No. 26-11607

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

AETNA HEALTH INC., AETNA HEALTH INSURANCE COMPANY,
AETNA LIFE INSURANCE COMPANY,

Plaintiffs-Appellants,

v.

RADIOLOGY PARTNERS, INC., MORI, BEAN AND BROOKS, INC.,

Defendants-Appellees.

On Appeal from the United States District Court
for the Middle District of Florida, No. 3:24-cv-01343-BJD-LLL
Hon. Brian J. Davis, U.S. District Judge

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September 16, 2026

AMENDED CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT*

In accordance with 11th Cir. Rule 26.1-1(a), the following is a list of all known trial judges, attorneys, persons, associations of persons, firms, partnerships, or corporations with an interest in the outcome of this case or appeal:

1. Aetna Health Holdings, LLC (Parent company of Appellant Aetna Health Inc.)
2. Aetna Health Inc. (Appellant)
3. Aetna Health Insurance Company (Appellant)
4. Aetna Inc. (Parent company of Aetna Health Holdings, LLC and Appellants Aetna Life Insurance Company and Aetna Health Insurance Company)
5. Aetna Life Insurance Company (Appellant)
6. Brinkmann, Sara (Counsel for Appellees)
7. Bronson, Ardith (Appellate Counsel for Appellants)
8. Chaifetz, Samantha (Appellate Counsel for Appellants)
9. CVS Pharmacy, Inc. (Parent company of Aetna Inc.)
10. CVS Health Corporation (CVS) (Parent company of CVS Pharmacy, Inc.)
11. Davis, Hon. Brian J. (U.S. District Judge)

* The entry marked by an asterisk in this amended certificate contains a typographical correction.

12. DLA Piper LLP (US) (Appellate Counsel for Appellants)
13. Gokey, Charles (District Court Counsel for Appellants)
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15. Jew, Christopher (Counsel for Appellees)
16. Kavanaugh, Samantha (Counsel for Appellees)
17. King and Spalding LLP (Counsel for Appellees)
18. Lambert, Hon. Laura Lothman (U.S. Magistrate Judge)
19. McGrath, Colin (District Court Counsel for Appellants)
20. Mezzina, Paul Alessio (Counsel for Appellees)
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23. Moore, Nathaniel (District Court Counsel for Appellants)
24. Mori, Bean and Brooks, Inc. (Appellee)
25. Nelson, Kyle (District Court Counsel for Appellants)
26. Radiology Partners, Inc. (Appellee)
27. Robins Kaplan, LLP (District Court Counsel for Appellants)*
28. Solomon, Glenn (Counsel for Appellees)
29. Thompson, Michael (Counsel for Appellees)
30. Weller, Paul (District Court Counsel for Appellants)

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1(a), appellees make the following disclosures: Appellee Mori, Bean and Brooks, Inc. is a wholly owned subsidiary of appellee Radiology Partners, Inc., which is a wholly owned subsidiary of Radiology Partners Midco II, Inc., which is a wholly owned subsidiary of Radiology Partners Midco I, Inc., which is a wholly owned subsidiary of Radiology Partners Holdings, LLC. No publicly held corporation owns 10% or more of Radiology Partners Holdings, LLC.

Date: September 16, 2026

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STATEMENT REGARDING ORAL ARGUMENT

Appellees believe oral argument may aid the Court in resolving this appeal and respectfully request the opportunity to present oral argument.

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Rules

Other Authorities

INTRODUCTION

This appeal arises from Aetna's attempt to use unfounded fraud claims to claw back payments it made to healthcare providers. As the district court correctly held, Aetna's suit is barred by the No Surprises Act ("NSA"), a federal statute that comprehensively governs payment disputes like this one. The NSA requires insurance companies like Aetna to promptly pay or deny medical bills, and it gives the parties the right to have any payment disputes—including disputes over whether the services at issue are within the NSA's scope—resolved in binding arbitration. Aetna's fraud claims concern issues that could and should have been addressed in that federal process, except that Aetna chose not to raise them.

The particular dispute here grew out of Aetna's longstanding objections to Radiology Partners' legitimate business practices. Mori, Bean and Brooks, Inc. ("MBB") is a Florida radiology group that Radiology Partners acquired in 2018. Radiology Partners also acquired other radiology groups in Florida.[1] Over time, the other groups' hospital

[1] Except where otherwise specified, references in this brief to MBB and other "radiology groups" refer to distinct legal entities rather than internal operating divisions.

staffing contracts were transferred or assigned to MBB with the hospitals' consent; the other groups' physicians entered into employment or contracting agreements with MBB; and MBB appropriately started billing Aetna for services MBB rendered through those physicians, which it had every right to do.

Aetna contends—with zero factual support—that MBB was committing fraud by billing for services performed by physicians who Aetna wrongly asserts were not genuinely affiliated with MBB. Based on that assertion, Aetna seeks to vacate tens of thousands of federal arbitral awards that MBB received under the No Surprises Act. Aetna also seeks to recover payments it made under the Act and that MBB did not contest by invoking its arbitration rights under the NSA. The district court dismissed all of Aetna's claims. This Court should affirm for three reasons:

First, Aetna failed to plead a viable basis for vacating the arbitral awards. "Judicial review of arbitration decisions is among the narrowest known to the law." *Gherardi v. Citigroup Glob. Mkts. Inc.*, 975 F.3d 1232, 1236–37 (11th Cir. 2020) (quotation marks omitted). Aetna says the awards were procured by fraud, but its pleadings make clear that the

supposed fraud was known or could have been discovered through the exercise of due diligence before or during the arbitrations. Aetna, a sophisticated health insurer, had already terminated its contract with MBB based on what it considered red flags in MBB's billing before all the bills at issue in this lawsuit. Aetna also had many opportunities to raise its concerns and obtain more information about MBB's bills, but it never did so. Aetna also says the arbitrators exceeded their powers by resolving disputes that were not eligible for arbitration. But the NSA makes eligibility an issue for the arbitrators, who acted well within their powers by deciding, based on the undisputed evidence before them, that MBB's bills were eligible.

Second, Aetna's attempt to recoup payments it made on bills subject to the No Surprises Act without MBB invoking arbitration is an impermissible end-run around the Act. The statute set deadlines for Aetna to pay or dispute MBB's bills, and it gave MBB the right to submit any disputes—including the type of eligibility dispute Aetna raises in this litigation—to binding arbitration. Allowing an insurer to pay a provider's bill under the Act, wait until the provider's deadline to invoke arbitration

has expired, and then sue to recover the payment would nullify the Act's carefully designed scheme for resolving disputes like this one.

Third, this Court can also affirm on the ground that Aetna failed to plead fraud with the particularity Rule 9(b) requires. Aetna's operative complaint mentions six supposedly fraudulent medical bills submitted by MBB. But under Aetna's theory, those bills were false *only* if MBB did not have an employment or other contractual relationship with the physicians who performed the services. So to plead fraud with particularity, Aetna needed to allege facts showing that the physicians were not actually MBB employees or contractors when providing those services. Aetna's allegations on that score are wholly conclusory. Nowhere does Aetna allege that any of the physicians lacked employment or other contractual agreements with MBB. And while it insinuates—in a single paragraph of the complaint—that any agreements that existed were not genuine, it offers no specific facts to support that bald assertion. This is exactly the type of conjecture Rule 9(b) prohibits.

This Court should affirm.

JURISDICTION

The district court had jurisdiction under 28 U.S.C. § 1331 and 28 U.S.C. § 1367. The district court dismissed Aetna's amended complaint with prejudice on April 16, 2026. Dkt. 105. Aetna timely appealed that final judgment on May 6, 2026. Dkt. 109. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether Aetna's vacatur claim is barred because Aetna's own pleadings show that the alleged fraud was known or discoverable and the arbitrators did not exceed their delegated authority.

2. Whether Aetna's remaining claims are preempted or barred by the NSA because they represent an impermissible attempt to circumvent the NSA's dispute-resolution scheme.

3. Whether Aetna failed to plead fraud with particularity where it alleged no specific facts to support its conclusory assertion that the physicians lacked an employment or other contractual relationship with MBB for the services at issue.

STATEMENT OF THE CASE

A. Billing for Hospital-Based Radiology

Radiology is a critical hospital specialty. As a condition of participation in federal healthcare programs, hospitals are required to maintain or have available radiologic services. 42 C.F.R. § 482.26.

To meet that obligation, hospitals routinely enter into exclusive staffing contracts with outside radiology groups. Courts have long recognized the propriety of such arrangements. *See, e.g.*, *J. Sternberg, S. Schulman & Assocs., M.D., P.A. v. Hosp. Corp.*, 571 So. 2d 1334, 1335 (Fla. 4th DCA 1989) (affirming denial of injunction where hospital solicited competitive bids and awarded exclusive radiology contract to a single group); *Radiology Pro. Corp. v. Trinidad Area Health Ass'n*, 577 P.2d 748, 751–52 (Colo. 1978) (discussing common practice of hospitals entering into exclusive staffing contracts with external radiology groups).

Under these staffing arrangements, the hospital provides the "technical component" of the service (a scan using imaging equipment such as a PET, CT, or MRI machine), and the radiology group supplies the "professional component" (the physicians who read and interpret the images). *See, e.g.*, *Aurora Med. Imaging LLC v. Allstate Ins. Co.*, 2014 WL 12703635, at *1 n.2 (N.D. Fla. Oct. 6, 2014). Because the professional

component requires only the images and not the patient's physical presence, radiologists commonly read scans remotely and may interpret images for more than one hospital. *See, e.g.*, CMS, Medicare Claims Processing Manual, ch. 13, § 150(A) (2015) (recognizing that some radiology services "do not require a face-to-face encounter with the patient" and allowing radiologists to provide "interpretation of a diagnostic test[] from a distant site").

