UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

GUARDIAN FLIGHT LLC and MED-TRANS CORPORATION	§	
	§	
	§	
Plaintiffs,	§	
v.	§	**Civil Action No. 3:23-CV-01861-B**
	§	**Hon. Jane J. Boyle**
HEALTH CARE SERVICE CORPORATION	§	
	§	**JURY TRIAL DEMANDED**
	§	
Defendant.	§	
	§	

PLAINTIFFS' OPPOSITION TO DEFENDANT HEALTH CARE SERVICE CORPORATION'S MOTION TO DISMISS PLAINTIFFS' COMPLAINT

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Plaintiffs Guardian Flight LLC ("Guardian Flight") and Med-Trans Corporation ("Med-Trans") (collectively "Plaintiffs") oppose Defendant Health Care Service Corporation's ("HCSC") Motion to Dismiss Plaintiffs' Complaint ("Motion") and would respectfully show the Court as follows:

INTRODUCTION

HCSC claims it can violate federal law by not paying millions of dollars it owes to out-of-network providers under the No Surprises Act ("NSA") and that Plaintiffs and this Court are powerless to do anything about it. HCSC is wrong. It is not above the law, and its request for this Court to declare it so by dismissing Plaintiffs' complaint should be denied.

None of HCSC's arguments have merit. As a federal judge already concluded, the NSA carries an implied right of action to enforce Independent Dispute Resolution ("IDR") awards. And Plaintiffs have exhausted their administrative remedies by obtaining an award through the IDR process.

Plaintiffs have also asserted valid claims under ERISA because they have assignments from their patients and thus derivative standing to assert them. Plaintiffs are not required to allege specific plan terms because there is no dispute that each plan provides coverage for emergency services as this is a prerequisite to the IDR process itself.

Lastly, HCSC continues to be unjustly enriched when the IDR award is issued and HCSC refuses to pay it within the 30 days as required by the NSA. After that point, HCSC is collecting investment or interest income on funds rightfully owed to Plaintiffs. HCSC's case law on unjust enrichment all predates the NSA, which now provides a direct right to payment by health plans and insurers, and thus a common law claim for unjust enrichment when that payment is not made.

For all these reasons, HCSC's Motion to Dismiss must be denied.

LEGAL STANDARD

I. FED. R. CIV. P. 12(b)(1)

"It is extremely difficult to dismiss a claim for lack of subject matter jurisdiction." *Santerre v. Agip Petroleum Co., Inc.*, 45 F. Supp. 2d 558, 566 (S.D. Tex. 1999) (quoting *Garcia v. Copenhaver, Bell & Assocs., M.D.'s, P.A.*, 104 F.3d 1256, 1260 (11th Cir. 1997)). "12(b)(1) challenges to subject matter jurisdiction come in two forms: 'facial' attacks and 'factual' attacks." *A.W. v. Humble Indep. Sch. Dist.*, 25 F. Supp. 3d 973, 981 (S.D. Tex. 2014) *aff'd sub nom*. *King-White v. Humble Indep. Sch. Dist.*, 803 F.3d 754 (5th Cir. 2015) (citing *Paterson v. Weinberger*, 644 F.2d 521, 523 (5th Cir. 1981)). "A facial attack consists of a Rule 12(b)(1) motion unaccompanied by supporting evidence that challenges the court's jurisdiction based solely on the pleadings." *Id.* "A factual attack challenges the existence of subject matter jurisdiction in fact—irrespective of the pleadings—and matters outside the pleadings, such as testimony and affidavits, are considered." *Id.*

II. FED. R. CIV. P. 12(b)(6)

Motions to dismiss for failure to state a claim are "viewed with disfavor and rarely granted." *Lormand v. U.S. Unwired, Inc.*, 565 F.3d 228, 232 (5th Cir. 2009) (quoting *Test Masters Educ. Services, Inc. v. Singh*, 428 F.3d 559, 570 (5th Cir. 2005)). When a federal court reviews a complaint on a motion to dismiss, it must accept the well-pleaded factual allegations in the complaint as true. *See Von Der Ahe v. 1-800-Pack-Rat, LLC*, 597 F.Supp. 1051, 1056 (N.D. Tex. 2022) (Boyle, J.). Moreover, "[t]he court's inquiry should focus on the complaint as a whole, 'regardless of how much of it is discussed in the motion to dismiss." *U.S. ex rel. Bias v. Tangipahoa Par. Sch. Bd.*, 816 F.3d 315, 321 (5th Cir. 2016) (quoting *Wilson v. Birnberg*, 667 F.3d 591, 595 (5th Cir. 2012)). A plaintiff need not plead facts that would "probably" establish a violation; all that is required is that the factual allegations, taken as true, demonstrate "more than

