No. 26-11607

**UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT**

AETNA HEALTH INC., ET AL.,

*Plaintiffs–Appellants*,

v.

RADIOLOGY PARTNERS, INC., ET AL.,

*Defendants–Appellees*.

On appeal from the United States District Court for the
Middle District of Florida
Jacksonville Division
No. 24-cv-01343

# BRIEF OF PLAINTIFFS-APPELLANTS


Colin McGrath
**DLA PIPER LLP (US)**
2000 Avenue of the Stars
Suite 400 North Tower
Los Angeles, CA 90067
(310) 595-3000
colin.mcgrath@us.dlapiper.com

Ardith Bronson
**DLA PIPER LLP (US)**
200 South Biscayne Blvd.
Suite 2500
Miami, FL 33131
(305) 423-8562
ardith.bronson@us.dlapiper.com

Samantha L. Chaifetz
**DLA PIPER LLP (US)**
500 Eighth Street, NW
Washington, DC 20004
(202) 799-4000
samantha.chaifetz@us.dlapiper.com

*Counsel for Appellants Aetna Health Inc. et al.*

## CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Eleventh Circuit Rules 26.1-1, 26.1-2, and 26.1-3, Appellants submit this Certificate of Interested Persons and Corporate Disclosure statement. The following is a complete list of all trial judges, attorneys, persons, associations of persons, firms, partnerships, or corporations that have an interest in the outcome of this 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. Bethesda Radiology Associates, Inc. (affiliate of Radiology Partners, Inc.)
7. Boca Radiology Group, P.A. (affiliate of Radiology Partners, Inc.)
8. Brinkmann, Sara (Counsel for Appellees)

9. Bronson, Ardith (Appellate Counsel for Appellants)
10. Chaifetz, Samantha (Appellate Counsel for Appellants)
11. CVS Pharmacy, Inc. (Parent company of Aetna Inc.)
12. CVS Health Corporation (CVS) (Parent company of CVS Pharmacy, Inc.)
13. Davis, Hon. Brian J. (U.S. District Judge)
14. DLA Piper LLP (US) (Appellate Counsel for Appellants)
15. Gokey, Charles (District Court Counsel for Appellants)
16. Guith, Marcus (District Court Counsel for Appellants)
17. Jew, Christopher (Counsel for Appellees)
18. Kavanaugh, Samantha (Counsel for Appellees)
19. King and Spalding LLP (Counsel for Appellees)
20. McGrath, Colin (Counsel for Appellants)
21. Miller, Brian (Counsel for Appellees)
22. Moore, Nathaniel (District Court Counsel for Appellants)
23. Mori, Bean and Brooks, Inc. (Appellee)
24. Nelson, Kyle (District Court Counsel for Appellants)
25. Radiology Associates of Tampa P.A. d/b/a Radiology Associates of Florida (affiliate of Radiology Partners, Inc.)

26. Radiology Associates of South Florida, Inc. (affiliate of Radiology Partners, Inc.)

27. Radiology Partners, Inc. (Appellee)

28. Robins Kaplan, LLP (District Court Counsel for Appellants)

29. Solomon, Glenn (Counsel for Appellees)

30. Thompson, Michael (Counsel for Appellees)

31. Weller, Paul (District Court Counsel for Appellants)

Dated: July 17, 2026

Respectfully submitted,

*/s/* Samantha L. Chaifetz
Samantha L. Chaifetz

*Counsel for Plaintiffs–Appellants*
*Aetna Health Inc. et al.*

## STATEMENT REGARDING ORAL ARGUMENT

The litigation arises from Defendants-Appellees' fraudulent medical billing practices, including their scheme to fraudulently profit from the independent dispute-resolution ("IDR") process established under the federal No Surprises Act. This Court has resolved only one prior appeal involving a challenge to an IDR determination under the No Surprises Act, and the legal issues presented here are different. Plaintiffs-Appellants Aetna Health Inc., Aetna Health Insurance Company, and Aetna Life Insurance Company (collectively, "Aetna") respectfully request an opportunity to present oral argument as it may aid this Court in its resolution of this appeal.