Once a hospital enters into a staffing contract with a radiology group, the group that holds the staffing contract provides the physician services and bills the patient's insurance company for those services under its own name and Tax Identification Number ("TIN"). A TIN is a unique identification number that allows the insurer to identify the provider billing for the service. As Aetna acknowledges, "medical groups have their own TINs," and Aetna uses "the TIN billed by providers to identify the medical group that performed the services." Dkt. 80 ¶¶ 58, 193.

This billing structure creates a financial risk for patients. Because the technical and professional components of radiology services are billed separately, an insurance company like Aetna may contract with a

hospital but not with the radiology group that staffs it. As a result, a patient may receive a scan at an in-network hospital, only for the scan to be interpreted by an out-of-network radiology group. Insurers like Aetna have typically covered a larger share of the cost for in-network services than for out-of-network services. This difference historically left patients responsible for the out-of-network balance. *See AMISUB (SFH), Inc. v. Cigna Health & Life Ins. Co.*, 142 F.4th 403, 405 (6th Cir. 2025).

B. The No Surprises Act

To protect patients from unexpected out-of-network bills, Congress enacted the No Surprises Act. *See* Pub. L. No. 116-260, div. BB, tit. 1, 134 Stat. 1182, 2758 (2020) (codified at 42 U.S.C. § 300gg-111 *et seq.*). Through the NSA, Congress sought to protect patients from surprise medical bills, such as those that occur in emergencies and when a patient "choose[s] a participating [*i.e.*, in-network] facility" but does "not know that at least one provider involved in their care (for example, an anesthesiologist or radiologist) is a nonparticipating [*i.e.*, out-of-network] provider." Requirements Related to Surprise Billing, Part I, 86 Fed. Reg. 36872, 36874 (July 13, 2021).

The NSA "prohibits out-of-network health care providers from billing [insured patients] directly for certain items or services" and requires insurers and providers to address billing and payment between themselves. *Neurological Surgery Prac. of Long Island, PLLC v. HHS*, 145 F.4th 212, 219 (2d Cir. 2025) (quotation marks omitted); *see* 42 U.S.C. §§ 300gg-131, 300gg-132. The NSA also creates a detailed, comprehensive statutory scheme for determining how much the insurer ultimately should pay the out-of-network provider. *See generally* 42 U.S.C. § 300gg-111; 45 C.F.R. § 149.510 (2024) (HHS's implementing regulation).[2] That statutory scheme includes a series of specific "deadlines for various steps in the process" that begins the moment a covered bill is submitted. *Neurological Surgery*, 145 F.4th at 219.[3]

[2] The implementing regulation, 45 C.F.R. § 149.510, has been amended several times. We cite the January 2024 version because that version was in effect when Aetna filed its original complaint in this case. All provisions of the regulation relevant to this appeal were in effect throughout the period covered by Aetna's lawsuit (from July 2022 through December 2024).

[3] The NSA uses both "bill" and "claim" to refer to a provider's submission seeking payment for services. To avoid confusion with Aetna's causes of action in this lawsuit, we use "bills" to refer to providers' submissions seeking payment and reserve "claims" for Aetna's legal claims asserted in the lawsuit.

Initial Payment or Denial. The provider kicks off the process by submitting a bill for payment to the patient's insurer. The NSA gives the insurer 30 calendar days to either deny payment or provide an initial payment. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I), (b)(1)(C). During this 30-day period, the insurer is expected to "communicate with [the] provider[] to obtain the information [the insurer] needs … to determine whether the services are subject to the protections of the No Surprises Act." HHS et al., Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties 10 n.8 (2023) ("IDR Guidance").

Open Negotiation Period. If the parties disagree on the amount of payment due, either party may initiate an "open negotiation" period, which runs for 30 business days and allows the parties to continue their discussions. This period also gives the insurer additional time to investigate the bill and to request any information it needs from the provider to determine if the bill is properly subject to the NSA. *See* 42 U.S.C. § 300gg-111(c)(1)(A); 45 C.F.R. § 149.510(b)(1)(i) (2024).

Independent Dispute Resolution. If negotiations during the open negotiation period fail, either party has four business days to initiate the NSA's independent dispute resolution ("IDR") process.

42 U.S.C. § 300gg-111(c)(1)(B); 45 C.F.R. § 149.510(b)(2)(i) (2024). If the non-initiating party "believes that the Federal IDR process is not applicable," it "must" raise that issue and "provide information regarding the Federal IDR process's inapplicability." 45 C.F.R. § 149.510(c)(1)(iii)–(iv) (2024).

The dispute is then submitted to a "third-party arbitrator" (which the statute calls an "IDR entity") that is either agreed on by the parties or selected by the Secretary. *Neurological Surgery*, 145 F.4th at 219; *see* 42 U.S.C. § 300gg-111(c)(4)(F); 45 C.F.R. § 149.510(c)(1) (2024). Once selected, the arbitrator reviews the information submitted by the parties, and any additional information the arbitrator requests, to "determine whether the Federal IDR process applies." 45 C.F.R. § 149.510(c)(1)(v) (2024); *see* Requirements Related to Surprise Billing, Part II, 86 Fed. Reg. 55980, 55992 (Oct. 7, 2021). If the arbitrator determines that the process does not apply, it will "notify the Secretary and the parties within 3 business days." 45 C.F.R. § 149.510(c)(1)(v) (2024). Roughly 40% of IDR arbitrations involve a challenge to whether the dispute is IDR-eligible, and roughly 17% are closed because the arbitrator determines that the

dispute is ineligible. Federal Independent Dispute Resolution Operations, 91 Fed. Reg. 33900, 33923 & n.70 (June 4, 2026).[4]

Only if the IDR arbitrator determines that the dispute is IDR-eligible (meaning, among other things, the provider was out-of-network when it provided the service) will the arbitrator proceed to the next step: determining how much the insurer should pay the provider for the service using "baseball-style arbitration." *Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc.*, 160 F.4th 1110, 1116 (11th Cir. 2025). Each party has ten business days to submit its best and final offer, and the arbitrator has 30 business days to select one of the two offers. 42 U.S.C. § 300gg-111(c)(5)(A)–(B); 45 C.F.R. § 149.510(c)(4)(i)–(ii) (2024). The insurer must pay the provider the amount awarded by the arbitrator within 30 days. 42 U.S.C. § 300gg-111(c)(6).

[4] Recent amendments reaffirm that the arbitrator must "make a final determination" as to whether the service at issue "is a qualified IDR … service … that is eligible for the Federal IDR process." 45 C.F.R. § 149.510(c)(2) (effective Aug. 31, 2026). The regulatory preamble makes clear that such "eligibility reviews" were already required under prior versions of the regulation and that the recent amendments "are intended to facilitate more efficient processing of" those reviews. 91 Fed. Reg. at 33941–42.

Judicial Review. As with other arbitration awards, judicial review of an IDR decision is extremely limited. Congress provided that an arbitrator's decision in an IDR proceeding "shall not be subject to judicial review" except on the same limited grounds on which a court can vacate an arbitral award under the Federal Arbitration Act ("FAA"). *Id.* § 300gg-111(c)(5)(E) (cross-referencing 9 U.S.C. § 10(a)).

C. Radiology Partners and Mori, Bean and Brooks

Since its formation in 2012, Dkt. 80 ¶ 38, Radiology Partners has grown into one of the leading physician-led radiology practices in the United States. Radiology Partners and its affiliates employ more than 3,900 radiologists at 3,400 sites across all 50 states and handle more than 10% of the country's imaging volume. *Id.* ¶ 39.

Radiology Partners' growth has been fueled by its acquisition of outstanding radiology groups across the country. *Id.* ¶¶ 4, 46. By bringing these groups together under a common platform, Radiology Partners is able to provide them with centralized financial and administrative support, including "clerical and administrative personnel, accounting services, billing and collection, provision of medical and office supplies, maintenance of medical records, IT support, and advertising, marketing,

and promotional activities." *Id.* ¶ 52 (quotation marks omitted). While Aetna strains to imply that this business model is somehow sinister, the truth is that Radiology Partners' model is both legal and commonly used in the healthcare industry, and it enables doctors to deliver quality care to patients more efficiently and effectively. More hospitals now choose to staff radiology using groups affiliated with Radiology Partners than any other radiology company in the country.

Mori, Bean and Brooks, Inc. is a Florida corporation and radiology group originally based in Jacksonville, Florida. *Id.* ¶¶ 21, 47. For over a decade, MBB provided radiology services to hospitals in and around Jacksonville, including as an in-network provider with Aetna. *Id.* ¶¶ 47–48, 53. Radiology Partners acquired MBB in September 2018, a transaction that was well publicized. *Id.* ¶ 49.[5] Radiology Partners also

[5] The press release announcing the MBB acquisition was picked up by several industry publications. *E.g.*, *Radiology Partners Expands in Fla.*, AuntMinnie.com (Oct. 2, 2018), https://tinyurl.com/4dycydcn; Michael Walter, *Radiology Partners Announces Partnership with Jacksonville-based Mori, Bean & Brooks*, Radiology Bus. (Oct. 3, 2018), https://tinyurl.com/3wfr4pt2; *Radiology Partners Continues Growth in Florida Through Partnership with Mori, Bean & Brooks*, DOTmed.com (Oct. 4, 2018), https://www.dotmed.com/news/story/44680. MBB also publicly amended its articles of incorporation to indicate that its new President/CEO was Steve Tumbarello, a Radiology Partners officer. Articles of Amendment, Doc. No. 600545, Mori, Bean and Brooks, Inc.,

acquired several other Florida radiology groups that had in-network contracts with Aetna, including Radiology Associates of South Florida and Radiology Associates of Tampa. *Id.* ¶¶ 4, 63–65, 92–94.