a sheer possibility that a defendant has acted unlawfully." *Ashcroft v. Iqbal*, 556 U.S. 662, 678-79 (2009).

ARGUMENT AND AUTHORITIES

I. The NSA provides an implied right to enforce IDR awards in court.

A. Congress created a right to direct payment from health plans and insurers.

In exchange for taking away a provider's right to obtain payment from the patient of any amount not paid by their insurer (balance billing), Congress created a direct payment obligation from the health plan or insurer. If the insurer and provider are unable to reach agreement on the appropriate amount of such payment, it is determined by a third party IDR service. That amount must be paid within thirty days. As the statute explains:

> (E) **Effects of determination**
>
> (i) In general
>
> **A determination of a certified IDR entity** under subparagraph (A)-
>
> (I) **shall be binding upon the parties involved**, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and
>
> (II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9.
>
> [. . .]
>
> (6) Timing of payment
>
> The **total plan or coverage payment** required pursuant to subsection (a)(1) or (b)(1), with respect to a qualified IDR item or service **for which a determination is made** under paragraph (5)(A) or with respect to an item or service for which a payment amount is determined under open negotiations under paragraph (1), **shall be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made.**

42 U.S.C. § 300gg–111(c)(5)(E) (emphasis added).[1]

HCSC argues that "[t]here are no 'clear and unambiguous terms' in the NSA demonstrating congressional intent to grant Plaintiffs a new private right and remedy." Dkt. 11 at 19. HCSC misses the point. Plaintiffs are not seeking a new "private right and remedy." They are merely seeking to enforce the right and remedy that Congress provided. HCSC's argument that NSA awards are unenforceable and it cannot be compelled to pay them would render the statute meaningless.

This is the result recently reached by a federal court in New Jersey, which had no hesitation in enforcing an IDR award. *See GPS of New Jersey, M.D. v. Horizon Blue Cross & Blue Shield*, 2023 WL 5815821 (D.N.J. 2023). There, the court explained that the language in the NSA "indicates the decision is to be 'final and binding,' and gives the court authority to confirm the award." *Id.* at*10.

While IDR proceedings are not arbitrations, the D.C. District Court's decision in *Cheminova A/S v. Griffin LLC* further supports this court's power to enforce IDR awards. 182 F. Supp. 2d 68 (D.D.C. 2002). In *Cheminova*, the plaintiff moved to confirm an arbitration award under the Federal Insecticide, Fungicide, and Rodenticide Act ("FIFRA"). *Id.* at 71. Cheminova's request for judicial confirmation tasked the court with deciding for the first time whether it had jurisdiction to enforce an arbitration award under FIFRA. *Id.* at 73. In deciding that it did have jurisdiction, the court rejected Griffin LLC's argument that FIFRA only provided an administrative remedy. *Id.* The court reasoned that "[i]n light of FIFRA's unambiguous language and ***because judicial enforcement is necessary to effectuate the statute's express goals***, it must be concluded that FIFRA confers jurisdiction on the judiciary to enforce arbitration awards." *Id*. (emphasis

[1] This portion of the NSA is made applicable to air ambulance disputes at 42 U.S.C. § 300gg–112(b)(5).

added). The court also stated that "[the] terms 'binding' and 'final and conclusive' [in FIFRA] are understood to mean that an award will be enforceable in court" and that "purposes of the statute would be defeated if arbitration awards are not judicially enforceable." *Id*. at 73-74.