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## INTRODUCTION

Over the course of several years, Defendants Radiology Partners and Mori, Bean and Brooks ("MBB") submitted fraudulent bills for millions of dollars to Aetna while acting to conceal its fraudulent billing practices. This litigation arises from tens of thousands of bills Defendants fraudulently submitted as out-of-network services that were, in fact, rendered by in-network providers between July 2022 and Aetna's discovery of Defendants' fraud in 2024.

Radiology Partners is a private equity-backed company that has acquired numerous radiology practices in Florida, many of which have in-network contracts with Aetna. Providers who are in-network with Aetna agree to accept payment at negotiated rates, which vary from contract to contract. After Radiology Partners acquired MBB in 2018, it directed its other Florida practices that were in-network with Aetna to disregard their own contracts and to fraudulently bill Aetna for their services using MBB's Taxpayer Identification Number ("TIN") because its contract provided the most lucrative rates. The increase in MBB's billing volume prompted Aetna to terminate MBB's contract in July 2022. But Aetna did not discover the true reason for the increase at that time because Defendants succeeded in concealing their fraud.

At the start of 2022, shortly before Aetna terminated MBB's contract, the No Surprises Act ("NSA" or "Act") went into effect. The centerpiece of the Act is an

independent dispute resolution ("IDR") process for settling rate disputes between insurers and providers related to certain out-of-network services. With MBB now out-of-network with Aetna and thus able to make use of the NSA IDR process, Radiology Partners now directed all of its Florida in-network practices to fraudulently bill for their services as if rendered by MBB so that they would appear eligible for out-of-network rates and the IDR process.

As a result of Defendants' concealment, Aetna did not uncover Defendants' fraudulent practice of using MBB to submit claims and IDR disputes for services rendered by in-network groups until late 2024—and Aetna then commenced this litigation. Before that, Defendants' fraudulent billing allowed them to collect excess payments from Aetna in two ways: First, Aetna made inflated payments for services rendered by in-network providers that were billed as if they were performed by out-of-network providers. Second, when not satisfied with those amounts, Defendants sought and obtained additional payments by abusing the NSA's IDR process to secure windfall awards. Although Defendants certified that the claims it submitted to the IDR process were eligible, they were not because they were for services performed by in-network providers.

Altogether, Defendants obtained IDR awards for approximately 20,000 benefit claims that they knew were ineligible for the IDR process. Those awards are subject to vacatur because they were obtained by fraud and, further, because the IDR

entities exceeded their authority when they issued IDR awards on ineligible claims. Aetna's complaint presented these vacatur claims, as well as (1) a forward-looking claim under ERISA for declaratory and injunctive relief barring future fraudulent submissions to Aetna and (2) state-law claims for in-network benefit claims that Defendants' fraudulent use of MBB's out-of-network TIN caused Aetna to pay improperly and were not submitted to the NSA IDR process.

The district court erred in dismissing Aetna's claims with prejudice at the pleading stage. The court recognized that Aetna pleaded fraud with particularity, satisfying Federal Rule of Civil Procedure 9(b). But the court then erred by engaging in impermissible and erroneous factfinding. In what it termed a "close call," the court concluded that Aetna "knew" Defendants were engaged in fraud *before* the IDR processes and therefore could not obtain vacatur of the IDR determinations. But this was based on a misreading of Aetna's pleadings and contravened the well-established standard for resolving a Rule 12(b)(6) motion, which requires drawing all reasonable inferences in favor of the non-moving party.

Compounding this error, the district court dismissed Aetna's vacatur claim without addressing Aetna's additional argument that the IDR entities exceeded their authority and, further, incorrectly concluded it lacked authority to consider forward-looking declaratory or injunctive relief. The court also erroneously dismissed Aetna's state-law claims as preempted by the NSA—an argument that no party had

raised and that has no application where, as here, the benefit claims at issue were never submitted to the NSA's IDR process. This Court should reverse.

## JURISDICTIONAL STATEMENT

The district court had jurisdiction under 28 U.S.C. § 1331 and 28 U.S.C. § 1367. The district court entered a final order dismissing the complaint with prejudice on April 16, 2026. Dkt. 105. Aetna noticed its appeal on May 6, 2026. Dkt. 109. This Court has jurisdiction under 28 U.S.C. § 1291.