When Radiology Partners acquires a Florida radiology group, the group's physicians continue treating patients at the same hospitals as before, and for a time the group continues billing insurers like Aetna under the original group's existing TIN. *See, e.g.*, *id.* ¶¶ 65–67 (alleging that physicians employed by Radiology Associates of South Florida were billed under that group's TIN for more than three years following its acquisition); *id.* ¶ 94 (alleging that physicians employed by Radiology Associates of Tampa were billed under that group's TIN for more than a year following its acquisition).

Over time, however, Radiology Partners and MBB work with those groups and the hospitals they serve to have the other groups' hospital staffing contracts assigned or transferred to MBB. Once MBB obtains the hospital contracts, the radiologists who staff those hospitals enter into employment or other contracting agreements with MBB, after which

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Fla. Dep't of State, Div. of Corps. (filed Oct. 16, 2018), *available at* Sunbiz.org, https://tinyurl.com/y8skpx44.

MBB begins to bill for their services using MBB's TIN. *See id.* ¶¶ 67, 94, 180. To promote continuity for hospitals, referring physicians, and patients, the transitioned radiologists operate as a division of MBB under similar branding to that used by the radiologists' former employers. *Id.* ¶ 184.

There is nothing improper about any of this. To be sure, Aetna uses scare quotes to imply that the radiologists' employment agreements with MBB are fraudulent and only "make it appear as though [the physicians] are 'employed' by MBB." *Id.* ¶ 180. Similarly, Aetna alleges that it is "illogical" for the radiologists to continue using similar branding and call themselves "divisions" of MBB, *id.* ¶¶ 184–85 (cleaned up)—as if branding continuity were unusual when one company buys another. But Aetna's allegations do not support its sweeping fraud accusations. And Aetna is well aware of the truth, as explained below. Aetna does not like Radiology Partners' business model because it has the potential to result in Aetna paying higher rates for radiology services. But Aetna's desire to underpay radiologists does not make that model fraudulent.

D. Aetna's Campaign Against Radiology Partners

Aetna has long sought to eliminate the legitimate integration and billing practices used by Radiology Partners' affiliates, and the parties' contentious history—predating this lawsuit by years—leaves no doubt that Aetna is fully aware of those practices.

Aetna Accuses Radiology Partners of Fraud in Texas. In early 2022, Aetna raised the same fraud theories against Radiology Partners and another affiliated medical group in a Texas arbitration. Radiology Partners and MBB asked the district court here to take judicial notice of certain documents from that arbitration, which reflect Aetna's prior knowledge of the same business model challenged in this suit. Dkt. 29. Aetna objected but did not dispute the documents' authenticity. Dkt. 49. While the district court never ruled on the request, this Court can and should take judicial notice of these materials—not for the truth of any facts stated therein, but only to establish Aetna's prior knowledge long before this lawsuit. *See* Fed. R. Evid. 201.[6]

[6] *See, e.g.*, *Tandian v. State Univ. of N.Y.*, 698 F. Supp. 3d 425, 437 (N.D.N.Y. 2023) ("[T]he Court may take judicial notice of an arbitrator's decision in a prior proceeding but may do so only to establish the existence of the opinion, not for the truth of the facts asserted in the opinion." (quotation marks omitted)); *Rasha v. BellSouth Telecomms.,*

For example, Aetna alleged that Radiology Partners and its Houston-based affiliate, Singleton Associates, P.A., had "scheme[d] to defraud Aetna … by submitting medical claims under Singleton's TIN when, in fact, the radiology services were provided by physicians who were employed by other Radiology Partners subsidiaries operating under different TINs and in different markets outside of Houston." Dkt. 29-6 ¶ 170. Aetna further alleged it had "uncovered this misconduct" in 2020. *Id.* ¶ 1; *see also* Dkt. 29-7 at 1–2. Aetna also alleged that Radiology Partners had "acquired other group radiology practices … all over the country" that it was managing "in the same or in a similar manner." Dkt. 29-6 ¶ 51.

Aetna Terminates MBB's Contract in Florida. At the same time Aetna was alleging fraud by Radiology Partners and Singleton in Texas, Aetna alleges it became aware of similar billing patterns in Florida. Specifically, Aetna alleges that "[b]y 2022, MBB was submitting significantly more claims to Aetna than it had historically." Dkt. 80 ¶ 6.

Inc., 2009 WL 10697350, at *3 n.5 (N.D. Ga. Apr. 17, 2009) (Carnes, C.J.) ("[T]his Court may take judicial notice of plaintiff's prior statements because the Court is noticing them for a non-hearsay reason: to show plaintiff's awareness of, or belief in, certain factual assertions, not the truth of those assertions.").

Aetna also alleges that the number of physicians billing under MBB's TIN grew sharply, from "approximately 50" to "more than 1,000," *id.* ¶¶ 54–56 (emphasis omitted), and that it "noticed" that many of those physicians were located "outside the Jacksonville area," *id.* ¶ 172. Aetna alleges it inquired about MBB's new billing patterns, including asking whether MBB had "been acquired." *Id.* ¶ 175 (quotation marks omitted). Aetna further alleges that when it was unsatisfied with MBB's responses, Aetna terminated MBB's in-network contract in July 2022. *Id.* ¶¶ 6, 59, 172–76.

After Aetna terminated the contract, MBB became an out-of-network provider for Aetna. *Id.* ¶ 6. MBB continued submitting bills using its TIN for services provided by radiologists who had been hired or otherwise contracted by MBB from other Florida groups, just as MBB had done before the termination. *Id.* ¶¶ 8, 59. The only difference was that, because of the contract termination, MBB's bills were now out-of-network bills. That meant Aetna had to pay or deny those bills within 30 days under the NSA. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I), (b)(1)(C).

At times, MBB invoked the NSA's dispute-resolution process to contest Aetna's initial payment decision—first initiating 30 days of open

negotiation, and when that failed to resolve the parties' disagreement, submitting the dispute to binding arbitration. Dkt. 80 ¶¶ 11, 119. Aetna alleges that MBB submitted "tens of thousands" of disputes to arbitration under the NSA's IDR process. *Id.* ¶ 11. Each time, as the NSA requires, MBB attested that the service at issue was "within the scope of the Federal IDR process." *Id.* ¶¶ 105–07, 117 (quotation marks omitted).

Despite having terminated MBB's contract over what it considered suspicious billing patterns—and despite having alleged fraud in Texas based on similar billing patterns—Aetna does not allege that it ever used any of its rights under the NSA process to dispute or even investigate the propriety of MBB's bills. That was not for lack of opportunity. As explained above, Aetna had many chances to request more information about MBB's bills before and during the NSA's open negotiation period. Aetna also could have disputed the bills' out-of-network status before the IDR arbitrator, who then could have requested additional information from MBB if necessary to resolve the dispute. *See* pp. 9–12, *supra*. Yet Aetna does not allege it did any of this.

As Aetna admitted, MBB prevailed in the vast majority of its NSA arbitrations involving Aetna, as the independent arbitrators valued the

radiology services at issue above Aetna's initial payments. Dkt. 80 ¶¶ 69–71, 128–31, 167. MBB's high success rate makes it "highly plausible to infer that [Aetna] engages in a consistent practice of submitting lowball offers to out-of-network providers in an effort to maximize its profits." *Blue Cross Blue Shield Healthcare Plan of Ga., Inc. v. HaloMD, Inc.* (*Blue Cross Ga.*), 2026 WL 2017291, at *23 (N.D. Ga. July 10, 2026), *appeal docketed*, No. 26-12777 (11th Cir. Aug. 6, 2026); *see also Texas Med. Ass'n v. HHS*, --- F.4th ---, 2026 WL 2322331, at *3 (5th Cir. Aug. 11, 2026) (per curiam) (concluding that insurers' offers on bills subject to the NSA "were artificially low").

The Texas Arbitrator Rejects Aetna's Fraud Claims. In May 2023, the arbitrator presiding over the Texas dispute rejected Aetna's claim that Radiology Partners and Singleton "committed fraud by submitting claims under [Singleton]'s TIN, rather than the TIN for other entities." Dkt. 29-3 at 34. The arbitrator determined that there was "nothing inherently improper" about Singleton using its TIN to bill for services it provided pursuant to its staffing contracts with hospitals, whether the physicians who provided those services were Singleton employees or contractors "provided by another group or entity." *Id.* at 35–

37. The arbitrator also determined that (as is equally true here) Aetna had access to all the information it needed to determine "whether [Singleton] was the appropriate billing provider" and thus could not prove reliance. *Id.* at 37–39.[7]

Aetna Sues Radiology Partners and MBB in Florida. Aetna filed its original complaint in this case on December 23, 2024. That was almost three years after Aetna accused Radiology Partners in the Texas arbitration of committing fraud similarly "all over the country," and two-and-a-half years after Aetna terminated MBB's contract in Florida because of the same purportedly suspicious billing patterns at issue here.

After Radiology Partners and MBB moved to dismiss, the district court struck Aetna's initial complaint, Dkt. 79, and Aetna filed the operative first amended complaint. Dkt. 80. That complaint alleges that after Aetna terminated MBB's contract in July 2022, MBB committed fraud by "continu[ing]" to bill Aetna under MBB's TIN for services provided by physicians formerly associated with other radiology groups.

[7] The Texas arbitrator also ruled that both sides had breached the contract between them in certain respects. Dkt. 29-3 at 29–30. Those rulings are not relevant here, as the operative complaint pertains only to non-contracted services.

