.

A. GS Labs Is a Member of the Class of Persons for Whose Benefit Congress Enacted § 3202(a) and Required Reimbursement.

The first *Cort* factor is whether GS Labs is a member of the class of persons for whose benefit Congress enacted the reimbursement right in § 3202(a). The language of this section plainly demonstrates an intent to benefit providers: "A group health plan or a health insurance issuer . . . *shall* reimburse the provider of the diagnostic testing." CARES Act, § 3202(a) (emphasis added). This text denotes an "unmistakable focus on the benefited class"—here, "provider of the diagnostic testing," the person to be protected—as distinguished from a general ban on conduct or expression of public policy. *Cannon v. University of Chicago*, 441 U.S. 677, 691 (1979); *see also Maine Com'y Health Options v. United States*, 140 S. Ct. 1308, 1320-21 (2020) (finding *insurers* had right to payment from federal Government based on mandatory statutory term "shall").

Section § 3202(a) is in line with those statutes the Supreme Court has identified as containing rights-creating language because the statute focuses on the benefited class, and not just the party to be regulated. The Supreme Court identified two examples of such statutes in *Gonzaga Univ. v. Doe*, 536 U.S. 273, 287 n.3 (2002):

- Title VI provides: "**No person** in the United States *shall* . . . be subjected to discrimination under any program or activity receiving Federal financial assistance"

on the basis of race, color, or national origin. 78 Stat. 252, 42 U.S.C. § 2000d (1994 ed.) (emphasis added).

- Title IX provides: "**No person** in the United States *shall*, on the basis of sex, . . . be subjected to discrimination under any education program or activity receiving Federal financial assistance." 86 Stat. 373, 20 U.S.C. § 1681(a) (emphasis added).

- For comparison, § 3202(a): ""A group health plan or a health insurance issuer *shall* reimburse **the provider of the diagnostic testing**." (emphasis added).

In both Title VI and IX, Congress identifies rights and obligations by mandating that **no person** *shall* be subjected to discrimination by educational programs or activities receiving federal financial assistance. The statutes speak to both the parties who have rights and the parties who have responsibilities, rather than focus solely on the party whose conduct is to be regulated or the regulating agency. Section 3202(a) contains the same ingredients: mandatory language that identifies the specific parties who have rights and responsibilities, without identifying (much less *focusing on*) a regulating federal agency.

It has long been the law, that "in every case, where a statute enacts or prohibits a thing for the benefit of a person, he shall have a remedy upon the same statute for the thing enacted for his advantage, or for the recompense of a wrong done to him contrary to the said law." *Texas & P. Ry. Co. v. Rigsby*, 241 U.S. 33, 39 (1916) (citation omitted). The Supreme Court "has *never* refused to imply a cause of action where the language of the statute explicitly conferred a right directly on a class of persons that included the plaintiff in the case." *Cannon*, 441 U.S. at 693 n.13 (1979) (emphasis added). This Court should not break with this tradition in this case, where § 3202(a) explicitly confers a right on diagnostic testing providers to obtain reimbursement from insurers.

Medica erroneously argues that Congress intended to benefit patients, not providers, as indicated by: (1) the title of the part in which § 3202(a) is found is "PART II—ACCESS TO HEALTH CARE FOR COVID–19 PATIENTS"; and (2) § 3202(a) focuses on insurers, not diagnostic testing providers. (Dkt.No.31 at 9-11; Dkt.No.36 at 18-21.)

1. The Title of Part II of Subtitle A of Title III of Division A of the CARES Act Does Not Demonstrate Congress Meant Only to Benefit Patients.

The title of the *part* in which a statute is found has no bearing on its terms or meaning. However, even if it did, the full list of headings for § 3202(a) demonstrate Congress intended to benefit more than just patients in enacting this statute:

> DIVISION A—KEEPING WORKERS PAID AND EMPLOYED, **HEALTH CARE SYSTEM ENHANCEMENTS**, AND ECONOMIC STABILIZATION
>
> > TITLE III—**SUPPORTING AMERICA'S HEALTH CARE SYSTEM** IN THE FIGHT AGAINST THE CORONAVIRUS
> >
> > > PART II—ACCESS TO HEALTH CARE FOR COVID–19 PATIENTS
> > >
> > > > SUBPART A—COVERAGE OF TESTING AND PREVENTIVE SERVICES

CARES Act § 2 ("Table of Contents") (emphasis added) (portions omitted).

2. Medica Relies on the False Premise that § 3202(a) Only Focuses on the Parties to be Regulated and Contains Mere Broad Proscriptions.

Section 3202(a) creates both rights and obligations by mandating that insurers "shall reimburse . . . the provider of diagnostic testing"; it speaks to both parties—like Titles VI and IX. Section 3202(a) does not focus *solely* on the party whose conduct is to be regulated or an agency who is to regulate; it only mentions insurers to identify the person against

whom the provider of diagnostic testing has the right of reimbursement. Otherwise, § 3202(a) shares its focus by spotlighting both providers and insurers

As the court in *Diagnostic Affiliates* explained, Congress sought to benefit both patients and diagnostic testing providers because both are necessary to achieve the ultimate goal of increased testing in the "FIGHT AGAINST THE CORONAVIRUS":

> It is clear that the legislative objective was to ensure that COVID-19 testing was widely available to the entire population. *This required that providers be willing to supply and administer the tests, which in turn required a reliable method of payment for that service. Payment of providers was sufficiently essential for the legislature to create a mandatory scheme, using the term "shall,"* for determining the amount to be paid and protecting patients from any burden associated with the cost or other administrative requirements.

2022 WL 214101, at *6 (emphasis added). Further: "The FFCRA and CARES Act do intend to benefit patients. But to effectuate that, it also intends to benefit testing providers. ***These are not mutually exclusive concepts***." *Id.* at *7 (emphasis added).

Medica argues that § 3202(a) contains similar language as several other statutes for which courts have declined to find an implied cause of action. (Dkt.No.31 at 8-9.) However, not one of these cases contained the same mandatory language that identifies both parties with rights and obligations.

For example, in *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002), the Supreme Court declined to find a federal right to education records under the Family Educational Rights and Privacy Act ("FERPA") because there was no rights-creating language. *Id.* FERPA's text only focuses on a regulator; it directs the Secretary of Education that no funds be made available to an institution that has a prohibited policy or practice. *Id.* at 287.

In contrast, § 3202(a) does not identify any regulator, and it specifically identifies providers of diagnostic testing as beneficiaries.