## STATEMENT OF THE ISSUES

1. Whether the district court erred when, at the pleading stage, it made findings contrary to the allegations in Aetna's complaint, failed to draw reasonable inferences in Aetna's favor, and dismissed Aetna's claim for vacatur of Defendants' IDR determinations with prejudice based on a "close call" factual determination.

2. Whether the district court erred in dismissing Aetna's vacatur claim without considering Aetna's additional basis for relief—that the IDR entities exceeded their authority when they issued IDR determinations on claims not eligible for consideration under the NSA.

3. Whether the district court erred in dismissing Aetna's state law and ERISA claims as preempted by the NSA, where no party argued preemption and, in any event, the claims do not involve or implicate the NSA's IDR process.

## STATEMENT OF THE CASE

### I. Legal Framework

#### A. The NSA regulates certain out-of-network billing practices.

Congress enacted the No Surprises Act in 2020 to protect patients from certain "surprise" medical bills from out-of-network healthcare providers and to offer a mechanism for insurers and providers to efficiently resolve disputes over out-of-network rates (should one party or the other elect to use it). No Surprises Act, Pub. L. 116-260, 134 Stat. 2758 (Dec. 27, 2020).

In the U.S., insurers (such as Aetna) regularly contract with healthcare providers, who agree (1) to provide medical care to enrollees at predetermined rates and (2) not to seek additional payment from the insured beyond any cost-sharing responsibility (*e.g.*, copay, coinsurance, or deductible) they may owe under their health plan. Providers who are *not* part of an insurer's network of contracted providers (*i.e.*, "nonparticipating" or out-of-network providers[1]) "usually charge higher amounts than the contracted rates that plans and issuers have negotiated." Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36872, 36874 (July 13, 2021). Because they are not bound by contract, out-of-network providers

[1] A nonparticipating provider is "a physician or other health care provider … who does not have a contractual relationship with the … issuer … for furnishing such item or service"—in short, an out-of-network provider. 42 U.S.C. § 300gg-111(a)(3)(G)(i). The Act also refers to nonparticipating facilities, as relevant; for sake of simplicity, we default to referring to providers throughout.

frequently bill the patient for any portion of their charges not covered by the patient's insurer—a practice called "balance billing." *Id*. In some circumstances, that bill would come as a surprise to a patient who did not realize the provider was out-of-network. *Id.* As Congress recognized, this was particularly likely when a patient sought care at an emergency department, or when a patient at an in-network facility received non-emergency services from an out-of-network provider. *See id*.

The NSA, which principally took effect on January 1, 2022, regulates out-of-network billing in those scenarios. No Surprises Act, Pub. L. 116-260, § 102(e), 134 Stat. 2758 at 2797. The Act generally limits patients' cost-sharing responsibilities for these out-of-network services to the amounts that would be owed if they had been furnished by in-network providers. 42 U.S.C. § 300gg-111(a) (emergency services by nonparticipating providers or emergency facilities); *id*. § 300gg-111(b) (non-emergency services by nonparticipating providers at participating facilities); *id.* § 300gg-112(a) (air ambulance services by nonparticipating providers). And patients cannot be held liable for more than their cost-sharing responsibilities, precluding balancing billing. 42 U.S.C. §§ 300gg-131(a), 300gg-132(a), 300gg-135.

### B. The NSA provides a dispute-resolution process for out-of-network rates.

Recognizing that the NSA's consumer protections would shift responsibility for resolving payment disputes to insurers and providers, Congress included in the NSA an optional independent dispute-resolution process for "determin[ing] the out-of-network rate" for qualified items or services. Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980, 55984 (Oct. 7, 2021). The Act and implementing regulations set out the IDR process—intended to facilitate the timely resolution and payment of disputed out-of-network claims—in detail. By statute, the IDR process is only available to "nonparticipating provider[s]"—*i.e.*, a provider "who does not have a contractual relationship with the plan or issuer" for the services at issue. 42 U.S.C. § 300gg-111(a)(3)(G)(i).