Id. ¶¶ 6–8, 126, 140, 153. Aetna asked the court to vacate the IDR arbitration awards obtained by MBB, alleging that the awards were procured by fraud and that the arbitrators exceeded their powers. *Id.* ¶¶ 251–66 (count 6). Aetna also brought supplemental state-law claims for fraud, negligent misrepresentation, civil conspiracy, unjust enrichment, and violation of the Florida Deceptive and Unfair Trade Practices Act ("FDUTPA"). *Id.* ¶¶ 188–250 (counts 1–5). Finally, Aetna asked the court to declare that MBB's billing practices were unlawful and resulted in overpayments and to permanently enjoin those practices. *Id.* ¶¶ 267–86 (counts 7–8). Defendants once again moved to dismiss. Dkt. 84.

The District Court Dismisses Aetna's Complaint. On April 16, 2026, the district court dismissed Aetna's complaint with prejudice. Dkt. 105 at 10. The court held that the complaint did not allege a sufficient basis for vacating the IDR awards because the alleged fraud "was discoverable upon the exercise of due diligence prior to or during arbitration." *Id.* at 8. Noting Aetna's "admission" that it was aware of MBB's supposedly improper billing patterns leading to the contract termination, the court held that Aetna's other allegations did not "excuse

[its] failure to raise the issue in the IDR disputes." *Id.* at 8–9. The court also held that Aetna's remaining claims were all preempted or barred by the NSA because they were "attempt[s] to end-around the NSA and FAA strictures" that "would have the same effect as discarding the administrative process established by Congress." *Id.* at 9.

STANDARD OF REVIEW

This Court reviews the dismissal of a complaint for failure to state a claim *de novo*, taking as true the well-pleaded factual allegations, but giving no effect to legal conclusions couched as factual allegations. *Wainberg v. Mellichamp*, 93 F.4th 1221, 1224 (11th Cir. 2024) (per curiam).

SUMMARY OF ARGUMENT

I. Both of Aetna's asserted grounds for NSA vacatur fail. *First*, the alleged fraud was known or discoverable through the exercise of due diligence before or during the IDR arbitrations. Aetna's own pleadings show that it possessed the data identifying who was billing under MBB's TIN, noticed the increase in billing volume, investigated it, and terminated MBB's in-network contract because of that pattern, all months before the IDR arbitrations at issue. And the thousands of IDR arbitrations gave Aetna thousands of opportunities to raise its concerns

or request more information about the bills, but Aetna never did so. *Second*, the arbitrators did not exceed their statutory authority. Aetna never challenged eligibility before the arbitrators and thus forfeited that challenge. And in any event, the NSA delegates eligibility determinations to the arbitrators, who do not exceed their authority by deciding that issue based on the undisputed evidence before them.

II. Aetna's remaining claims are likewise barred. Aetna's state-law claims are preempted because they conflict with the NSA's reticulated scheme for resolving payment disputes and would deprive MBB of its federal arbitration rights. And Aetna's claims seeking declaratory and injunctive relief fail because, as many courts have held, they seek to evade the NSA's strict limitations on judicial review of IDR determinations. In addition, Aetna's awareness of the billing patterns it now alleges as fraud makes its state-law claims untenable.

III. This Court can also affirm on the ground that Aetna failed to plead fraud with particularity. Aetna's entire theory of fraud rests on its assertion that physicians who billed under MBB's TIN were not actually employees or contractors of MBB. But Aetna admits it has no direct or actual knowledge of the physicians' employment or other contractual

arrangements, and its allegation on information and belief that the physicians were not supervised or controlled by MBB is conclusory. The discovery responses Aetna cites are irrelevant to whether the doctor in question was an MBB employee or contractor when he performed the services at issue. And Aetna cannot fill the gap with innuendo based on websites and LinkedIn pages that reflect public marketing but say nothing about MBB's actual legal relationships with the physicians.

IV. The district court did not abuse its discretion by dismissing the complaint with prejudice because Aetna never filed a proper request for leave to amend and has never identified any additional facts it could plead that would cure the deficiencies in its complaint.

ARGUMENT

I. Aetna failed to plead a basis for vacatur of the IDR awards.

Aetna's challenge to the IDR arbitration awards is subject to the same restrictive standards that apply when a party seeks to vacate an arbitral award under the Federal Arbitration Act. 42 U.S.C. § 300gg-111(c)(5)(E); *Reach Air*, 160 F.4th at 1118–19; *see also Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 275 (5th Cir. 2025) ("The NSA expressly *bars* judicial review of IDR awards *except* as to the specific provisions borrowed from the FAA …."). Under both the NSA and the

FAA, this Court "review[s] arbitration decisions very narrowly, and there is a strong legal presumption that arbitration awards will be confirmed." *Reach Air*, 160 F.4th at 1115.

Here, Aetna sought to erase "tens of thousands" of arbitral awards issued between July 2022 and December 2024 in one fell swoop. Dkt. 80 ¶ 161. Aetna alleged two grounds for vacatur: that the awards were "procured by … fraud" and that "the arbitrators exceeded their powers." 9 U.S.C. § 10(a)(1), (4); *see* Dkt. 80 ¶¶ 257, 262. The district court correctly held that Aetna did not plead a sufficient basis to support vacatur on either ground.

A. The alleged fraud was known or discoverable.

This Court applies a three-part test to determine whether an arbitral award should be vacated due to fraud: "(1) The movant must establish the fraud by clear and convincing evidence; (2) the fraud must not have been discoverable upon the exercise of due diligence prior to or during the arbitration; and (3) the person seeking to vacate the award must demonstrate that the fraud materially related to an issue in the arbitration." *Reach Air*, 160 F.4th at 1121 (cleaned up) (quoting *Bonar v. Dean Witter Reynolds, Inc.*, 835 F.2d 1378, 1383 (11th Cir. 1988)).

The district court correctly held that Aetna's pleadings foreclose that showing. Aetna's own admissions establish that the "fraud" it alleges was known or easily could have been discovered through the exercise of due diligence prior to or during the IDR proceedings. *See Morgan Keegan & Co. v. Garrett*, 495 F. App'x 443, 447 (5th Cir. 2012) (per curiam) (denying vacatur where "the grounds for fraud were discoverable by due diligence before or during the … arbitration"). The non-discoverability requirement is crucial to preserving the finality of arbitral awards. Without it, a party could sit on its rights during arbitration and then file a lawsuit raising issues that could and should have been resolved in arbitration.[8]

With respect to the non-discoverability requirement, Aetna pleaded itself out of court in at least three ways:

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[8] Aetna contends (at 23–24) that Rule 9(b)'s requirement of pleading with particularity applies only to the existence of the fraud and not to whether the fraud could have been discovered by due diligence. That is both incorrect and irrelevant. It is incorrect because non-discoverability is part of the "circumstances constituting fraud" under section 10(a). Fed. R. Civ. P. 9(b); *cf. Oregon Pub. Emps. Ret. Fund v. Apollo Grp. Inc.*, 774 F.3d 598, 605 (9th Cir. 2014) ("Loss causation is part of the 'circumstances' constituting fraud because, without it, a claim of securities fraud does not exist."). It is irrelevant because the facts Aetna itself alleged show discoverability regardless of which pleading standard applies.

First, Aetna admitted that it became aware of what it considered red flags in MBB's billing long before July 2022. Aetna claims it noted a dramatic rise in the number of bills MBB was submitting; a more than 20-fold increase in the number of physicians billing under MBB's TIN, from around 50 to more than 1,000; and that many of the physicians billing under MBB's TIN were located outside the Jacksonville area, where MBB had historically practiced. Dkt. 80 ¶¶ 6, 54–56, 172. These facts troubled Aetna enough that it "asked for an explanation" over a period of "months," including by phone, email, and even LinkedIn. *Id.* ¶¶ 6, 172–75. And when Aetna was not satisfied with MBB's responses regarding these purported red flags, Aetna took the dramatic step of terminating MBB's contract. *Id.* ¶¶ 6, 59, 112.

Second, Aetna admitted that the supposed "fraud" after July 2022 consisted of the very same practices that had caused Aetna to terminate MBB's contract. *See, e.g.*, *id.* ¶ 8 (after Aetna terminated the contract, "Defendants *continued* to bill all services through MBB, using MBB's TIN" (emphasis added)); *id.* ¶ 59 ("Aetna terminated the In-Network Agreement with MBB in July 2022, but Defendants *did not stop* funneling bills from other medical groups through MBB's TIN."

(emphasis added)); *id.* ¶ 126 ("When Aetna terminated the In-Network Agreement with MBB, Dr. Diez's claims *continued* to be billed under MBB's TIN on an out-of-network basis …." (emphasis added)); *id.* ¶ 140 (same for Dr. Freeman); *id.* ¶ 153 (same for Dr. Fernandez). The only difference was that before the termination MBB billed as an in-network provider, whereas after the termination it billed as an out-of-network provider. But that did not affect the substance of the alleged fraud, which by Aetna's account consisted of billing for services provided by physicians who Aetna contends were not affiliated with MBB.

Third, despite admitting that it was so concerned about MBB's pre-termination bills that it terminated MBB's contract, Aetna did not allege that it asked MBB about MBB's post-termination bills, including through the NSA's dispute-resolution process. That is a glaring omission, as the statute gave Aetna literally thousands of opportunities to do so. Every IDR arbitration was preceded by a 30-calendar-day period before the initial payment deadline, followed by a 30-business-day "open negotiation" period. Aetna was supposed to use that time to "communicate with [MBB] to obtain the information [it] need[ed] to provide a full and fair review" of the bills. IDR Guidance at 10 n.8. And

if Aetna was not satisfied by the information MBB provided during this more-than-two-month period, then Aetna was not only free but *required* to raise its concerns with the arbitrator, who then could have requested more information from MBB in order to resolve the dispute. *See* 45 C.F.R. § 149.510(a)(2)(xi), (b)(2)(iii)(A)(6) (2024); 86 Fed. Reg. at 55992; pp. 10–12, *supra*. Yet Aetna did none of those things.