Medica cites *Osher v. City of St. Louis, Missouri*, 903 F.3d 698, 702 (8th Cir. 2018), which quotes *Does v. Gillespie*, 867 F.3d 1034, 1039-1040 (8th Cir. 2017). The *Osher* case involved a suit to enjoin condemnation proceedings and obtain relocation benefits under the Uniform Relocation Assistance and Real Property Acquisition Policy Act. That statute, like FERPA, focused on the displacing agency's conduct and did not contain any rights-creating language. *Id.* at 703. Similarly, *Gillespie* involved the Medicaid Act and a claimed right to choose any qualified provider of services even after termination of a provider. The relevant statute directed the Secretary of Health and Human Services to approve certain plan decisions regarding providers. The statute did not contain any focus on the individuals protected or funding being regulated, but instead focused on the regulating agency. *Id.* at 1041. Again, § 3202(a) contains no such focus on the regulating agency.

Medica further cites *Universities Research Ass'n v. Coutu*, 450 U.S. 754, 772 (1981). (Dkt.No.36 at 19.) This case involved the Davis-Bacon Act, which requires certain stipulations in construction contracts for the benefit of mechanics and laborers, but is "phrased as a directive to federal agencies engaged in the disbursement of public funds." 450 U.S. at 772. Section 3202(a), by contrast, does not direct any federal agencies to disburse funds on behalf of insurers; instead, it mandates insurers reimburse providers.

Medica also cites *American Premier Underwriters, Inc. v. Nat'l R.R. Passenger Corp.*, 709 F.3d 584, 590 (6th Cir. 2013). (Dkt.No.31 at 9-10; Dkt.No.36 at 18-1.) This case involved the Amtrak Reform and Accountability Act ("ARAA"), which provides:

"Amtrak shall, before October 1, 2002, redeem all common stock previously issued, for the fair market value of such stock." The Sixth Circuit held that Amtrak shareholders are not a class for whose benefit this section was enacted because its purpose was instead to create greater financing options for Amtrak. 709 F.3d at 590. By comparison, § 3202(a) identifies the intended beneficiary of the reimbursement: providers of diagnostic testing. And, as *Diagnostic Affiliates* recognized, the CARES Act's purpose was to streamline access to diagnostic testing by streamlining payment for it. 2022 WL 214101, at *6, 9.

In attempting to diminish the relevance of the Supreme Court's decision in *Cannon v. University of Chicago*, 441 U.S. 677, 681 (1979), which held there is an implied private cause of action to enforce Title IX, Medica omits the entire text of Title IX, as well as the key reasoning in that case: "The language in these statutes—which expressly identifies the class Congress intended to benefit—contrasts sharply with statutory language customarily found in criminal statutes, such as that construed in *Cort, supra*, and other laws enacted for the protection of the general public." *Id.* (emphasis added). Again, § 3202(a) explicitly identifies the class to be benefited—providers of diagnostic testing—and contains no general language that would customarily be found in criminal statutes, just like Title IX.

In arguing *Transamerica Mortgage Advisors v. Lewis*, 444 U.S. 11, 18-19 (1979) does not support GS Labs' claims, Medica conflates the two different sections of the Investment Advisers Act of 1940 at issue in that case—§ 215 versus § 206. (Dkt.No.36 at 19-20.) Section 206 broadly proscribes fraudulent practices by investment advisers, making it unlawful for any investment adviser "to employ any device, scheme, or artifice to defraud . . . [or] to engage in any transaction, practice, or course of business which

operates as a fraud or deceit upon any client or prospective client," or to engage in specified transactions with clients without making required disclosures. This is the kind of broad "statutory language customarily found in criminal statutes" discussed in *Cannon*, 441 U.S. at 681. The Court held that this broad proscription did not create or alter any civil liabilities, but instead merely general proscriptions. *Transamerica*, 444 U.S. at 18-19. On the other hand, Section 215 provides that contracts whose formation or performance would violate the Act "*shall* be void . . . as regards the rights of" the violator and knowing successors in interest. *Id.* (emphasis added). This section, which spoke to voiding contracts, thus necessarily contemplated the right to rescission and "to obtain restitution of consideration paid," so there was a private cause of action. *Id.* Similarly, even if § 3202(a) only mentioned the defendant party like § 215, the customary legal incident of a reimbursement right is the ability to recover indemnity through the courts. In *Transamerica*, the Supreme Court held that § 215 provides for an implied cause of action for restitution. This Court should hold that § 3202(a) likewise provides an implied cause of action for reimbursement.

Finally, Medica argues that *Maine Community Health Options v. United States*, 140 S. Ct. 1308, 1320-21 (2020) "has no clear bearing here." (Dkt.No.36 at 19-20.) However, *Maine* explains that Congress may create obligations directly by statute "without also providing details about how it must be satisfied." *Id.* Health insurers in that case sued the federal government under the Tucker Act, claiming an obligation created by the Affordable Care Act. The Supreme Court held the mandatory "shall pay" entitled the insurers to payment. 140 S. Ct. at 1320-21. The court in *Diagnostic Affiliates* cited *Maine* to correctly

reason that the mandatory language in § 3202(a) likewise "supports finding an implied private right of action for the claims." 2022 WL 214101, at *6.

It would deviate from all Supreme Court precedent and the only other case to have squarely addressed the issue, *Diagnostic Affiliates*, to hold that § 3202(a) does not contain rights-creating language intended to benefit providers of diagnostic testing.

B. Congress Manifested Its Intention to Create a Private Right of Action By Creating a Reimbursement Right with No Alternative Enforcement Mechanisms.

The second *Cort* factor is whether Congress manifested an intent to create an implied private right of action. This factor favors finding such an intention here because Congress did not enact any mechanism to enforce its mandate in § 3202(a). Indeed, Medica concedes that "**This is technically correct**; the enforcement mechanism of Section 3202(a) is not in the CARES Act, but rather in the FFCRA." (Dkt.No.36 at 21 (emphasis added).)

The CARES Act is a 355+ page bill that was intended to expeditiously address numerous issues, across multiple subjects, to protect the public health and safety during the COVID-19 pandemic. Indeed, the CARES Act is the *largest economic stimulus package in United States History*, almost tripling in size the act passed in response to the Great Recession. In light of both the length and the breadth of the CARES Act, it must be recognized that where Congress created rights, but did not create enforcement mechanisms—such as in those provisions requiring diagnostic testing reimbursement—Congress necessarily intended to create implied private causes of action.