Here, the NSA's language requiring insurers to pay IDR awards within thirty days is unambiguous. 42 U.S.C. § 300gg-112(b)(6). And like in *Cheminova* in which the court reasoned that the "purposes of the statute would be defeated if arbitration awards are not judicially enforceable[,]" the same is true of the NSA and IDR awards. *Cheminova*, 182 F. Supp. at 74. And so the NSA gives this Court the ability to confirm IDR awards and convert them into a federal judgment and award Plaintiffs' pre and post-judgment interest in accordance with 28 U.S.C. § 1961.

This Court need go no further than the language of the NSA itself in concluding it has full authority to enforce NSA awards like those at issue herein.

B. Alternatively, the NSA implies a private right of action.

The Supreme Court has stated that several factors are to be considered in "determining whether a private remedy is implicit in a statute not expressly providing one." *Cort v. Ash*, 422 U.S. 66, 78 (1975)[2]. A court performing this analysis asks

> First, is the plaintiff 'one of the class for whose especial benefit the statute was enacted,'—that is, does the statute ***create a federal right in favor of the plaintiff***? Second, is there any indication of ***legislative intent***, explicit or implicit, either to create such a remedy or to deny one? Third, is it ***consistent with the underlying purposes of the legislative scheme*** to imply such a remedy for the plaintiff? And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be ***inappropriate to infer a cause of action based solely on federal law?***

[2] Federal Courts today, including the Fifth Circuit and Southern District of Texas continue to apply the *Cort* factors in deciding whether federal statues contain implied causes of action. *See Wright v. Allstate Ins. Co.*, 250 Fed. App'x 1 (5th Cir. 2007); *Glanville v. Dupar Inc.*, 727 F. Supp. 2d 596 (S.D. Tex. 2010); *Lil' Man in the Boat, Inc. v. City & Cnty. of San Francisco*, 5 F.4th 952 (9th Cir. 2021).

Id. (internal citations omitted) (emphasis added). Applying these factors weigh in favor of Plaintiffs being able to sue ***under the NSA*** to obtain payment of IDR awards HCSC was obligated to pay within thirty days but did not.

First air ambulance providers are clearly a group for whose benefit the statute was created. Indeed, Congress created a separate section in the NSA that applies just to air ambulance providers and § 300gg-112 explicitly applies to air ambulances bills. Next, as Defendant admits in its motion, "Congress specifically designed the IDR process to provide an 'efficien[t]' and streamlined means of dispute resolution at a minimal cost." Dkt. 12 at 18. To carry out Congress's will, a cause of action must exist for providers to enforce unpaid awards. Otherwise, payors will have no incentive to timely pay such awards, which would defeat efficiency and increase cost. Last, the cause of action implied in the NSA is one not traditionally relegated to state law because the IDR process is mandated by federal law and the awards are decided by federal contractors. In fact, states are prohibited from regulating the prices, routes or services of air ambulances under the Airline Deregulation Act. *See, e.g.*, *Hodges v. Delta Airlines, Inc.*, 44 F.3d 334, 335 (5th Cir. 1995); *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374 (1992). The NSA therefore carries an implied right of action for air ambulance providers to confirm unpaid IDR awards and convert such awards into a federal judgment.

HCSC attempts to draw a comparison between the NSA's "Timing of Payment" provision with a similar payment provision in the Coronavirus Aid, Relief, and Economic Security Act ("CARES") to support its argument that no private right of actions exists. Dkt. 11 at 21. But the two acts are not comparable. The courts holding that CARES did not provide a private right of action found under the first *Cort* factor that it was the ***patients*** and not the providers whose benefit the statute was created. *See GS Labs, Inc. v. Medica Insurance Company*, 2022 WL 4357542, at

*8 (D. Minn., 2022) ("Instead, when read in context, [the act] was intended to implement access to COVID-19 testing for the benefit of patients."). Here, the NSA, and specifically the "Timing of Payment" provision, was enacted specifically for the benefit of emergency medical service providers. There are no other potential groups, such as patients, that benefit from the "Timing of Payment" provision. Moreover, unlike CARES, where the court's found that the text and structure of the act did not indicate an implied cause of action, the NSA is different. *See Genesis Lab. Mgmt. LLC v. United Health Grp., Inc.*, 2023 WL 2387400, at *3 (D.N.J. Mar. 6, 2023) ("[E]ven if Congress intended to create a personal right of reimbursement for providers, like Plaintiff, through the FFCRA and the CARES Act, there is nothing in the text or structure of those acts suggesting that Congress intended to afford a privately enforceable remedy to Plaintiff."). 42 U.S.C. § 300gg–111(c)(5)(E)(i)(I) explicitly states that IDR determinations "***Shall be binding . . .***" Congress clearly intended to create a private right of action to enforce the timely payment of IDR awards.