In short, Aetna's complaint told the following story: Aetna observed enough red flags of a purportedly fraudulent scheme that it terminated MBB's contract; but when MBB continued the same billing practices post-termination, Aetna remained silent, even when presented with literally *thousands* of opportunities to have a neutral third party examine the validity of MBB's bills. That is the opposite of due diligence. As the district court held, "Aetna's own admission[s]" were thus "fatal to [its] position" that the so-called fraud was not discoverable. Dkt. 105 at 8–9.

Courts regularly refuse vacatur under § 10(a) where, as here, the party seeking vacatur was alerted to the possibility of fraud before or during the arbitration but failed to pursue it. *See, e.g.*, *Floridians for Solar Choice, Inc. v. Paparella*, 802 F. App'x 519, 523 n.1 (11th Cir. 2020) (per curiam) (no vacatur where party failed to "take any action, much less

raise its fraud ground or even object," during arbitration hearing); *Karaha Bodas Co. v. Perusahaan Pertambangan Minyak Dan Gas Bumi Negara*, 364 F.3d 274, 307 (5th Cir. 2004) (no vacatur where party "had the opportunity to ask additional questions [during arbitration], which it chose not to pursue"); *LaFarge Conseils et Etudes, S.A. v. Kaiser Cement & Gypsum Corp.*, 791 F.2d 1334, 1339 (9th Cir. 1986) (where party "suspected" during arbitration that witness may have falsified documents, party's "[n]eglecting to subpoena" witness "vitiate[d] its claim that the alleged fraud was not discoverable by due diligence"); *Limited v. J.J. Ryan Corp.*, 757 F. Supp. 3d 806, 811 (N.D. Ohio 2024) (no vacatur where party was aware of contrary facts before arbitration hearing but failed to raise the issue before, during, or after hearing); *Verso Israel, LLC v. PAI Prod. Adam Inv., Ltd.*, 2024 WL 7002277, at *3 (S.D. Fla. July 29, 2024) (no vacatur where party "never explain[ed] why it failed" to "investigate[] the evidence presented to the arbitration panel"); *ARMA, S.R.O. v. BAE Sys. Overseas, Inc.*, 961 F. Supp. 2d 245, 257, 260 (D.D.C. 2013) (no vacatur where party had "multiple opportunities" to "raise its concerns about [other party's] claims … during the arbitration" but "chose not to do so"); *In re MarketXT Holdings Corp.*, 2009 WL 2957809,

at *5–6 (Bankr. S.D.N.Y. July 20, 2009) (no vacatur where parties had "opportunity prior to and at the [arbitration] hearings to discover the facts" and "provided no explanation as to why they failed to pursue the discovery available to them"), *aff'd*, 428 B.R. 579, 590 (S.D.N.Y. 2010); *cf.* *Bonar*, 835 F.2d at 1384 (vacating award where, unlike here, arbitral rules gave party no "pre-hearing opportunity" to investigate witness, making it impossible for party to have "discovered [witness's] perjury before or during the arbitration hearing").

If all this were not enough, the Texas arbitration provides further evidence that Aetna knew about the alleged fraud, or at a minimum could have uncovered it through due diligence. Months before it terminated MBB's contract, Aetna alleged it had "uncovered" an identical "fraudulent scheme" by Radiology Partners in Texas. Dkt. 29-6 ¶¶ 1–4. It alleged that a Houston-based affiliate of Radiology Partners was committing fraud by using its TIN to bill for services furnished by radiologists who Aetna contended were actually affiliated with different groups—the very same accusation Aetna would later make against MBB. *Id.* Aetna also alleged in the Texas arbitration that Radiology Partners and its affiliates were engaging in similar conduct "all over the country."

Id. ¶ 51. Aetna was thus aware that the billing patterns that led it to terminate MBB's contract were the same ones it had decried as fraud just a few hundred miles down the I-10. Yet Aetna did nothing to investigate those recurring patterns either before or during the thousands of post-termination IDR arbitrations it now challenges.

Aetna's contrary arguments are unpersuasive. Aetna first contends (at 26) that it made "reasonable inquiries" that failed to uncover the alleged fraud. But the complaint alleges only that Aetna made inquiries in 2022, "MBB deflected Aetna's inquiries," and Aetna responded by "terminat[ing] MBB's in-network contract." Dkt. 80 ¶ 6. If Aetna was not satisfied with how MBB responded to its inquiries in 2022 (and by Aetna's own admission it was not), the IDR process gave it thousands of opportunities to follow up—either by requesting information about specific bills during the 30-calendar-day initial review period and the 30-business-day open-negotiation process, or by raising its concerns with the IDR arbitrators, who could have requested additional information from MBB. Yet Aetna did none of that. And while it says (at 26) it "did not discover [the fraud] until late 2024," it does not explain what changed

then or why whatever steps it took in late 2024 could not have been taken earlier.

Aetna's only explanation for its dereliction is to complain (at 26 & n.13) that the NSA's "rapid deadlines" and MBB's use of batched submissions "inundated Aetna with more disputes than it could reasonably investigate." But Aetna did not just fail to investigate *all* of the bills it now objects to; it failed to investigate *any* of them.

In any event, Congress allowed providers to batch related disputes into a single IDR submission and determined that the statutory deadlines were reasonable, including for batched submissions. 42 U.S.C. § 300gg-111(c)(3)(A); *see* 45 C.F.R. § 149.510(c)(3) (2024). And the implementing regulation states that concerns like Aetna's "must" be raised within the applicable deadlines. 45 C.F.R. § 149.510(c)(1)(iii)–(iv) (2024). The regulation also provides that the deadlines can be extended for good cause upon request, *id.* § 149.510(g) (2024), but Aetna does not contend it ever requested an extension.

Nor can Aetna plausibly assert it lacks the resources to investigate IDR disputes within the statutory timeframe. Aetna is a subsidiary of CVS Health, one of the largest corporations in the United States, which

is consistently ranked in the top 10 of the Fortune 500. During the relevant period (July 2022 through December 2024), CVS Health's consolidated annual revenues grew from $322.5 billion to $372.8 billion, and Aetna's revenue grew from $91.4 billion to $130.7 billion; CVS Health employed over 300,000 people; Aetna's nationwide provider network grew from 1.6 million to 1.9 million participating providers; and Aetna's medical membership grew from 24.4 million to 27.1 million.[9] A company of this scale—which routinely processes medical bills for tens of millions of members—cannot credibly assert it lacked the ability to review IDR submissions.

Aetna insists (at 27) that "[r]easonable diligence does not require parties to assume the other side is lying" (quoting *France v. Bernstein*, 43 F.4th 367, 380 (3d Cir. 2022)). But as the cases collected above demonstrate, reasonable diligence *does* require a party that suspects fraud in an arbitral proceeding to take reasonable steps to investigate. *France* is in accord: there, Bernstein, the party seeking vacatur, "did in

[9] CVS Health Corp., Annual Report (Form 10-K) at 4, 73, 76, 78, 80 (Feb. 8, 2023); CVS Health Corp., Annual Report (Form 10-K) at 3, 15, 17, 72, 76, 78, 80 (Feb. 10, 2025); *see also* Press Release, CVS Health Corp., CVS Health Corporation Reports Fourth Quarter and Full-Year 2024 Results (Feb. 12, 2025), https://tinyurl.com/4r238vhd.

fact take substantial measures toward uncovering France's perjury" during the proceeding that "were appropriate under the circumstances," including requesting documents from France, taking a pre-hearing deposition of France, and serving document subpoenas on non-parties. 43 F.4th at 380. The court held only that diligence did not require Bernstein to "pursue every possible discovery mechanism," including bringing separate lawsuits against non-parties who failed to comply with subpoenas. *Id.* at 381. Here, Aetna failed to use *any* of the mechanisms that were available within the NSA's dispute-resolution process for investigating the supposed red flags it had already identified in MBB's bills.[10]

Finally, Aetna protests (at 28–29) that it never actually admitted it had "discovered MBB's fraud" when it terminated the contract in 2022. That is splitting hairs. Aetna admitted that it had serious concerns about

[10] Aetna also cites (at 27) this Court's observation that it was "reasonable for [a party] to believe" a witness who swore under oath he was not being coached. *NuVasive, Inc. v. Absolute Med., LLC*, 71 F.4th 861, 879 n.11 (11th Cir. 2023). But unlike Aetna, NuVasive had no reason to suspect impropriety and no means of investigating it. *See id.* at 878–79 ("[T]he arbitration was conducted from remote locations over videoconference," and "[t]he defendants do not explain how NuVasive could have discovered the coaching remotely.").

what it considered suspicious billing patterns by MBB, that it found MBB's explanations unsatisfactory, and that it terminated the contract as a result. Whether or not Aetna had fully documented the supposed fraud (and even setting aside that Aetna was simultaneously alleging fraud in Texas based on the same conduct), it certainly had enough information to raise the issue before or during the NSA arbitrations. But it never did.

The district court was thus correct to hold that Aetna failed to plausibly plead that the arbitral awards were procured by undiscoverable fraud.

B. The arbitrators did not exceed their powers.

Aetna contends the arbitrators "exceeded their powers" because the services at issue supposedly were furnished by in-network physicians not affiliated with MBB, and thus were not "qualified IDR … service[s]" eligible for the NSA's dispute-resolution process, which is limited to services furnished by out-of-network providers. Aetna Br. 30–31 (quoting 9 U.S.C. § 10(a)(4) & 42 U.S.C. § 300gg-111(c)(2)(A)–(B)). This argument fails for two reasons.