Upon receiving a bill for these out-of-network items or services, an insurer has only 30 days to assess the claim and send an initial payment or notice of denial of payment to the provider. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I), (b)(1)(C). The provider or insurer then "may," within 30 days, initiate "open negotiations" to determine "an amount agreed on" by the parties for the item or service. *Id.* § 300gg-111(c)(1)(A). If open negotiations do not "result in a determination of an amount" by the end of the 30-day period, either the provider or insurer "may," within four days, initiate an "independent dispute resolution process" with respect to the

disputed item or service. *Id.* § 300gg-111(c)(1)(B).[2] The initiating party does so by submitting a written notice to the other party and to the Secretary of the Department of Health and Human Services ("HHS"). *Id.*; *see* 45 C.F.R § 149.510(b)(2). The notice must include "[a]n attestation that the items and services under dispute are qualified IDR items or services." 45 C.F.R. § 149.510(b)(2)(iii)(A)(6). That is, the dispute concerns items or services furnished by nonparticipating providers and subject to the NSA. 42 U.S.C. § 300gg-111(c)(1)(A).

The NSA's statutory deadlines aim to move the IDR process forward quickly: The parties have three days to agree on a "certified IDR entity" to decide the out-of-network rate for the disputed item or service, otherwise HHS chooses. *Id.* § 300gg-111(c)(4)(F)(i); *see* 45 C.F.R. § 149.510(c)(1)(i). A non-initiating party disputing the applicability of the IDR process has just one additional day to do so. 45 C.F.R. § 149.510(c)(1)(iii).

Within ten days of the IDR entity's selection, each party must submit its respective "offer for a payment amount" for the disputed item or service and accompanying information about the "circumstances" of the item or service, such as the acuity of the patient's condition. 42 U.S.C. §§ 300gg-111(c)(5)(B), (C); *see* 45 C.F.R. § 149.510(c)(4)(i).

[2] IDR is thus only used if it is elected by one party or the other; otherwise, nothing in the NSA requires that payment disputes be resolved through IDR.

The IDR entity has thirty days from its selection to reach a decision[3] and is required to "select one of the offers submitted [by the respective parties] to be the amount of payment" for the disputed item or service. *Id*. § 300gg-111(c)(5)(A); *see* 45 C.F.R. § 149.510(c)(4)(ii).[4] It is a narrow process; there is no discovery and no opportunity to respond to (or even to see) the opposing party's submissions.

Under certain circumstances, the NSA allows for "batching" of multiple qualified items and services furnished by the same provider and subject to payment by the same insurer to be "considered jointly as part of a single determination" by the IDR entity. *Id*. § 300gg-111(c)(3)(A)(i)–(iv) (allowing batching of disputed items or services furnished by the same provider within a specified timeframe that are related to the treatment of a similar condition, where the same insurer is responsible for payment); *see* 45 C.F.R. § 149.510(c)(3).

Absent certain exceptions, within 30 days of an IDR determination (or a negotiated agreement), the insurer is required to have paid the amount decided to the

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[3] In keeping with the elective nature of the IDR process, the parties may continue their own negotiations to try to resolve the dispute by agreement before the IDR entity reaches its decision. 42 U.S.C. § 300gg-111(c)(2)(B).

[4] The IDR entity generally must consider the "qualifying payment amount"—the median of certain contracted rates for comparable services within the insurance market. 42 U.S.C. §§ 300gg-111(c)(5)(C)(i)(I), 300gg-111(a)(3)(E). "Additional circumstances" also must be considered, such as the provider's level of training, outcomes, and market share, as well as the complexity of the treatment. *Id.* § 300gg-111(c)(5)(C)(ii).

provider. 42 U.S.C. § 300gg-111(c)(6). The party whose offer is not selected by the IDR entity is responsible for paying the entity's fees. *Id.* § 300gg-111(c)(5)(F).

### C. The NSA specifies grounds for judicial review of determinations by independent dispute-resolution entities.

The IDR entity's decision is "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). It is subject to judicial review "in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9," *i.e.*, Section 10(a) of the Federal Arbitration Act ("FAA"). *Id.* § 300gg-111(c)(5)(E)(i)(II); *see* 9 U.S.C. § 10(a).

Section 10(a) of the FAA identifies the following four grounds for vacatur:

> (1) where the award was procured by corruption, fraud, or undue means;
>
> (2) where there was evident partiality or corruption in the arbitrators, or either of them;
>
> (3) where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or
>
> (4) where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made.