C. No administrative remedy exists for Plaintiffs.

HCSC also argues that "Congress . . . vested HHS and other agencies with extensive rulemaking authority and regulatory oversight over the IDR process[,]" and thus no private right of action exists because there is an exclusive administrative remedy. Dkt. 11 at 20. But nowhere in the NSA is there an administrative process for compelling payment of IDR awards. Simply stated, NSA does not provide any administrative remedy at all for unpaid awards, much less an exclusive one. As such, HCSC's implication—that Plaintiffs' sole administrative remedy is to complain to the Departments because HHs has a right to audit HCSC's compliance with the NSA—is unfounded.

To the extent there is an administrative remedy that must be exhausted, that remedy is obtaining a payment award from an IDR entity. Once that award has been issued, the

administrative process is complete. The only thing that remains is to enforce and collect on the award. That is the realm of the judicial branch, not the executive.

Furthermore, "to mandate exhaustion, a statute must contain '[s]weeping and direct' statutory language indicating that there is no federal jurisdiction prior to exhaustion, or the exhaustion requirement is treated as an element of the underlying claim." *Avocado Plus Inc. v. Veneman*, 370 F.3d 1243, 1248 (D.C. Cir. 2004) (quoting *Weinberger v. Salfi*, 422 U.S. 749, 757 (1975)). Nowhere does the NSA contain language that there is any enforcement process, much less one that must be exhausted. Second, the fact the Department has the right to audit payors is irrelevant. That is not a process for providers to enforce and obtain payment on awards. Moreover, the Departments have no obligation to even conduct an audit upon receiving a complaint. And HHS has stated that it "expects to conduct no more than 9 audits annually." *See* 86 Fed. Reg. 36935 (July 13, 2021). With more than six hundred payors participating in the IDR process during the first six month that it was available[3], HCSC's argument that Plaintiffs have an administrative remedy to recover unpaid IDR awards is nonsensical. Under the NSA, the judiciary is ***the only means*** to enforce unpaid IDR awards.

D. Judicial enforcement is not judicial review.

HCSC lastly argues that "the NSA expressly limits judicial review of IDR awards to the four grounds for vacatur under the Federal Arbitration Act, [and] the 'Timing of Payment' provision on which Plaintiffs rely does not contemplate any type of judicial review or remedy for enforcing IDR awards. Dkt. 11 at 20. HCSC is mixing the distinct concepts of judicial review

[3] *See* Initial Report on the Independent Dispute Resolution (IDR) Process April 15 – September 30, 2022 at pp.16, 26, available at https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf.

and judicial enforcement. Plaintiffs are not asking this Court to review the decision made by the IDR entity for error. It is asking the Court to enforce the award that was made.

> The NSA states:
>
> ***A determination*** of a certified IDR entity under subparagraph (A)—
>
> (I) ***shall be binding upon the parties involved***, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim;

42 U.S.C. § 300gg–111(c)(5)(E)(i)(I) (emphasis added). The statute could not be clearer that IDR awards are binding on health plans and insurers. The purpose of the NSA is stop balance billing and resolve payment disputes between health plans and emergency service providers. The NSA would be rendered meaningless if insurers like HCSC could ignore and never be compelled to pay awards.

For these reasons, HCSC's motion to dismiss on the grounds that the NSA carries an administrative remedy and no private right of action is baseless, and it should be denied.

II. Plaintiffs maintain derivative standing and have stated a claim for ERISA benefits.

HCSC relies on two arguments for dismissing Plaintiffs ERISA claim. Both lack merit. First, HCSC argues that because member-beneficiaries have no concrete interest in IDR disputes, and thus no Article III standing, Plaintiffs' assignment of benefits does not confer derivative standing. Dkt. 11 at 22-24. But no court has held that member-beneficiaries need to have a concrete interest for a healthcare provider to maintain derivative standing. Second, HCSC argues that Plaintiffs have identified no plan terms to compel HCSC to pay IDR awards and that "these responsibilities arise from the NSA, not any ERISA plan terms." Dkt. 11 at 24. But payment disputes are only eligible for the IDR process if the health plan provides coverage for the service at issue. That means that every IDR award at issue in this lawsuit concerns a health plan with coverage for the emergency services at issue here.