First, Aetna forfeited any argument that the services were outside the arbitrators' statutory jurisdiction by not raising that argument during the arbitrations. An objection to an arbitrator's jurisdiction is not like an objection to a court's jurisdiction, which can be raised at any time, even for the first time on appeal. Instead, "[t]here is broad agreement among the federal courts of appeal that a jurisdictional objection comes too late if it is only raised after the arbitrator has ruled on the merits." *Ribadeneira v. New Balance Athletics, Inc.*, 65 F.4th 1, 15 (1st Cir. 2023) (collecting cases from the Third, Fifth, Seventh, and Ninth Circuits). This rule is critical because without it, "a party could wait to see how the arbitration tribunal ruled before deciding whether to challenge its jurisdiction." *Id.* at 16 (quotation marks omitted).[11]

[11] While this Court does not appear to have addressed the issue in a published opinion, the Fifth Circuit traced the contemporaneous-objection requirement back to an "Old Fifth" decision that is binding on this Court. *See OJSC Ukrnafta v. Carpatsky Petroleum Corp.*, 957 F.3d 487, 498 (5th Cir. 2020) (citing *Piggly Wiggly Operators' Warehouse, Inc. v. Piggly Wiggly Operators' Warehouse Indep. Truck Drivers Union, Loc. No. 1*, 611 F.2d 580, 584 (5th Cir. 1980)); *see also Ardis v. Anderson*, 662 F. App'x 729, 732 n.3 (11th Cir. 2016) (per curiam) (holding, in nonprecedential opinion, that party who participated in arbitration "without ever challenging the manner in which the arbitrator was selected … waived his right to do so in subsequent proceedings").

That rule applies with full force here. The NSA's implementing regulation required Aetna to raise any objection "regarding the Federal IDR process's inapplicability" *during* that process. 45 C.F.R. § 149.510(c)(1)(iii)–(iv) (2024). Having failed to do so, Aetna may not raise that objection for the first time in court. As one district court recently explained, in a case where an insurer claimed that a billing dispute resolved in an IDR arbitration was "entirely outside the scope of the NSA and its IDR framework": "The [IDR process] provides a specific and exclusive mechanism for a non-initiating party, who believes the IDR process does not apply, to challenge that applicability. ... [An insurer who] did not avail itself of this procedure to contest the claim in front of the IDR ... waived any argument that the IDR process was inapplicable to this claim." *New England PA, LLC v. Cigna Health & Life Ins. Co.*, 2026 WL 2099041, at *6 (D. Conn. July 21, 2026), *appeal docketed*, No. 26-2289 (2d Cir. Aug. 17, 2026).

Second, even setting aside forfeiture, Aetna cannot overcome the deferential standard of review that applies here. Under the NSA, arbitrators—not courts—are tasked with determining whether a dispute involves IDR-eligible services. *See* 45 C.F.R. § 149.510(c)(1)(v) (2024)

(arbitrator must "determine whether the Federal IDR process applies"); *Anthem Blue Cross Life & Health Ins. Co. v. HaloMD LLC*, 2026 WL 982629, at *9 (C.D. Cal. Apr. 9, 2026) ("[P]art of the IDREs' assigned task is to decide eligibility."), *appeal docketed*, No. 26-2355 (9th Cir. Apr. 16, 2026); *Blue Cross Ga.,* 2026 WL 2017291, at *12 ("[F]ederal regulations require IDREs to make eligibility determinations as part of the IDR process."); *New England PA*, 2026 WL 2099041, at *7 ("[T]he [IDR entity] determined that the IDR process applied to this claim. That determination was made by the entity Congress charged with making it."). And where the threshold question of whether a dispute is eligible for arbitration is delegated to the arbitrator to decide, the arbitrator's resolution of that question receives the same deference that applies to any other delegated question. *First Options of Chi., Inc. v. Kaplan*, 514 U.S. 938, 943 (1995); *see Blue Cross Blue Shield of Tex. v. HaloMD, LLC*, 2026 WL 1557492, at *4 (E.D. Tex. May 22, 2026) ("[I]nherent in the NSA's bar of judicial review of payment determinations is a limitation on the review of eligibility decisions.").

That deference is extraordinarily high. An arbitrator's resolution of a delegated question—including a question concerning arbitrability—

does not exceed the arbitrator's powers so long as the arbitrator "even arguably performed the assigned task," regardless of "whether she got the outcome right or wrong." *Reach Air*, 160 F.4th at 1120 (cleaned up) (quoting *Gherardi*, 975 F.3d at 1238). Only if the arbitrator "act[ed] outside the scope of his authority" by "issuing an award that simply reflects his own notions of economic justice" may the court overturn the award for exceeding the arbitrator's powers. *Id.* (cleaned up) (quoting *Oxford Health Plans LLC v. Sutter*, 569 U.S. 564, 569 (2013)).

Aetna does not allege that happened here, and plainly it did not. Aetna never disputed eligibility in any of the IDR arbitrations at issue. As a result, the only evidence before the arbitrators that was relevant to eligibility was MBB's attestations. Dkt. 80 ¶ 117. The arbitrators did not act outside the scope of their authority by finding MBB's bills eligible based on that uncontroverted evidence. *See U.S. Trinity Energy Servs., L.L.C. v. Se. Directional Drilling, L.L.C.*, 135 F.4th 303, 309 (5th Cir. 2025) (arbitrators do not exceed their authority by deciding a delegated question based on "the evidence presented" by the parties); *Anthem*, 2026 WL 982629, at *9 ("Plaintiffs do not (and cannot) allege that IDREs failed to rule in Anthem's favor in the complete absence of factual support for

eligibility, because Plaintiffs allege that Defendants consistently represent (albeit falsely) to the IDREs that the claims are eligible."). The recently issued regulations Aetna cites (at 31 n.14) confirm as much: "[I]f a party fails … to contest the eligibility of a dispute, the certified IDR entity may determine the dispute is eligible for the IDR process." 91 Fed. Reg. at 33945.

The district court was thus correct to hold that Aetna failed to plausibly plead that the arbitrators exceeded their powers.

II. Aetna's remaining claims fail.

A. Aetna's state-law claims are preempted by the NSA.

In addition to seeking vacatur of the IDR awards, Aetna brings supplemental state-law claims for fraud, negligent misrepresentation, FDUTPA violations, unjust enrichment, and civil conspiracy. Dkt. 80 ¶¶ 188–250. Aetna says these claims apply only with respect to bills that Aetna paid *without* MBB invoking the IDR process. *Id.* ¶¶ 188, 203, 219, 228, 238. The district court correctly held that these claims are preempted "attempt[s] to end-around … the administrative process established by Congress" in the No Surprises Act. Dkt. 105 at 9; *see Wiersum v. U.S. Bank, N.A.*, 785 F.3d 483, 486 (11th Cir. 2015) ("Conflict preemption exists … where state law stands as an obstacle to the

accomplishment and execution of the full purposes and objectives of Congress." (quotation marks omitted)).[12]

Aetna protests (at 33) that because its state-law causes of action involve only payments made without invocation of the IDR process, they fall outside the NSA's scope. Not true. The NSA provides certain rights and obligations from the moment a provider submits a covered out-of-network bill to an insurer, regardless of whether the dispute ultimately proceeds to an IDR arbitration. *See* pp. 9–13, *supra*. When MBB submitted a covered bill to Aetna, Aetna was required to pay or deny the bill within 30 days. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I). And if Aetna disputed the bill—including on the ground that, as Aetna now contends,

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[12] Aetna contends (at 32) the district court violated the party-presentation principle because defendants did not raise preemption below. But this Court can "affirm on any ground that finds support in the record," "regardless of whether it was raised below." *American United Life Ins. Co. v. Martinez*, 480 F.3d 1043, 1059 (11th Cir. 2007) (quotation marks omitted); *see Zann v. Whidby*, 525 F. App'x 924, 924 (11th Cir. 2013) (per curiam) ("[W]e will not reverse a district court for applying the proper law and reaching the correct result even though the prevailing party was not as helpful as it could have been."). And judicial efficiency favors deciding the purely legal preemption issue now. If the case were remanded, defendants would simply move for judgment on the pleadings based on preemption, necessitating another appeal. *See Spaziano v. Singletary*, 36 F.3d 1028, 1041 (11th Cir. 1994) (affirming on ground not argued below because the "issue is purely one of law and we would review the district court's decision of it *de novo* anyway").

the bill was not subject to the NSA because the services at issue were not truly furnished out-of-network—the NSA entitled MBB to demand binding IDR arbitration to resolve that dispute. *Id.* § 300gg-111(c)(1)(A)–(B); 45 C.F.R. § 149.510(c)(1)(v) (2024).

Aetna's state-law claims thus seek to rescind payments that Aetna made subject to the NSA long after the NSA's deadlines have passed. In doing so, Aetna would deprive MBB of its right under the NSA to have any dispute about those payments resolved through the NSA's dispute-resolution process. These claims are preempted because they conflict with the NSA's "comprehensive framework," *Club Madonna Inc. v. City of Miami Beach*, 42 F.4th 1231, 1253 (11th Cir. 2022) (quoting *Arizona v. United States*, 567 U.S. 387, 404 (2012)), for resolving payment disputes between insurers and out-of-network providers.

First, Aetna's state-law claims conflict with the NSA's 30-day deadline for an insurer to pay or deny a provider's bills. That deadline reflects Congress's judgment that providers are entitled to prompt payment determinations, and that disputes should be resolved through "an efficient and streamlined" process "designed to minimize costs." *Reach Air*, 160 F.4th at 1119 (cleaned up). The federal payment deadline

would be meaningless if an insurer could pay bills under the NSA's 30-day timeline but then, months or years later, seek to claw back those payments through state tort litigation. Aetna's grumbling (at 26 n.13) that the NSA's "rapid deadlines" prevented it from carefully reviewing any of MBB's bills challenges the deadlines Congress and CMS established, overlooks that the law permitted Aetna to request an extension, and underscores that Aetna seeks to circumvent the NSA's dispute-resolution framework.