9 U.S.C. § 10(a).

## II. Factual Background

### A. Radiology Partners caused MBB to fraudulently submit bills for other providers' services at MBB's higher in-network rates.

Radiology Partners is a private-equity backed entity formed in 2012 that acquires radiology practices. Dkt. 80 ¶¶ 3–4 (Am. Compl.).[5] In 2018, Radiology Partners acquired Mori, Bean, and Brooks, Inc., a Florida radiology practice with an in-network contract with Aetna. *Id.* ¶¶ 49, 53.

Radiology Partners had acquired other Florida practices that were also in-network with Aetna, but their contracts did not provide rates as lucrative as MBB's rates. *Id*. ¶¶ 4, 53, 57–59.[6] To increase profits, Radiology Partners had its other radiology groups bill for their physicians' services using MBB's tax identification number as if MBB's physicians had provided the services. *Id.* ¶¶ 53, 58. Because Aetna relies on the TIN to identify the medical group that performed the services and the applicable rate for payment, this led Aetna to pay MBB's lucrative rates for services provided by other non-MBB providers owned by Radiology Partners, rather than the lower rates the non-MBB providers had actually negotiated and agreed on with Aetna. *Id.* ¶ 193.

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[5] This is consistent with the trend observed by Congress prior to passage of the NSA. *See, e.g.*, H.R. Rep. No. 116-615, Part 1, at 53, 56–58 (2020) (noting that "inflated out-of-network prices" had drawn "private equity" investments and discussing IDR proposals).

[6] The various practices remained separate and standalone legal entities registered in Florida. Dkt. 80 ¶¶ 3–4, 185.

When Aetna asked about this increased claim volume, MBB delayed, obfuscated, and ultimately gave an untrue response, claiming providers were "being 'hired into MBB.'" *Id.* ¶¶ 6, 173–76. As detailed in the complaint, it is now clear that MBB was shielding the real reason for its growth from Aetna. *Id*. In light of MBB's increased volume of claims, Aetna decided in July 2022 to terminate MBB's in-network contract. *Id*. ¶¶ 5–6, 59. But, because of Defendants' steps to hide their scheme, Aetna did so without having learned of Defendants' fraudulent practice (*i.e.*, that MBB was billing for services rendered by other in-network medical groups). *See id.* ¶¶ 6, 170–87, 265.

### B. Beginning in July 2022, Radiology Partners took advantage of MBB's termination to fraudulently bill in-network claims on an out-of-network basis.

After MBB went out-of-network in July 2022, Radiology Partners—whose fraud had not been revealed—pivoted: As an out-of-contract provider, MBB was no longer held to negotiated contractual rates and could bill Aetna more for its services. Radiology Partners directed its in-network Florida practices to fraudulently use MBB's TIN and thus bill as if the services were rendered by an out-of-network provider. Dkt. 80 ¶¶ 58–59. As Radiology Partners expanded its scheme, the number of physicians billing under MBB's TIN gradually grew from about 50 in 2018 to over 1,000 different physicians in 2024. *Id.* ¶¶ 54–56. MBB's out-of-network submission of in-network claims resulted in Aetna paying significantly inflated

rates. *See id*. ¶¶ 60, 66–67, 82–85, 94–96, 116.[7]

Defendants' fraudulent billing practice also allowed them to improperly take advantage of the NSA's IDR process for a subset of out-of-network claims submitted by MBB. While the IDR process was established only for claims for certain out-of-network services, 42 U.S.C. § 300gg-111(a)(3)(G)(i), (c)(1)(A), Defendants knowingly initiated IDRs with respect to claims for services rendered by hundreds of in-network providers. Dkt. 80 ¶ 119; *see id.* ¶¶ 8–15, 112–15.[8] In each instance, Defendants falsely represented as a condition of participation in the IDR process that the in-network radiology practices owned by Radiology Partners "[did] not have a contractual relationship with the plan or issuer" for the services at issue. 42 U.S.C. § 300gg-111(a)(3)(G)(i). As a result of MBB's misrepresentation that the claims were IDR eligible, Aetna paid millions of dollars in inflated rates and unnecessary

[7] For example, while Aetna should have paid $75.67 for an in-network ultrasound performed by Dr. Whitley given its contract with her practice, Aetna paid $526 because MBB billed her work on an out-of-network basis. *See* Dkt. 80 ¶¶ 82–84, 89 (alleging Aetna paid MBB over $49,000 on such claims for Dr. Whitley).