The *Diagnostic Affiliates* court reached the very same conclusions:

> These administrative enforcement provisions have different purposes and fall short of providing any avenue for a COVID-19 testing provider to recover the reimbursements required by the statutes. And Defendants have not suggested what recourse, other than this action, Diagnostics Affiliates might have for its claims.
>
> . . . FFCRA § 6001 is relevant here because it requires insurers to cover COVID-19 testing through their health insurance plans. This provision indicates who is responsible for payment, not how payment is to be made. Its enforcement scheme is appropriately designed for the purpose of ensuring coverage for insureds. Nothing in the amended complaint indicates Defendants have denied or reduced claims because the service is not covered or that it was provided to a person who was not an insured.
>
> The direct requirement for reimbursement to COVID-19 testing providers is, instead, in the CARES Act § 3202(a). The only enforcement provision related to that requirement is for a civil fine against providers who do not publish their cash price—the premise on which their payment is to be calculated. CARES Act § 3202(b). There is no dispute that Diagnostic Affiliates properly published its cash price. Thus, the CARES Act has no express enforcement provision—administrative or otherwise—that is relevant here for claims against insurance companies responsible for reimbursements.

2022 WL 214101, at *7-8. "An implied private right of action is a more appropriate construction of the statute than the creation of a right without any remedy." *Id.* at *8.

The Supreme Court has long held that when Congress enacts statutory provisions "stated in the form of commands," but for which "there is no mode of enforcement other than resort to the courts," courts have the "jurisdiction and duty to afford a remedy for a breach of statutory duty." *Steele v. Louisville & N.R. Co.*, 323 U.S. 192, 207 (1944). Otherwise, the "right would be sacrificed or obliterated if it were without the remedy which courts can give for breach of such a duty or obligation." *Id.*

Medica argues that the Supreme Court has "abandoned" this understanding. (Dkt.No.36 at 22-23.) But there has been no such repudiation of *Steele*. Indeed, the Supreme Court has never rejected this precedent, and has instead reaffirmed it several times. *Janus v. Am. Fed'n of State, Cty., & Mun. Emps., Council 31*, 138 S. Ct. 2448, 2468 (2018); *Int'l Bhd. of Elec. Workers v. Foust*, 442 U.S. 42, 47 (1979); *Cannon*, 441 U.S. at 693 n.13; *Graham v. Bhd. of Locomotive Firemen & Enginemen*, 338 U.S. 232, 239 (1949). Medica's argument ignores that *Steele* applies when the statute at issue contains a command (e.g., "shall reimburse"), but provides no enforcement mechanism.

Medica erroneously argues the potential for some agencies to enforce § 3202(a) cuts against a finding of congressional intent to allow private parties to enforce § 3202(a). (Dkt.No.31 at 4; Dkt.No.36 at 4-5.) As a threshold matter, agency intentions are inferior to Congressional intentions. Further, the theoretical expressions of agency intent to enforce § 3202(a) are nowhere to be found in Medica's cited authorities. The only mention of enforcement in these guidance materials instead relate to (1) the requirement that insurers provide *coverage* for diagnostic testing, as set forth in § 6001(a) of the FFCRA, and (2) the requirement that diagnostic testing providers publish their cash prices on publicly accessible websites. This is consistent with the terms of these statues which, as Medica "technically" agrees, do not delegate enforcement of § 3202(a) to any agency.[3]

[3] Medica's reference to the *California* Insurance Commissioner certainly has no relevance to GS Labs' claims in this case based on testing *in Minnesota*. (Dkt.No.36 at 5 & n.4.)

All of the cases cited by Medica regarding the CARES Act involved situations in which, unlike in *Steele* or here, there is no alternative remedy available. For example, in *Gonzaga*, FERPA did not contained enforcement provisions and empowers the Secretary of Education to investigate and adjudicate violations. 536 U.S. at 289-90. In *Osher* and *Gillespie*, Congress had created an administrative enforcement mechanism to obtain compliance with the relevant statutory command. 903 F.3d at 702; 867 F.3d at 1039-40. And in *Universities Research*, the Supreme Court identified alternative remedies available to the plaintiff. 450 U.S. at 772.

Therefore, the second *Cort* strongly weighs in favor of finding an implied private cause of action because Congress provided a clear directive that insurers reimburse diagnostic testing provider at the publicly-posted cash price, but did not provide any enforcement mechanisms for the reimbursement right it created in § 3202(a).

C. A Reimbursement Right Is Consistent with the Purpose of the CARES Act, Which Sought to Rapidly Increase Access to COVID-19 Testing.

The third *Cort* factor is whether an implied private cause of action is consistent with the purpose of the statute at issue. Here, a holding that providers of diagnostic testing have a right to obtain denied reimbursement from insurers is not only consistent with the plain and unambiguous intention of Congress as expressed in § 3202(a) of the CARES Act, but it is also the only interpretation that is consistent with the underlying purpose of Act to rapidly increase access to COVID-19 testing.

This overriding Congressional purpose was summarized well by Senator Lamar Alexander (R-TN), who stated in debate:

> In the end, the only way to end this crisis—and the only way to get the American economy moving again—is to contain the disease. This will require, as soon as possible, adopting a new goal. *That goal should be to test every American who needs it for COVID-19 as soon as possible . . . . the sooner we make more tests available and stop telling Americans not to get a test, the better*.

166 Cong. Rec. S1893, S1895 (emphasis added).[4]

It would completely defy Congress's objective to increase testing capacity and accessibility if there were no mechanism whatsoever to enforce the requirement that insurers reimburse providers for testing services at this critical time. The strong legislative resolve to increase the development of, and accessibility to, testing facilities requires there be a remedy for reimbursement to ensure the start-up *and continued* implementation of that legislative purpose when insurers unlawfully withhold reimbursement.

As the Supreme Court stated in *Cort*: "in situations in which it is clear that federal law has granted a class of persons certain rights, *it is not necessary to show an intention to create a private cause of action*, although an explicit purpose to *deny such cause of action* would be controlling." *Cort*, 422 U.S. at 82 (emphasis added). Thus, even if legislators did not express an intention to create a private cause of action, that does not prevent or deter finding that an implied private cause of action for reimbursement is consistent with the purposes of the CARES Act.

In *Cort*, the Court also explained that the maxim of *expressio unius est exclusio alterius* does not apply when there was "no discussion whatever in Congress concerning

[4] *Available at*: https://www.congress.gov/116/crec/2020/03/22/CREC-2020-03-22-senate.pdf.

private enforcement." *Id.* at 82 n.14. Here, there was no discussion in Congress concerning private enforcement; Congress was concerned more with the pressing matters of an escalating pandemic. Thus, the rule that "[t]he express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others," *Alexander*, 532 U.S. at 290, has no application to this case.