Second, Aetna's state-law claims conflict with MBB's right under the NSA to have disputes over its bills—including the eligibility dispute Aetna now raises—resolved in NSA arbitration. If Aetna had denied MBB's bills by the 30-day deadline on the grounds Aetna now asserts, then MBB would have been entitled to demand arbitration under the NSA. The IDR arbitrator then would have decided whether the bills were for qualified out-of-network services, and Aetna could not have challenged the arbitrator's resolution of that issue except on the limited grounds available under section 10 of the FAA. But because Aetna paid the bills without contesting their out-of-network status, MBB had no reason or opportunity to exercise its right to IDR arbitration of that

question. An insurer cannot frustrate a provider's federal rights by paying the provider's bill without contest, waiting until the deadline for the provider to invoke IDR arbitration expires, and then suing to recover the payment under state law. Doing so would strip away the provider's rights under the NSA and circumvent the process Congress provided for resolving these kinds of disputes. *Cf. Preston v. Ferrer*, 552 U.S. 346, 359 (2008) (holding that the FAA preempts state procedures that would route arbitrable disputes away from the arbitral forum).[13]

Aetna may respond that none of these conflicts exist because, as Aetna now contends, MBB's bills did not *actually* pertain to out-of-network services within the scope of the NSA. But the question of whether the bills were legitimately out-of-network is itself a question the NSA commits to the IDR process—specifically, to the IDR entity's eligibility review. *See* pp. 10–12, 40–41, *supra*. And the NSA addresses

[13] The NSA routes certain disputes to state rather than federal dispute-resolution processes, *see* 42 U.S.C. § 300gg-111(a)(3)(K)(i), but Aetna's complaint does not allege that any of the bills at issue here fall within that category. Regardless, Aetna's state-law claims seek to override a federally established payment framework that the NSA applies to all surprise-billing disputes, whether the rate is ultimately determined through federal arbitration or a state process that the NSA itself designates.

fraud through its cross-reference to the FAA's grounds for vacatur, demonstrating that Congress anticipated the possibility of fraud and provided a specific federal remedy.

This lawsuit is not the first time a court has rejected Aetna's attempt to circumvent unfavorable awards. Another court recently held that the NSA preempted Aetna's state-law claims alleging that providers fraudulently submitted bills for ineligible services to the IDR process. As the court recognized, the NSA "specifies an exclusive procedure to challenge" IDR awards, including on the grounds that the services were not IDR-eligible. *Guardian Flight LLC v. Aetna Life Ins. Co.*, 2026 WL 1734646, at *4 (D. Conn. June 16, 2026). That court also rejected Aetna's argument that it could challenge "'systemic'" misconduct in connection with IDR proceedings, reasoning that "[t]o find any merit in this argument would be to permit a workaround to the barrier to plenary judicial review Congress imposed." *Id.* at *5. Here, too, Aetna seeks an impermissible "workaround" by paying providers' bills upfront so arbitration is never invoked, then seeking to recoup the payments on grounds that would have been subject to arbitration if Aetna had raised them in a timely manner.

In sum, the district court was correct that allowing Aetna to bring its state-law claims to try to claw back payments it made under the NSA, rather than disputing MBB's bills in a timely fashion so that MBB could have invoked arbitration to resolve that dispute, "would have the same effect as discarding the administrative process established by Congress." Dkt. 105 at 9. Such claims conflict with federal law and are therefore preempted.

B. The NSA bars Aetna's claims for declaratory and injunctive relief.

Aetna also brings federal claims for injunctive and declaratory relief under ERISA and the Declaratory Judgment Act. Dkt. 80 ¶¶ 267–286. Unlike the state-law claims, these claims are not limited to payments made without invocation of the IDR process. *See id.*

Aetna's declaratory- and injunctive-relief claims are precluded by the NSA's limitations on judicial review. *See* 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). As another federal court recently explained in rejecting similar claims by a different insurance company, Aetna's claims "cannot be adjudicated without reviewing the correctness of past IDR awards or inserting the district court in overseeing future IDR awards." *Anthem*, 2026 WL 982629, at *10; *see also Blue Cross Ga.*, 2026 WL 2017291, at

*15 (observing that "district courts across the nation" have rejected similar claims and collecting cases).

First, to the extent Aetna seeks backward-looking declaratory relief, *see, e.g.*, Dkt. 80 ¶ 280(b) (seeking a declaration that defendants "received overpayments"), its claims would require the court to "review whether the Defendants previously complied with the requirements of the IDR process and determine whether specific items and services were actually eligible for IDR, something that has already been done by the [arbitrator] before making the payment determination in each case." *Blue Cross Ga.*, 2026 WL 2017291, at *15. And to grant Aetna relief, "the Court would have to ultimately conclude that the [arbitrators] erred in their conclusion that the IDR items and services were, in fact, eligible for IDR." *Id.* The NSA bars such a collateral attack on past IDR awards outside the strictures of the FAA.

Second, to the extent Aetna seeks prospective relief limiting MBB's ability to invoke the IDR process in the future or declaring that Aetna need not abide by certain IDR awards (*see, e.g.*, Dkt. 80 ¶¶ 277, 286), such relief would likewise conflict with the NSA because it would require the court to "take a preliminary review" of disputes "yet to be submitted to

the IDR." Dkt. 105 at 9–10. If, in the future, MBB submits a bill that Aetna believes is improper, the NSA allows Aetna to simply deny the bill. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I), (b)(1)(C). But in that event, the statute gives MBB the right to bring the dispute before an arbitrator and have the arbitrator determine whether the dispute is subject to the federal IDR process, including whether the services were furnished by an out-of-network provider. *Id.* § 300gg-111(c)(2).

Aetna's requested relief would short-circuit that congressionally mandated process and deprive MBB of its statutory right to have any dispute over bills it might submit in the future resolved by an IDR arbitrator. "[I]f, for example, the district court entered a follow-the-law injunction that prohibited [MBB] from making future false eligibility attestations, then [Aetna] would be able to come back into court to request a contempt remedy for violations of such an injunction, a remedy that would require litigating whether the challenged attestation was false"—which is a task the NSA assigns to the arbitrator. *Anthem*, 2026 WL 982629, at *10.

The district court thus correctly held that Aetna's declaratory- and injunctive-relief claims are impermissible attempts to circumvent the NSA's limitations on judicial review.

C. Aetna's state-law claims fail because Aetna knew about the conduct it now calls fraudulent.

Aetna's prior awareness of the putatively fraudulent scheme defeats each of its state-law claims. Aetna's own pleadings and judicially noticeable materials make clear that (1) Aetna had identified the billing patterns it now describes as fraudulent by no later than 2022; (2) Aetna inquired about those patterns and found MBB's responses evasive and unsatisfying; (3) Aetna terminated MBB's contract as a result; and (4) Aetna was simultaneously alleging fraud in Texas based on the same conduct, while asserting that Radiology Partners and its affiliates were engaging in this conduct all over the country. *See* Part I.A, *supra*.

Under Florida law, none of Aetna's claims can be maintained by a party that was aware of the alleged falsity and chose to ignore it. First, with respect to the fraud claim, "[t]he recipient of a fraudulent misrepresentation is not justified in relying upon its truth if he knows that it is false or its falsity is obvious to him." *Norman v. Padgett*, 125 So. 3d 977, 978 (Fla. 4th DCA 2013) (per curiam) (quoting *Besett v.*

Basnett, 389 So. 2d 995, 997 (Fla. 1980)). Second, the negligent-misrepresentation claim requires justifiable reliance, meaning Aetna was "responsible for investigating information that a reasonable person in [its] position … would be expected to investigate." *Kurimski v. Shell Oil Co.*, 570 F. Supp. 3d 1228, 1250 (S.D. Fla. 2021) (cleaned up) (quoting *Butler v. Yusem*, 44 So. 3d 102, 105 (Fla. 2010) (per curiam)). Third, the FDUTPA claim requires proof that "the alleged practice was likely to deceive a consumer acting reasonably in the same circumstances." *Id.* at 1243 (quoting *Carriuolo v. Gen. Motors Co.*, 823 F.3d 977, 984–85 (11th Cir. 2016)). Finally, Aetna's unjust-enrichment and civil-conspiracy claims "seek[] recovery for the exact same wrongful conduct" as its other claims and thus fail for the same reasons. *Guerrero v. Target Corp.*, 889 F. Supp. 2d 1348, 1356–57 (S.D. Fla. 2012).

III. Aetna did not plead fraud with particularity.

This Court also can affirm dismissal on the ground that Aetna did not plead fraud with the particularity required by Federal Rule of Civil Procedure 9(b). *See Martinez*, 480 F.3d at 1059 (court can affirm on any ground supported by the record); *United States v. Atlanta Primary Care Peachtree, PC*, 2025 WL 1823269, at *7 (11th Cir. July 2, 2025) (per

curiam) (although district court had dismissed claim on other grounds, this Court affirmed based on failure to satisfy Rule 9(b)).