[8] For example, MBB submitted a claim for imaging performed by Dr. Diez, another physician with an in-network provider. After Aetna paid $48.98 on the claim, MBB initiated an IDR process to dispute the amount and attested that the claim involved "qualified item(s) and/or service(s) within the scope of the Federal IDR process." Dkt. 80 ¶ 117; *see id.* ¶¶ 122–23, 128–30. The IDR entity determined the payment should be $427.79. *Id.* ¶ 131. The supporting documentation MBB submitted for the IDR entity's consideration likely inflated the market data for reimbursement rates by including amounts fraudulently billed using MBB's more lucrative in-network rates before July 2022. *See id*. ¶¶ 130, 261.

administrative fees. *See* Dkt. 80 ¶¶ 131, 143–45, 161; *id.*, Ex. A.

### C. Defendants concealed their fraud, so that it would not be discovered by Aetna.

Defendants used a series of tactics to conceal their fraudulent practices from Aetna: At the outset, Radiology Partners instructed MBB employees to add in-network physicians to MBB's TIN gradually rather than precipitously to avoid raising suspicions. Dkt. 80 ¶ 177. When Aetna asked MBB to explain why it was submitting claims for providers outside the Jacksonville, Florida-area, MBB personnel evaded Aetna's phone calls and emails. *Id.* ¶¶ 172–73. And when Aetna finally received a response, MBB's representative falsely claimed that the new providers were being "hired into MBB." *Id.* ¶ 176. In fact, they were part of other medical groups owned by Radiology Partners that continued to have their own in-network contracts with Aetna and were not employed by or part of MBB. *Id*.

Over time, the cover-up expanded as Defendants sought to mislead hospitals about which of Radiology Partners' medical groups and physicians were performing services, created sham "employment" agreements between doctors and MBB, and eventually began publicly referring to legally independent medical groups as "divisions" of MBB. *See, e.g.*, *id*. ¶¶ 179–80, 184–85.

Defendants advanced and concealed their IDR-related fraud by falsely attesting in MBB's IDR notices that the claims being submitted were eligible for the NSA's dispute-resolution process. *Id*. ¶¶ 256, 258–60. And Defendants' submission

of a high volume of claims and use of batched IDR submissions made it particularly difficulty for Aetna to determine that these notices contained misrepresentations, especially while processing over a million claims per day and complying with statutory deadlines. *Id.* ¶ 120 (explaining that, through batching, MBB initiated thousands of IDRs at the same time); *see id.* ¶ 196 (explaining the reasonable limitations on Aetna's investigations given claims volume). As the complaint explained, under these circumstances, despite reasonable efforts, Aetna did not uncover Defendants' fraud until late 2024—after MBB had obtained millions of dollars in IDR determinations. Dkt. 80 ¶ 265.

## III. Prior Proceedings

After uncovering Defendants' fraud, Aetna initiated this litigation in December 2024. Dkt. 1. In October 2025, Aetna filed the operative complaint ("complaint"). Dkt. 80 (Am. Compl.).[9]

### A. Aetna's claims

In light of the factual allegations described *supra*, Aetna's suit seeks vacatur of improperly obtained IDR determinations (including those identified in Exhibit A to the complaint) on the ground that (1) they were obtained through fraud, including fraudulent representations that the claims were eligible for IDR, and (2) the IDR

[9] The complaint was amended once to expressly delineate the relevant time period for each count. Dkts. 74, 79, 80.

entity exceeded its authority by deciding such claims. Dkt. 80 ¶¶ 256–60, 262–64 (Count Six); *see id*., Ex. A (non-exhaustive list of IDR determinations Defendants fraudulently obtained for services furnished by ineligible providers).

Aetna also seeks declaratory and injunctive relief under Section 502(a)(3) of the Employee Retirement Income Security Act ("ERISA") and the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202. As a claims administrator for certain health benefit plans governed by ERISA, Aetna has authority to pursue claims for the overpayment of funds. Dkt. 80 ¶¶ 268–71. To prevent further overpayments, the complaint seeks to enjoin Defendants from billing in-network claims using MBB's TIN, *id.* ¶ 277 (Count Seven), and seeks a declaration that Aetna is not obligated to pay for services billed for non-MBB providers using MBB's TIN, *id.* ¶ 286 (Count Eight).