Medica argues that "not only does this legislative history omit any mention of a private right of action for diagnostic labs to enforce the 'cash price' provisions, it indicates that '*the Federal Government* needs to take a much more active role in establishing that infrastructure.'" (Dkt.No.36 at 24-25.) Medica offers no evidence, however, that Congress intended *not* to provide an implied private cause of action in § 3202(a), or that legislators expressed a concern that private enforcement would be inconsistent with the CARES Act. Here, the lack of any discussion on private causes of action demonstrates that Congress did not intend to foreclose this form of relief.

Medica next argues that "Congress surely did not mean to permit diagnostic labs to recover millions of dollars per test through private enforcement of the statute." (Dkt.No.31 at 11-12; Dkt.No.36 at 25.) But just because Medica would have liked Congress to have set prices differently, or to have given insures unilateral authority to impose prices, does not make it so; nor does it show that an implied private cause of action for reimbursement is inconsistent with the purposes of the CARES Act.

Ultimately, Medica does not seriously dispute that the third *Cort* factor favors finding an implied private cause of action here. For example, Medica does not dispute that an implied private cause of action in favor of diagnostic testing providers is "not only

consistent with the plain and unambiguous intention of Congress as expressed in § 3202(a) of the CARES Act, but . . . also the only interpretation that **is consistent with** the underlying purpose of Act." (Dkt.No.10 at 13.) Medica also does not dispute: "The executive branch has also provided direction to insurers like Medica as to how they should proceed if they are disinclined to reimburse providers. Notably, the executive branch has *not* advised insurers that they can refuse reimbursement." (Dkt.No.10 at 17.)

The Court in *Diagnostic Affiliates* came to the same conclusions, reasoning the third *Cort* factor favors finding an implied private cause of action for violations of § 3202(a):

> As discussed, Congress wanted widespread COVID-19 testing, *which could only be accomplished by private entities quickly incurring the cost of establishing testing sites across the country and procuring the necessary supplies to administer tests.* Legislative impatience with the finer points of the relationship between providers and insurance companies to properly allocate those costs or to determine appropriate pricing is evidenced by the inclusion of a mandatory methodology for determining the rate to be paid, if the parties did not have the time or cooperation to negotiate rates. A private right of action to recover the mandated reimbursement is fully consistent with the legislative scheme.

2022 WL 214101, at *9 (emphasis added).

The Court should likewise find the third *Cort* factor favors finding an implied private cause of action for violations of § 3202(a).

D. Pandemic Response Is Inherently Interstate (and even International), and Is Not a Matter That Has Ever Been Left Solely to the States.

The final *Cort* factor is whether the cause of action sought is traditionally a creature of state law, such that inferring a cause of action based solely on federal law would be inappropriate. The CARES Act is the latest example of Congress responding to a pandemic, and pandemic response has never been a matter traditionally left to state law. (*See*

Dkt.No.10 at 19-20 (overviewing polio vaccine legislation to H1N1.) The CARES Act is Congress's most recent response to an emerging pandemic crisis.

Medica appears to concede that the issue before the Court is *not* traditionally relegated to state law: "**Be that as it may,** the regulation of insurance *is* a traditional state function." (Dkt.No.36 at 25 (emphasis added).) Medica does not dispute: "In every major pandemic over the last 100 years, Congress has enacted legislation at the federal level to respond to the national disaster of the time." (Dkt.No.10 at 19.) Further, Medica does not dispute: "Pandemics historically and practically transcend state-only concerns. Pandemics are similar in kind to securities registered on national and international exchanges, as well as civil rights that apply to all citizens regardless of state"—areas in which the Supreme Court has recognized implied private causes of action. (Dkt.No.10 at 20.)

Medica instead argues that the federal agencies entrusted with enforcing the CARES Act have attempted to preserve the traditional role of state law of insurance, explaining that "to the extent that a state law does not prevent the application of the requirements of section 3202(a) of the CARES Act, the state law is not preempted and continues to apply." (Dkt.No.36 at 25-26 & n.14 (citation omitted).) However, *the CARES Act* makes no such reservation; and this statement merely reflects a basic principle of preemption law.

Medica's assertion that regulation of insurance is traditionally a state function is also an overstatement. (Dkt.No.36 at 25 (emphasis added).) The federal government has traditionally regulated insurance by imposing minimum standards on fundamental matters affecting interstate commerce and the general welfare. Examples include the National Flood Insurance Program (1968), Employee Retirement Income Security Act (1974),

Terrorism Risk Insurance Act (2002), and Dodd–Frank Wall Street Reform and Consumer Protection Act (2010). Congress has also specifically regulated health insurance on issues of coverage, pricing, and insurer obligations, such as through the Social Security Act (1935 and subsequent amendments), Medicare and Medicaid Act (1965), Gramm-Leach-Bliley Financial Modernization Act (1999), and Affordable Care Act (2010). Insurance regulation is only left to the states on issues Congress has chosen not to regulate.

As the court in *Diagnostic Affiliates* reasoned, "the regulation of group health care plans, including ERISA, already contemplates federal litigation for enforcement. And the federal response to the COVID-19 pandemic is consistent with, not contrary to, state interests. Therefore, no state concerns counsel against recognizing an implied private right of action as a remedy to redress a federally-created right." 2022 WL 214101, at *9. The Court should come to the same conclusion as to the fourth *Cort* factor.

E. None of the "CARES Act" Cases Medica Relies Upon Actually Analyzed § 3202(a); and These Cases Actually Establish Why a Private Cause of Action Is Implied in § 3202(a).

Medica argues that "binding precedent forecloses GS Labs' request that this Court supply the private right of action that Congress omitted from the CARES Act." (Dkt.No.36 at 2.) But notably absent from Medica's submissions are cases that supply any such "binding precedent." Instead, Medica cites a scattering of district court cases that do not address the issue before the Court and instead analyze different sections of the 335+ page CARES Act. (*See* Dkt.No.31 at 8; Dkt.No.36 at 17-18 & n.10.) Not one of the cases cited by Medica addresses the section at issue—§ 3202(a). And each such case only serves to further support a finding of an implied private cause of action for § 3202(a) by comparison.