Rule 9(b) requires a party alleging fraud to "state with particularity the circumstances constituting fraud." This requirement applies to any "claim that 'sounds in fraud' based on the allegations underlying the claim," regardless of "how the plaintiff styles [the] claim." *Pop v. LuliFama.com LLC*, 145 F.4th 1285, 1293 (11th Cir. 2025). Because all of Aetna's claims rest on its allegation of a "years-long healthcare fraud scheme," Dkt. 80 ¶ 1, they are all subject to Rule 9(b).[14]

Rule 9(b) serves a vital gatekeeping function. It requires a plaintiff to have a substantial basis for allegations of fraud, preventing suits that "needlessly harm a defendant's goodwill and reputation" with "spurious charges of immoral and fraudulent behavior." *U.S. ex rel. Clausen v. Lab'y Corp. of Am., Inc.*, 290 F.3d 1301, 1313 n.24 (11th Cir. 2002) (quotation marks omitted). It also blocks suits that exist only to extract

[14] *See, e.g.*, *Reach Air*, 160 F.4th at 1121 (applying Rule 9(b) to NSA vacatur claims that sounded in fraud); *Pop*, 145 F.4th at 1293 (same for FDUTPA); *Omnipol, A.S. v. Multinat'l Def. Servs., LLC*, 32 F.4th 1298, 1307 & n.11 (11th Cir. 2022) (same for unjust enrichment); *Wilding v. DNC Servs. Corp.*, 941 F.3d 1116, 1127–28 (11th Cir. 2019) (same for negligent misrepresentation); *Lawrie v. Ginn Dev. Co.*, 656 F. App'x 464, 474 (11th Cir. 2016) (per curiam) (same for civil conspiracy).

information through discovery and to coerce settlements through the enormous cost and business disruption associated with such discovery. *Id.*; *see also U.S. ex rel. Atkins v. McInteer*, 470 F.3d 1350, 1359–60 (11th Cir. 2006).

Here, the district court suggested that Aetna's complaint passed muster because it identified the "location, date, and individual/entity" associated with a particular bill that Aetna alleges was fraudulent. Dkt. 105 at 6. But a plaintiff cannot satisfy Rule 9(b) just by asserting that specifically identified bills were fraudulent; the plaintiff also must plead specific facts showing *why* the bills were fraudulent. "If Rule 9(b) is to carry any water, it must mean that an essential allegation and circumstance of fraudulent conduct cannot be alleged in … conclusory fashion." *Clausen*, 290 F.3d at 1313; *see Wilding*, 941 F.3d at 1128 ("[S]imply alleg[ing] the technical elements of fraud without providing ... underlying supporting details will not satisfy the rule's pleading-with-particularity requirement." (quotation marks omitted)); *Mandala v. Tire Stickers, LLC*, 829 F. App'x 896, 901 (11th Cir. 2020) (per curiam) ("Rule 9(b) requires a plaintiff to plead more than conclusory allegations

that certain statements were fraudulent; a complaint must allege facts giving rise to an inference of fraud.").

Aetna's complaint falls far short of that standard. It mentions six specific bills submitted by MBB that Aetna says were fraudulent because the physicians who performed the services supposedly were not actually affiliated with MBB. *See* Dkt. 80 ¶¶ 69, 82, 95, 128, 141, 154. But it provides no particularized support for that contention. Its allegations that those bills were fraudulent are based on wholly conclusory assertions.

Aetna's fraud theory rises or falls with whether those radiologists were working for MBB at the time those six bills were submitted. Aetna all but admits that the bills would be proper if, at the time of the services, the physicians were employed by or otherwise contracted with MBB to perform services. And Aetna does not allege that no such employment or other contractual agreements existed for MBB to secure services from those physicians. Instead, Aetna relies entirely on its one-paragraph, information-and-belief assertion that any agreements between MBB and the physicians were somehow a sham:

> Upon information and belief, Radiology Partners also had physicians sign "agreements" with MBB

> to make it appear as though they are "employed" by MBB, when in reality they are not supervised or controlled by MBB, as exemplified by the sworn discovery responses set forth above.

Id. ¶ 180. This allegation does not set forth any factual basis for Aetna's belief that physicians who had agreements with MBB were "not supervised or controlled" by MBB, let alone provide factual support with the specificity that Rule 9(b) requires. *See Clausen*, 290 F.3d at 1314 n.25 ("where allegations are based on information and belief, the complaint must set forth a factual basis for such belief" (quotation marks omitted)); *Vargas v. Lincare, Inc.*, 134 F.4th 1150, 1158 (11th Cir. 2025) (affirming Rule 9(b) dismissal where fraud allegations were based not on personal knowledge but on "'rumors'" and plaintiff's "own opinions about others' conduct" (quoting *Atkins*, 470 F.3d at 1359)).

The allegation's reference to "the discovery responses set forth above" does not cure Aetna's deficient complaint. Aetna alleges only that in discovery in an entirely separate medical malpractice case, Dr. Navid Nouri "admitted that he 'was an employee of Radiology Associates of South Florida … on May 5, 2022.'" *Id.* ¶¶ 75–76. But Aetna alleges no facts to support its assumption that a radiologist cannot work for multiple medical groups or have multiple employers. In any event, the

bill that Aetna alleges MBB submitted for Dr. Nouri concerns an ultrasound that was conducted on September 18, 2022. *Id.* ¶ 69. Whether Dr. Nouri was an employee of Radiology Associates of South Florida in May 2022 says nothing about whether he was an MBB employee or contractor four-and-a-half months later.

Aetna also alleges that Dr. Nouri and the other physicians continue to be publicly associated with their former groups, including on the groups' websites and the physicians' LinkedIn pages. Dkt. 80 ¶¶ 72–73, 86–87, 98, 122–23, 136–37. But Aetna does not explain how this public-facing branding is inconsistent with physicians also having bona fide agreements with MBB as either employees or independent contractors. Contrary to Aetna's suggestion, there is nothing "illogical," let alone illegal, about MBB setting up divisions that use similar branding to that of the former group. *Id.* ¶¶ 184–85. Brands are bought, sold, and repurposed in all businesses.

Aetna does not allege any knowledge of the physicians' employment or other contractual arrangements with MBB, and it alleges no specific facts indicating that the physicians were not MBB employees or independent contractors when they performed the services at issue for

MBB. Aetna cannot bring fraud claims in the hope that discovery will reveal evidence that supports its fraud theory; it must allege specific facts supporting that theory in its complaint in order to survive a motion to dismiss.

This Court and other courts regularly dismiss complaints under Rule 9(b) where, as here, the plaintiff identifies supposedly false statements but does not plead particularized facts showing that the statements were false. *See, e.g.*, *Vargas*, 134 F.4th at 1161–62 (complaint alleged technicians' compensation was fraudulent but did not plead "why the compensation … should be viewed as anything other than payment for work done"); *Miccosukee Tribe of Indians v. Cypress*, 814 F.3d 1202, 1212–13 (11th Cir. 2015) (complaint contained "insufficient specificity" to show that services billed for were "illegitimate"); *Bingham v. HCA, Inc.*, 783 F. App'x 868, 877 (11th Cir. 2019) (complaint "state[d] in conclusory fashion" that leases did not reflect fair market value but did not "provide specific details or evidence to support [those] claims"); *Glock v. Glock*, 247 F. Supp. 3d 1307, 1314–15 (N.D. Ga. 2017) (plaintiff alleged "fraudulent sale of shares" but "provide[d] no additional facts to support her conclusion that [purchaser] did not actually pay for the shares").

In sum, Aetna's theory of fraud falls apart if the physicians named in the complaint were MBB employees or contractors when they performed the services at issue. Yet on that "essential element of the lawsuit," Aetna provides nothing but "mere conjecture." *Clausen*, 290 F.3d at 1313. This is an independently sufficient ground for affirming the dismissal of all of Aetna's claims.

IV. The district court properly denied leave to amend.

Aetna's argument (at 35) that the district court should have allowed it to further amend its already-amended complaint "is foreclosed by [Aetna's] failure to properly request leave to amend." *Long v. Satz*, 181 F.3d 1275, 1279 (11th Cir. 1999) (per curiam). A party seeking leave to amend must file a motion and either attach a copy of the proposed amendment or describe its substance. *Id.* Aetna did neither: instead, it buried a generic, one-sentence request for leave to amend in a footnote of its brief in opposition to defendants' motion to dismiss. Dkt. 90 at 21 n.4.

As this Court has repeatedly made clear, "[w]here a request for leave to file an amended complaint simply is imbedded within an opposition memorandum, the issue has not been raised properly," the request is "null" and "possesses no legal effect," and the district court does

not abuse its discretion by dismissing with prejudice. *Pop*, 145 F.4th at 1298 (cleaned up); *accord Rosenberg v. Gould*, 554 F.3d 962, 967 (11th Cir. 2009) ("When [plaintiffs] requested leave to amend their complaint in a footnote to their brief in opposition to the defendants' motion to dismiss, it was within the discretion of the district court to deny that request *sub silentio*.").

In any event, amendment would be futile because the deficiencies in Aetna's complaint were primarily legal, not factual. Aetna's own pleadings established that there is no basis to vacate the IDR awards, and Aetna's other claims are preempted or barred by the No Surprises Act. Nor has Aetna ever asserted that it could plead additional facts about the alleged fraud that would satisfy Rule 9(b). Aetna already amended its complaint once after receiving defendants' first motion to dismiss, and it has shown no reason why it should get a third bite at the apple. *Cf. Walker v. Sec'y of the Army*, 2024 WL 4635382, at *3–4 (11th Cir. Oct. 31, 2024) (per curiam) (leave to amend was properly denied where plaintiff had "already amended her complaint once" and no amendment could alter court's conclusion that Civil Service Reform Act's "comprehensive framework" precluded judicial review).

CONCLUSION

This Court should affirm the district court's judgment.

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B), because it contains 12,582 words, excluding the parts exempted by Fed. R. App. P. 32(f).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6), because it has been prepared in a proportionately spaced typeface using Microsoft Word Century Schoolbook 14-point font.

Date: September 16, 2026

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CERTIFICATE OF SERVICE

I hereby certify that on September 16, 2026, the foregoing was filed with the Clerk of the United States Court of Appeals for the Eleventh Circuit using the CM/ECF system, which will cause a notice of electronic filing to be served on all registered counsel of record.

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