A. HCSC's health plan members have a concrete stake in this proceeding.

As to HCSC's first argument, it relies on the Supreme Court's recent opinion in *Thole v. U.S. Bank N.A.*, 140 S. Ct. 1615 (2020). HCSC posits that *Thole* supports its position that Plaintiffs must explain how HCSC's member-beneficiaries have suffered injury by HCSC's failure to timely pay IDR awards for Plaintiffs to maintain standing. But *Thole* is distinguishable. There, the Court held that ***retirement*** plan participant plaintiffs did not have standing to pursue a putative action for alleged mismanagement of a defined benefit plan. *Id.* at 1621. The Court reasoned that because the alleged mismanagement concerned a defined benefit plan, meaning that the benefits were contractually fixed regardless of fiduciary mismanagement, that the participant plaintiffs had no concrete stake in the case that could amount to standing. *Id.* at 1619-1620 ("If [plaintiffs] were to lose this lawsuit, they would still receive the exact same monthly benefits that they are already slated to receive, not a penny less").

Here, health plan members have a concrete stake in this case in numerous ways. First, the only reason plan members are not balance billed for air transports is because their health plan now has a direct payment obligation. If the plan does not make that payment, it endangers members' balance billing protections under numerous legal theories. Second, members risk higher premiums if their health plans do not pay IDR awards and incur additional liabilities for interest, unjust enrichment, attorney's fees and penalties. Third, health plan members have a concrete interest in having their health plans comply with federal law and pay air ambulance transports so that air ambulance transports remain accessible and providers do not go bankrupt, as did Air Methods just today.[4]

[4] *See* https://www.reuters.com/legal/medical-helicopter-company-air-methods-files-bankruptcy-2023-10-24/.

Moreover, the Fifth Circuit makes clear that a valid assignment confers derivative standing to bring a cause of action under ERISA. *See Tango Transp. v. Healthcare Fin. Services LLC*, 332 F.3d 888, 892 (5th Cir. 2003). And here, Plaintiffs have valid assignments. As the attached declaration and exemplar document demonstrate, all of the Plaintiffs use the same assignment of benefits form and it is standard practice to obtain the patient or legal guardian's signature for each transport. Ex. A. Those assignments include assignment of "all right to (and related or associate with)" payable benefits, including the right to file lawsuits, recover attorney's fees, and "additional recovery such as treble damages, punitive damages, or penalties." Plaintiffs have obtained valid, legally enforceable assignments of benefits and HCSC's challenge on this ground should be denied.

B. Plaintiffs' claim is not independent of HCSC's self-funded plans, and Plaintiffs need not identify any specific plan terms.

As to HCSC's second argument—that "Plaintiffs cannot 'identify a specific plan term that confers' on HCC member-beneficiaries the right to 'compel[] HCSC to use plan funds to pay Plaintiffs—it is also without merit. This is because NSA administration is itself a plan benefit for HCSC's insureds, and with that comes HCSC's responsibility to comply with the statute for the plans it administers. *Compl.* ¶ 19. Open negotiations, the IDR process, including submitting position statements, and paying the claim from plan funds is exactly what HCSC has agreed to do for plan beneficiaries in connection with administering their benefit plans. Thus, when HCSC violates the NSA through its nonpayment of IDR awards for air ambulance transports, it breaches its obligations to the self-funded plans it administers and to the plan beneficiaries. Connecting the dots, HCSC's failure to comply with the NSA improperly denies plan benefits, and thus states a claim under ERISA.