First, Medica cites *Lamar v. Hutchinson*, No. 4:21-CV-00529, 2021 WL 4047158, at *5 (E.D. Ark. Sept. 3, 2021). This case involved a portion of the CARES Act codified at 26 U.S.C. § 6428, which provides that eligible individuals are entitled to certain tax credits. In declining to find an implied private cause of action in this context, the *Lamar* court emphasized that the IRS already has claims procedures for tax credit refunds. Thus, unlike § 3202(a), the plaintiff in *Lamar* had alternative remedies—a key factor in the *Cort* analysis. *See, e.g.*, *Steele*, 323 U.S. at 207 (1944); *First Pac. Bancorp, Inc. v. Helfer*, 224 F.3d 1117, 1126 (9th Cir. 2000).

Medica also cites *Profiles, Inc. v. Bank of Am. Corp.*, 453 F. Supp. 3d 742, 748 (D. Md. 2020). This case involved Payroll Protection Program ("PPP") loans. The CARES Act temporarily added the PPP to the Small Business Administration's 7(a) Loan Program. CARES Act, Pub. L. No. 116-36, 134 Stat. 281, § 1102 (2020); 15 U.S.C. § 636(a)(36). The district court held that nothing in the CARES Act suggested an intent to confer a right to sue PPP lenders because there is a criminal and civil enforcement regime codified in the Small Business Act ("SBA"), which can be used to enforce the relevant provisions of the PPP loan program. Again, there is no such criminal or civil enforcement regime for diagnostic testing. In addition, the court held that the CARES Act *permitted* the lenders' conduct at issue (and the legislative history showed that a prohibition in a prior draft bill had been removed), so an implied cause of action designed to *prohibit* that conduct would have been inconsistent with the CARES Act's purpose and the legislative history. *Id.* There is no such legislative history here as to § 3202(a); instead, as stated, it is abundantly clear

that Congress intended to streamline access to diagnostic testing by streamlining payment pursuant to § 3202(a). (*See* Dkt.No.10.)

Medica also cites *American Video Duplicating, Inc. v. City Nat'l Bank*, No. 2:20-CV-04036, 2020 WL 6882735, at *5 (C.D. Cal. Nov. 20, 2020). Like *Profiles*, this case involved PPP loans. The court held there was no indication that the CARES Act created a private cause of action for loan agents to sue for agency fees, which are *not mandated* in the CARES Act. Here, by comparison, Congress used the word "shall" in mandating that insurers "shall reimburse." CARES Act, § 3202(a). In addition, the court noted that the SBA, which the CARES Act amended, does not support an implied cause of action. As explained below, the only court that has ruled on the availability of an implied cause of action in § 3202(a) has held that one exists.

Medica further cites *Shehan v. U.S. Dep't of Justice*, No. 1:20-CV-00500, 2020 WL 7711635, at *11 (S.D. Ohio Dec. 29, 2020). This case also involved PPP loans and denial of PPP loan applications. The court reasoned that there was no indication of an intent to confer a private right of action in favor of potential borrowers against lenders for denying an application. In doing so, the court cited the analysis in *Profiles*, which identified the civil and criminal regime in the SBA. Again, there is no such regime for enforcing diagnostic testing reimbursement as to § 3202(a).

Medica further cites *Adeleye v. Ducey*, No. CV-21-00679, 2021 U.S. Dist. LEXIS 122057, at *1-2 (D. Ariz. June 29, 2021). This case involved Pandemic Unemployment Assistance ("PUA"). The court did not analyze the *Cort* factors and instead cited two cases stating there is no PUA private cause of action under the CARES Act. First, the court cited

Paskiewicz v. Brower, No. 2:20-cv-02238 TLN AC PS, 2020 WL 7074605, at *2 (Dec. 3, 2020), which is also a PUA case, cites *American Video*, did not analyze the *Cort* factors, and noted that there is an administrative process for PUA claims. Second, the court cited *American Video* (the case on which *Paskiewicz* relies), which is discussed above. These cases offer no further assistance to the Court in analyzing § 3202(a).

Medica also cites *Autumn Ct. Operating Co. LLC v. Healthcare Ventures of Ohio*, No. 2:20-CV-4901, 2021 WL 325887, at *6 (S.D. Ohio Feb. 1, 2021). This case involved CARES Act funding for Medicare- and Medicaid-certified nursing homes. The court held there was no indication that the CARES Act provided a private cause of action to collect such funding if the funding was sent to the wrong recipients, and it reasoned that the plaintiffs had state law contract claims to collect the funds under contracts with the alleged wrongful recipients. Medica has argued, however, that GS Labs has no state law claims.

Medica also cites *Matava v. CTPPS, LLC*, No. 3:20-CV-01709 (KAD), 2020 WL 6784263, at *1 (D. Conn. Nov. 18, 2020). This case involved a tenant seeking to enjoin judicial proceedings instituted by a landlord. The plaintiff broadly asserted that the CARES Act prohibited the proceedings. The court held that the CARES Act did not provide a private cause of action to enforce any landlord-tenant provisions, and the plaintiff had not explained why the court should find an implied cause of action. Here, by contrast, there are a multitude of reasons for finding an implied cause of action for violations of § 3202(a), and GS Labs has explained each of those reasons. (*See* Dkt.No.10.)

All of these cases are distinguishable and reinforce the difference between § 3202(a) and these other provisions of the CARES Act, about which the courts in those cases

variously (1) held the language of the statute lacked rights-creating language, (2) identified alternative avenues of relief (whether in the form of civil, criminal, or administrative remedies), or (3) noted the plaintiff had failed to analyze the issue sufficiently.

The *Diagnostic Affiliates* court likewise analyzed the cases cited by Medica, holding that they were inapplicable and concluding:

> Defendants' cases fail to address whether the FFCRA or CARES Act contains an implied right of action in favor of a COVID-19 testing provider seeking statutorily-mandated reimbursements. Neither do the cases contain any analogous fact patterns that would make their conclusions persuasive. Thus, the Court considers the matter on a clean slate, using the Supreme Court's rubric.

2022 WL 214101, at *6.

The Supreme Court has held, and Medica has not disputed, that "unless and until Congress acts, the federal courts must fill in the interstices of the implied cause of action." *Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Curran*, 456 U.S. 353, 394–95 (1982). For all of these reasons, as well as those stated previously in its opening brief and that GS Labs will provide in its reply in support of its motion for summary judgment, the Court should find an implied private cause of action to enforce § 3202(a).[5]

II. GS Labs Has Alleged Plausible Claims for Unjust Enrichment Under Minnesota Law to Recoup Prepayment Credit and Outcome-related Benefits.