For example, in *Spring E.R., LLC v. Aetna Life Ins.,* the court held that the healthcare card issued by Aetna to its insureds created an implied contract to healthcare providers to render emergency services in exchange for compensation, and that such a claim was not independent of the insured's plan because the implied contract limited healthcare providers to the plan's terms. 2010 WL 598748, at *5-6 (S.D. Tex. Feb. 17, 2010). Here, the NSA only applies to group health plans where the service is provided "***if such services would be covered*** if provided by a participating provider. . . ***with respect to such plan or coverage***." 42 U.S. Code § 300gg–112(a). Far from being independent of the ERISA health plan, the NSA payment obligations are tightly tethered to it. Similarly, the NSA addresses other ERISA health plan benefits, such as the way cost-sharing will be handled for air ambulance claims. *Id.* Plaintiffs have derivative standing to pursue its claim under ERISA because the basis of this lawsuit is not entirely independent of HCSC's self-funded ERISA plans, and Plaintiffs need not identify specific plan terms that confer HCSC's member-beneficiaries the right to compel HCSC's payment.

In addition, the IDR process only applies to "eligible" health plans, which are health plans that provide coverage for emergency services and thus, under the NSA, ***must*** provide coverage for out-of-network emergency services. *See* 42 USC 300gg-111(a) (stating with respect to hospital services that if "a group health plan . . . provides or covers any benefits with respect to . . . emergency services . . . ***the plan*** or issuer ***shall cover emergency services*** . . . [and make] ***a total plan or coverage payment*** directly to such provider or facility" in accordance with the NSA); 42 U.S. Code § 300gg–112 (explaining that if air ambulance services from in-network providers are covered, the plan must "pay a total ***plan or coverage payment***" to an out-of-network provider in accordance with the NSA). Quite simply, the NSA prevents a health plan from excluding coverage for out-of-network providers of emergency services if the service is otherwise covered and

explains how payment disputes with them will be resolved. Eligibility is determined at the outset of the IDR process, and health plans have an opportunity to object to eligibility, such as if they do not cover emergency services at all and thus out-of-network services are not covered by the plan. Indeed, during the first six months of the IDR program, "non-initiating parties" such as health plans "challenged eligibility for the Federal IDR process in 1,297 OON air ambulance disputes, approximately 40% of those initiated." *See, e.g.* Initial Report on the Independent Dispute Resolution (IDR) Process, *supra* note 3, at 27.

Here, Plaintiffs seek to enforce IDR awards, meaning plan benefits exist. The IDR process resolved the dispute over the amount of plan benefits to which Plaintiffs are entitled. Because Defendant violated federal law by not making that payment within 30 days, Plaintiffs no seek those plan benefits through an ERISA cause of action. For these reasons, Defendant's motion to dismiss Plaintiffs' ERISA claim should be denied.

III. Plaintiffs state a claim for unjust enrichment.

Congress's passage of the NSA changed the provider-insurer landscape. HCSC argues that Plaintiffs' unjust enrichment claim must fail because "Plaintiffs did not render any services for HCSC's benefit." Dkt. 11 at 25. But this argument and HCSC's supporting case law ignores the current reality—under the NSA providers have a direct right to payment from health plans and insurers.[5] 42 U.S.C. § 300gg-111(b)(6). Thus, HCSC's citations to pre-NSA courts holding to the contrary are inapplicable and inapposite. These cases were premised on the notion that providers should sue patients, including for unjust enrichment, because they had the payment obligation.

[5] The IDR award creates a direct payment obligation between a provider and payor for a particular claim that is equivalent to contractual privity. In fact, the parties now have an implied Single Case Agreement ("SCA"). *See Hondo Oil & Gas Co. v. Texas Crude Operator, Inc.*, 970 F.2d 1433, 1436 (5th Cir. 1992) (implied contracts where "parties form a contract based upon their acts and conduct."). An SCA is a contract between an out-of-network provider and an insurer for a single episode of care, such as an air ambulance transport.

That obligation now resides solely on payors like HCSC. Accordingly, providing an air ambulance transport to its members now benefits the health plan because it is the one who as a matter of federal law must pay for it.