GS Labs has alleged that Medica is unjustly enriched by GS Labs providing Medica's insureds testing without prepayment. (¶¶29, 99.) GS Labs' testing has benefited

[5] Medica argues that the Declaratory Judgment Act does not support an independent cause of action; and because GS Labs has no claim under the CARES Act, the declaratory judgment claim in Count II likewise fails. (Dkt.No.31 at 12; Dkt.No.36 at 26-27.) But there is an implied private cause of action under the CARES Act, so Medica's argument fails.

Medica in multiple ways, by advancing Medica with a credit for prepayment-services and by reducing overall costs of care by improving the health outcomes of Medica's insureds, all of which substantially benefit Medica by reducing its medical spend. (*Id.*) Medica knew that GS Labs was giving it substantial benefits through the testing services GS Labs provided to Medica insureds, Medica accepted those substantial benefits, and Medica in equity and good conscience should fully reimburse GS Labs. (¶¶97-101.)

Medica argues for dismissal, however, because (1) unjust enrichment would constitute an end-run around the lack of an express cause of action under the CARES Act, (2) Medica did not obtain any benefits, (3) GS Labs did not unknowingly or unwillingly provide benefits to Medica, (4) Medica has express contracts with its insureds (although not with GS Labs), and (5) GS Labs has "express contracts" with Medica's insureds. Each of these arguments lacks authority under Minnesota law—the law that applies to this claim—and ignore the specific allegations in the Complaint that must be taken as true.

A. Congressional Intent as to an Implied Cause of Action Does Not Alter Minnesota's Law Regarding Unjust Enrichment.

Medica incongruously argues that allowing GS Labs to assert claims for unjust enrichment would exact "an end-run around Congress' decision not to include a private right of action under the CARES Act." (Dkt.No.31 at 13.)

Whether *Congress* intended an implied cause of action is simply irrelevant to whether *Minnesota* law recognizes an unjust enrichment claim in GS Labs' favor. Medica has not identified any part of the CARES Act that would preempt such claims, nor has Medica provided any analysis of federal preemption doctrines.

Moreover, Medica cannot have it both ways—arguing that state law is not preempted and continues to apply, (Dkt.No.36 at 25-26), but then arguing that state law remedies are "end-runs" around the lack of a private cause of action under federal law. There is no authority for the proposition that Minnesota's common law is automatically preempted or invalidated when Congress does *not* provide for express causes of action.

Regardless of the CARES Act implied causes of action, the facts establish a common law claim for unjust enrichment because Medica in equity and good conscience should reimburse GS Labs for the substantial benefits Medica has received and retained.

B. GS Labs Has Provided Medica with Substantial Benefits Through Prepayment Credit and Health Outcome-Related Benefits.

Medica erroneously argues that it has received no "benefit" from GS Labs, but instead that all testing-related benefits were received solely and exclusively by Medica's insureds. (Dkt.No.31 at 14.)

In fact, GS Labs' testing has substantially benefited Medica in multiple ways. (¶¶29, 99.) GS Labs' provision of a prepayment credit to Medica is a benefit to Medica and one that Medica should, in equity, not be allowed to retain. This prepayment credit exceeds $10 million. In addition, increased availability of rapid COVID-19 testing, which is facilitated and made readily accessible by providers like GS Labs, dramatically improves patient health outcomes, reduces the spread of the virus, saves lives, and prevents and (consequently) reduces Medica's overall medical spend. (¶29.)

Medica fails to squarely address these substantial benefits that GS Labs has alleged. Instead, Medica relies on cases that are not comparable to the claim alleged by GS Labs

and involve entirely inapposite circumstances (e.g., window sales, leasing, and employment), as well as that do not apply Minnesota law (instead, New York, California, Nevada, and Florida). (Dkt.No.31 at 14-15 & n.14.)

Here, GS Labs plausibly alleges that the diagnostic testing services it rendered, in the circumstances of this pandemic and in the context of Congress's call for aid, conveyed benefits that Medica in equity and good conscience should not be entitled to retain.

C. Minnesota's Law of Unjust Enrichment Does Not Require GS Labs to Have Conferred Benefits on Medica Unknowingly or Unwillingly.

Medica next argues that "a claim of unjust enrichment requires proof that Plaintiff conferred . . . benefits 'unknowingly or unwillingly.'" (Dkt.No.31 at 15; Dkt.No.31 at 17-18 n.6 (citation omitted).) However, this is an incorrect statement of the law.

Minnesota law does not focus on whether *the plaintiff* unknowingly or unwillingly conferred a benefit. The test under Minnesota law is whether *the defendant* knowingly or willfully accepted a benefit for which, in equity and good conscience, the defendant should pay. *Schumacher v. Schumacher*, 627 N.W.2d 725, 729 (Minn. Ct. App. 2001).

The cases cited by Medica narrowly apply only to the specific context in which a party alleges quasi-contract related to what turned out to be a bad bargain. These cases state that "to ensure that unjust enrichment *is not used to reward a bad bargain*," Minnesota courts require proof that "a benefit was conferred unknowingly or unwillingly." *Holmes v. Torguson*, 41 F.3d 1251, 1256 (8th Cir. 1994) (emphasis added) (quoting *Galante v. Oz, Inc.*, 379 N.W.2d 723, 726 (Minn. Ct. App. 1986)). The instant case does not, however, involve a claim that GS Labs entered into a "bad bargain" with Medica.

Rather, this case involves a quantum meruit theory of unjust enrichment. *See* 66 Am. Jur. 2d Restitution and Implied Contracts § 4 (2021) (distinguishing restitution claims from claims for "bargains gone awry"). The Minnesota Supreme Court recently reaffirmed the three elements of an unjust enrichment claim based on quantum meruit: "To prove a claim in quantum meruit, the [plaintiff] must prove '(1) that the services were rendered; (2) under circumstances from which a promise to pay for them should be implied; and (3) their value.'" *Faricy L. Firm, P.A. v. API, Inc. Asbestos Settlement Tr.*, 912 N.W.2d 652, 657–58 (Minn. 2018) (citation omitted). A party is unjustly enriched in the sense that unjustly means illegally or unlawfully, or that retention of the benefit is morally wrong. *Schumacher*, 627 N.W.2d at 729.

Here, GS Labs has plausibly alleged that it rendered diagnostic testing services in the circumstances of a global pandemic crisis from which a promise to pay for them by insurers should be implied for the value of those services.

D. Medica's Contracts with Its Own Insureds Are Irrelevant to GS Labs' Claim of Unjust Enrichment.

Medica argues that GS Labs' unjust enrichment claim is foreclosed because *Medica* has contracts (plans) with its insureds who underwent diagnostic testing at GS Labs facilities. (Dkt.No.31 at 16-17.) Medica relies on claims involving third-party beneficiary theories. (*See id.*) The issue is whether "the rights *of the parties* are governed by a valid contract." *U.S. Fire Ins. Co. v. Minnesota State Zoological Bd.*, 307 N.W.2d 490, 497 (Minn. 1981) (emphasis added). Here, "the parties" are GS Labs and Medica. There are no third-party beneficiary claims. Thus, Medica's contracts with its insureds are irrelevant.

E. Medica Inconsistently Goes Outside the Pleadings to Allege Contracts Between GS Labs and Insureds, While Also Alleging Such Contracts Would be Void Under Federal Law.

Medica argues that GS Labs enters into express contracts with its patients governing its right to payment, and those express contracts preclude unjust enrichment claims. (Dkt.No.31 at 17.) But in the same breadth, Medica argues that enforcing any such contract would "violate the CARES Act." (Dkt.No.31 at 18 (citing Departments' guidance).)

Again, unjust enrichment is foreclosed only when a valid contract governs the rights as between *the parties*—here, Medica and GS Labs. Even assuming GS Labs could enter into "contracts" with Medica's insureds related to the testing provided by GS Labs, the terms of any such "contracts" are outside the pleadings. Indeed, there is no allegation that these "contracts" govern the subject of reimbursement from Medica or necessarily address all of the benefits retained by Medica. *See Frankson v. Design Space Int'l*, 394 N.W.2d 140, 145 (Minn. 1986); *Ventura v. Titan Sports, Inc.*, 65 F.3d 725, 729 (8th Cir. 1995).

Moreover, Medica asserts that the CARES Act would not permit or allow GS Labs to seek payment from patients because the statute expressly requires that it is the insurers—not the insureds—who "shall reimburse the provider of the diagnostic testing," and that this is essential to achieving the underlying legislative purpose by ensuring patients will not be required to pay for potentially expensive testing. (Dkt.No.31 at 18.) Thus, Medica concedes that to the extent GS Labs and any of its patients could have entered into any "contracts" by virtue of patients' filling out pre-testing forms, those contracts are unenforceable because they would violate federal law. Thus, there could be no such enforceable express contracts precluding claims for unjust enrichment.

III. GS Labs Has Plausibly Alleged That Medica Breached Its Duty of Care, as Codified in CARES Act § 3202(a) and in the Circumstances of a Pandemic.

GS Labs has plausibly alleged a negligence *per se* claim against Medica by asserting Medica owes GS Labs the duty of care of an ordinarily prudent insurer acting in similar circumstances during a public health emergency and viral pandemic (¶106), and that the CARES Act established a statutory standard of care for that duty owed by the ordinary prudent insurer in these particular arising from the current COVID-19 pandemic. (¶107.) This is consistent with the long-standing theory of negligence *per se* under Minnesota law. *Osborne v. McMasters*, 41 N.W. 543, 543–44 (Minn. 1889).

The CARES Act's standard of care codifies that an ordinary prudent insurer in these circumstances would fully reimburse a provider at the publicly-posted cash rate for diagnostic testing in the event there is no separately-negotiated rate. (¶108.) Congress intended for § 3202(a) to protect diagnostic testing providers like GS Labs from both non-payment and under-payment. Congress thus set a statutory standard of care that requires insurers like Medica "shall reimburse" providers like GS Labs at the publicly-posted cash rate for diagnostic testing in the event there is no separately-negotiated rate and the provider administers tests without prepayment. (¶109.) Other insurance companies have acted consistent with this duty and fully paid GS Labs as required; and there is no reason Medica cannot do the same. (¶110.)

The Minnesota Supreme Court has held that negligence *per se* is "often" appropriate when statutes "do not provide for a civil action." *Seim v. Garavalia*, 306 N.W.2d 806, 810 (Minn. 1981). If § 3202(a) does not provide an implied cause of action, claims for

negligence *per se* may be based on this provision of the CARES Act as establishing a statutory minimum standard of care in these circumstances.

A. Section 3202(a) Codifies the Reasonable Standard of Care Owed by Insurers to Diagnostic Testing Providers in a Pandemic.

Medica broadly argues that the standard of care alleged by GS Labs cannot form the basis of a negligence claim. First, Medica argues that at common law, "parties in an arm's length transaction do not owe each other a duty of care beyond honesty." (Dkt.No.31 at 19.) However, this aspect of the common law relates to the duty to *supply information* to another party to a transaction—not the duty to pay providers in a pandemic. Moreover, GS Labs and Medica are not parties to an arms' length transaction. (¶56.)

Medica also argues that a negligence *per se* claim cannot be based on a violation of the CARES Act because there was no general duty to reimburse prior to enactment of that statute. (Dkt.No.31 at 19-20.) However, Medica's crabbed analysis displaces the essence of Minnesota law. *See Osborne*, 41 N.W. at 543-44 ("Negligence is the breach of legal duty. It is immaterial whether the duty is one imposed by the rule of common law requiring the exercise of ordinary care not to injure another, or is imposed by a statute designed for the protection of others."); *Seim*, 306 N.W.2d at 810. GS Labs has alleged that Medica owes the standard duty of care of that of an ordinary prudent insurer owes when acting in similar circumstances—and here, this means the duties owned by an ordinary prudent insurer during the "similar circumstances" of a public health emergency and viral pandemic. (¶106.) Pandemics are a rare occurrence, but this standard mirrors the duty of care that existed in Minnesota law before the CARES Act's enactment.

Medica argues this case is similar to that of *Elder v. Allstate Ins. Co.*, 341 F. Supp. 2d 1095, 1098 (D. Minn. 2004), which concerned an alleged common law duty for an insurer to inform an insured of a policy provision on which a claim denial was based, to make a reasonable investigation of an insurance claim, and inform the insured where to take complaints. (Dkt.No.31 at 20.) However, *Elder* is inapposite because GS Labs bases its negligence *per se* claim on the common law standard of reasonable care in a pandemic. (¶105.) The CARES Act codifies a standard of care in such circumstances that would be reasonable even in the absence of such a law—namely, that an insurer must reimburse providers for diagnostic testing designed to combat a pandemic and so as to ensure testing continues to exist to respond to and ameliorate the pandemic.