Furthermore, HCSC focuses on Plaintiffs' allegation that the unjust enrichment occurred because Plaintiffs provided transports to HCSC's members without commensurate compensation. *Compl.* ¶ 25. While true that this is one of the ways HCSC has been unjustly enriched, HCSC fails to address Plaintiffs additional allegations stating a second reason they have been unjustly enriched. In paragraphs 27 and 28, Plaintiffs have alleged that the NSA "required payment within thirty ("30") days of the IDR decision being issued" and "HCSC continued to improperly retain the required payment for the service provided past thirty days, ***which allowed it to become further unjustly enriched*** by receiving interest or investment income because of the unlawful retention of the funds. *Compl.* ¶¶ 27-28 (emphasis added). Accordingly, after the 30 day mark, Plaintiffs have provided HCSC with the benefit of financing as it is holding money that is no longer its own and should have been paid to Plaintiffs.

These allegations are clear that Plaintiffs have stated a claim for unjust enrichment. HCSC holds funds that are rightfully owed to Plaintiffs, and those funds continue to accrue investment and interest income. HCSC is being unjustly enriched by these ill-gotten gains. For these reasons, Plaintiffs have stated an unjust enrichment claim and Defendant's Motion should be denied.

CONCLUSION

For all these reasons, Plaintiffs respectfully requests that HCSC's Motion to Dismiss Plaintiffs' Original Complaint be denied. Should the Court grant the Motion, Plaintiffs request that the dismissal be without prejudice and that it be granted an opportunity to amend.

Dated: October 24, 2023

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Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I certify that on October 24, 2023, a true and correct copy of the foregoing was served via the Court's ECF system on all counsel of record.

/s/ Adam T. Schramek
Adam T. Schramek

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

GUARDIAN FLIGHT LLC and MED-TRANS CORPORATION	§	
	§	
Plaintiffs,	§	
v.	§	**Civil Action No. 3:23-CV-01861-B**
	§	**Hon. Jane J. Boyle**
HEALTH CARE SERVICE CORPORATION	§	
	§	
Defendant.	§	

DECLARATION OF ANGELA L. RICHMOND

I, Angela L. Richmond, am over the age of 18, am of sound mind, and based on personal knowledge state as follows:

1. I have been employed by Global Medical Response ("GMR") since May 15, 2012 and hold the position of Vice President Revenue Cycle Operations. The facts contained in this Declaration are based on my own personal knowledge, including the knowledge I gained from reviewing the records of GMR. If called as a witness, I could and would testify competently to the facts stated herein.

2. GMR, through its operating subsidiaries, provides air ambulance services across the country. Plaintiffs in this proceeding are some of those operating subsidiaries. GMR utilizes a uniform set of forms for patient transports. These forms include an assignment by a patient being transported to the company conducting the transport. Attached as Exhibit "A" is a true and correct copy of the assignment used for transporting the patient at issue in IDR proceeding DISP-18703. This form has been used since at least January 1, 2022 to present. It is standard practice across

companies to obtain this assignment and the patient's or legal representative's signature on the form.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: October 24, 2023

Angela L. Richmond

Angel L. Richmond

EXHIBIT A

EMS Agency Name: Guardian Flight, LLC-EAM-Farmington **Patient Name:** [redacted]

Authorized Representative (B/C)Ambulance Billing Authorization Form (Revision date 10/2019)

1/6/2022 - 21:40 - [redacted]

Header

Patient Last Name: [redacted] **Patient First Name:** [redacted]
Supplier means : Guardian Flight LLC-EAM-Farmington **Transport Date:** 01/06/2022 21:16:02

SECTION II

Question	Answer	Notes
The person signing below in section I or II only, (for himself/herself as the patient or as the legal representative, or surrogate for consent to treatment, on behalf of the patient named above): (1) acknowledges that the medical care furnished to the patient was actually received and was limited solely to emergency treatment and transporation; (2) authorizes such medical treatment and transportation as being medically necessary; (3) authorizes the submission of a claim for payment to Medicare, Medicaid or any other payer for any services provided by the Supplier, now or in the past or in the future and authorizes and directs any holder of medical information or documentation, to include city, county and state accident or incident reports about the patient to release such information to Supplier, its billing agents, CMS, its carriers and agents and/or any other payers or insurers as may be appropriate to determine any benefits payable for these or any other medical services provided to the patient by Supplier now or in the future; (4) requests that payment of authorized Medicare, Medicaid or any other insurance benefits be made on the patient's behalf directly to Supplier for any medical services provided to the patient by Supplier now or in the future, and, to the extent permitted, assigns all rights to (and related or associated with) such payments to Supplier, including but not limited to the right to file appeals, grievances, complaints, litigation, or arbitration relating to a claim for payment, as well as all rights to recover expenses or fees incurred for pursuing the claim and all rights, statutory or contractual, to any additional recovery such as treble damages, punitive damages, or penalties; (5) authorizes any law firm appointed by Supplier to file the appeals, grievances, complaints, litigation, or arbitration referred to in point (4);		
(6) agrees that the patient is financially responsible for, and obligated to pay, the amount charged by Supplier for the medical services, including any amount that is not paid by any applicable insurance (unless Supplier is a contracted network provider for such applicable insurance, in which case any applicable co-pay, coinsurance, or deductible is owed); (7) agrees to use his/her best efforts to cooperate with, and to assist, Supplier in receiving payment in full for the medical services rendered to patient, including immediately remitting to Supplier any payments received directly from an insurer or any source whatsoever for the medical services provided to the patient by Supplier; (8) designates Supplier to act as patient's "authorized representative" under 29 C.F.R. §2560.503-1(b)(4) and the Employee Retirement Income Security Act of 1974 (and any other applicable statutory or common law, rule or regulation), with respect to all aspects of patient's claim (Claim) for benefits under any applicable benefit or welfare plan for payment of the medical services rendered to patient by Supplier; directs patient's benefit or welfare plan and those who administer it, or those who communicate with participants and beneficiaries regarding claims for benefits, to communicate directly with Supplier regarding the Claim and payment of benefits relating to the Claim; and agrees that, as an integral part of pursuing the Claim (or an appeal of an adverse benefit determination) to its conclusion, Supplier shall receive any and all original information and notices, including without limitation checks or other forms of payment which are made to or on behalf of patient, or to which patient is entitled, with respect to the Claim (only copies may be sent to patient); (9) agrees that Supplier is not liable for any personal items that are lost or damaged during patient transport;		
(10) agrees that if collection proceedings take place, all Supplier legal costs (including attorney fees) are the responsibility of the patient; (11) agrees that the provisions of this agreement are severable; and (12) agrees that a copy of this document is valid as an original for all purposes.		

Authorization to Contact

Question	Answer	Notes
You may be contacted to obtain information to facilitate the billing process for your transport. I expressly authorize above, its related corporate entities, associates, agents, servicers, debt collectors and independent contractors, to contact me or any responsible party at any telephone number (including numbers assigned to any paging, cellular, or mobile service, or any service which charges for the call) mailing address, e-mail address, or any other electronic address used by, or associated with, me or any responsible party and obtained through any source (including any telephone number I, any responsible party, or any party accompanying me at the time of service, have provided previously or may provide in the future) for the purpose of resolving any unpaid balances or any other pertinent issues regarding this account.		
I expressly agree any such contact by above Company, its related corporate entities, associates, agents, servicers, debt collectors and independent contractors, may be through any means (including a dialer, automatic telephone dialing system, predictive dialer, interactive voice recognition system, pre-recorded or artificial voice, pre-set email messages, or any pre-set electronic messages delivered by any other electronic messaging or text messaging system). Patient or Guarantor agrees and acknowledges any e-mail address or any other electronic address Patient or Guarantor provides to above Company is Patient's or Guarantor's private address, is not owned or furnished by their employer and cannot be accessed by unauthorized third parties.		

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE:

Question	Answer	Notes
Complete this section only if the patient is physically or mentally incapable of signing.		
Of the choices below, explain the circumstances that make it impractical for the patient to sign:	Respiratory arrest, distress, or intubated	
AUTHORIZED REPRESENTATIVE SIGNATURE:	I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid or any other payor for any services provided to the patient by Supplier (named above) now or in the past (or in the future, where permitted). By signing below, I acknowledge that I am one of the authorized signers listed below. Unless I am the legal guardian as indicated below, my signature is not an acceptance of financial responsibility for the services rendered. [redacted]	
Printed Name of Authorized Representative	[redacted] (Spouse)	
Authorized representatives include only the following individuals:	Relative or other person who arranges for the patient's treatment or exercise other responsibility for the patient's affairs	