Medica lastly argues that the relevant provisions of the CARES Act bear little resemblance to the statutes that traditionally support a claim for negligence *per se*, such as those "requiring protective eye glasses when operating machinery," "requiring owners of refrigerators to detach door[s] before abandoning" their appliance, or "outlawing the sale of fireworks." (Dkt.No.31 at 21.) But these common situations in which negligence *per se* may arise do not detract from the standard of care of a reasonably prudent person in more rare and particularized circumstances such as a 100-year pandemic.

B. Medica's Intentional Breach of Its Duty of Care Can and Does Constitute Negligence.

Medica strangely argues that it is impossible for it to have acted negligently because it acted intentionally. (Dkt.No.31 at 22-23.) This is a *non sequitur*. Minnesota's common

law of negligence only requires showing breach of a duty, regardless of whether that breach is intentional or accidental. *E.g.*, *Domagala v. Rolland*, 805 N.W.2d 14, 22 (Minn. 2011).

The authorities cited by Medica do not establish otherwise. (Dkt.No.31 at 22-23.) Indeed, *Murphy v. Barlow Realty Co.*, 206 Minn. 527, 530-31 (1939) recognized the concept of "willful negligence." In *Pierson v. Minneapolis Police Dep't*, No. 10-1960 (JNE/FLN), at *10 (D. Minn. Jan. 6, 2012), the court merely held that gross negligence is insufficient to show malice to bring a Fourth Amendment claim. And Medica's misplaced reliance on Restatement (Second) of Torts § 282, is revealed by the portions of the Restatement that Medica conveniently omits: "The definition of negligence *given in this Section* includes only such conflict as creates liability for the reason that it involves a risk and not a certainty of invading the interest of another. It therefore excludes conduct which creates liability because of the actor's intention to invade a legally protected interest of the person injured or of a third person." (emphasis added.) Comment a further notes that negligent conduct "may consist either of an act (see § 2), or an omission to act when there is a duty to do so (see § 284)." Restatement (Second) of Torts § 282 cmt. a (1965). In short, negligent conduct may be either accidental or intentional. Restatement (Second) of Torts § 2 & cmt. c (1965). All that need be shown is a breach of a duty.

Thus, GS Labs has plausibly alleged an intentional breach of a statutorily defined duty of care—factual allegations that Medica itself recognizes here.

IV. The Overwhelming Authority in This District Establishes that Rules 8 and 15(a) Apply in Federal Court and Cannot Be Overridden by the Minnesota Legislature for Claims for Punitive Damages.

Medica argues that GS Labs' claim for punitive damages should be dismissed because it is improper to allege "punitive damages from the outset," citing Minnesota Statute § 549.191 and quoting *Bergman v. Johnson & Johnson*, No. CV 20-2693 (JRT/HB), 2021 WL 3604305, at *6 (D. Minn. Aug. 13, 2021). (Dkt.No.31 at 24.) However, neither Medica nor *Bergman*[6] offer any analysis of the interplay between Rules 8 and 15(a) and Minnesota Statute § 549.191—a subject that has spilled ink.

The practice established in the District is to apply Rules 8 and 15(a), which Congress and the Supreme Court have dictated shall apply in federal courts, rather than § 549.191, which the Minnesota Legislature can only require be applied in state courts. *Coleman v. Lakeview Loan Servicing, LLC*, No. 19-CV-1168 (DWF/HB), 2020 WL 1922569, at *3 (D. Minn. Apr. 21, 2020) (collecting cases). Clearly, the Minnesota Legislature has no authority to dictate what rules apply in federal courts created by Congress and regulated by the Supreme Court. Given that federal law imposes no prerequisites on alleging punitive damages claims and instead liberally permits pleading, a plaintiff in federal court may allege a claim for punitive damages from the outset in its lawsuit.

[6] Although *Bergman* determined that a punitive damages claim should be dismissed *without prejudice*, it did not analyze the sufficiency of the allegations under Rule 12(b)(6).

Medica does not challenge that the punitive damages claim is plausible; indeed, Medica argues it acted *deliberately*. (Dkt.No.31 at 22-23.) Accordingly, Medica has provided no basis to dismiss the punitive damages claim under Rule 12(b)(6).

V. It Would Be Unnecessary and Premature for the Court to Address Whether and to What Extent ERISA Preemption May Apply at This Early Stage of These Proceedings, and Any Such Ruling Would Constitute an Ill-Advised Advisory Opinion.

Finally, Medica argues that ERISA's express preemption provisions preempt "any and all State laws insofar as they . . . relate to any employee benefit plan" covered under the statute. 29 U.S.C. § 1144(a). (Dkt.No.31 at 25-26.) However, this argument rests on the assumption that ERISA plans are at issue in this case.

The Complaint makes no mention of ERISA. (Dkt.No.1 *passim*.) Thus, Medica's argument prematurely raises this issue based on assumptions outside the Complaint, such as Medica's suggestion that ERISA plan participants received testing from GS Labs. Any such issue must be determined at a later date—if at all. Rendering a vague and abstract ruling on this issue at this juncture would amount to an impermissible advisory opinion.

Regardless, COVID-19 did not exist when many of Medica's plans were written, so there would be no reason to reference the plan terms with respect to the obligation to pay for COVID-19 testing that is imposed by the FFCRA. And this would be a pure issue of law that does not involve administration of a plan or interpretation of its terms.

Therefore, the Court should deny Medica's motion to dismiss on this issue.

CONCLUSION

For the reasons stated above, and those in its forthcoming reply in support of its motion for partial summary judgment, GS Labs respectfully requests the Court deny Medica's motion to dismiss in all respects. Medica is not above the law, and the Court cannot condone Medica's flouting of § 3202(a) under state or federal law.

Respectfully submitted,

Dated: February 4, 2022

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UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

GS LABS, LLC, *a Nebraska limited liability company*, Plaintiff, v. MEDICA INSURANCE COMPANY, *a Minnesota insurance corporation*, Defendant.	Case No.: 21-cv-2400 (SRN/TNL) **LR 7.1(f) CERTIFICATE OF COMPLIANCE**

I, *Thomas H. Boyd*, certify that *Plaintiff's Memorandum in Opposition to Medica Insurance Company's Motion to Dismiss* complies with Local Rule 7.1(f).

I further certify that, in preparation of the above document, I used the following word processing program and version: *Word 2019* and that this word processing program has been applied specifically to include all text, including headings, footnotes, and quotations in the following word count.

I further certify that the above document contains the following number of words: *11,970*.

Dated: February 4, 2022

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