Finally, Aetna's complaint includes state-law claims (such as fraud and negligent misrepresentation) for damages arising from claims for in-network services that Defendants billed—and Aetna paid—on an out-of-network basis through MBB, but for which MBB did *not* invoke the NSA's IDR process to dispute the amounts Aetna paid. *Id*. ¶¶ 188, 203, 219, 228, 238 (Counts One through Five); *see id.* ¶¶ 196–97, 200, 214, 226, 234–36, 249; *see also id.* ¶¶ 77, 89, 99, 101 (examples). These state-law non-vacatur claims are distinct from, and do not depend on, Aetna's claim for vacatur.

### B. Dismissal with prejudice

In April 2026, the district court dismissed the complaint with prejudice. Dkt. 105. The court began with Aetna's claim for vacatur based on Defendants' fraud, noting that vacatur under Section 10(a)(1) of the FAA requires a plaintiff to establish fraud by clear and convincing evidence, show the fraud was "not … discoverable upon the exercise of due diligence," and demonstrate it materially related to an issue in arbitration. *Id*. at 7.

The court first concluded that Aetna had alleged fraud with sufficient particularity to satisfy Federal Rule of Civil Procedure 9(b). *Id*. at 6 (recognizing the allegations that "Aetna was harmed" by Defendants' scheme). The court then considered whether Aetna adequately alleged that Defendants' fraud was not discoverable through the exercise of due diligence. The court described the question as a "close call." *Id*. at 8. It read the complaint to include an "admission" that Aetna terminated its contract with MBB because it knew Defendants were engaged in fraud. *Id*. Because the court construed the complaint in this way—as if Aetna pleaded that Defendant's scheme was discovered well before any IDR proceedings—the court granted Defendants' motion to dismiss Aetna's claim for vacatur. *Id.* at 8. Moreover, the court did so without addressing Aetna's separate and independent ground for vacatur: that the IDR entities exceeded their authority under the NSA when they issued determinations on ineligible claims.

The district court then concluded that all of Aetna's "remaining claims"—primarily state-law counts concerning claims that Aetna paid and that were never submitted to any IDR processes—were "preempted by the NSA and FAA and otherwise inadequate grounds to challenge the IDR awards." *Id.* at 9. Because Defendants had not raised preemption, the court did not have the benefit of any briefing by the parties. Believing that these claims would "[a]llow[] Aetna to recover for the IDR awards," the court characterized the claims as an "end-around the NSA and FAA strictures." *Id*. The court seemingly did not recognize that none of the "remaining claims" challenged any IDR determinations.[10] The district court did not expressly address Aetna's ERISA claim. It stated only that "the Court is not empowered to take a preliminary review" on "claims yet to be submitted to the IDR." *Id.* at 9–10.

Aetna's opposition to Defendants' motion to dismiss proposed that, if the district court found the complaint inadequate, any such defect could be cured "via amendment." Dkt. 90 at 21 n.4. The district court's order dismissed "with prejudice," calling amendment "futile." Dkt. 105 at 10.

This appeal followed.

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[10] *See*, *e.g.*, Dkt. 80 ¶ 188 (asserting that Aetna's state-law fraud claim "applies with respect to benefit claims that were submitted under MBB's TIN on an out of-network basis for non-MBB providers, and that were paid by Aetna without invocation of the NSA IDR process").

## STANDARD OF REVIEW

This Court reviews *de novo* the district court's dismissal of the complaint for failure to state a claim. *Pereda v. Brookdale Senior Living Cmtys., Inc.*, 666 F.3d 1269, 1272 (11th Cir. 2012). When doing so, the Court "accept[s] the factual allegations in the complaint as true and construe[s] them in the light most favorable to the plaintiff." *Id.* The Court "review[s] the district court's decision to deny leave to amend for an abuse of discretion," but "review[s] *de novo* an order denying leave to amend on the grounds of futility, because it is a conclusion of law that an amended complaint would necessarily fail." *City of Miami v. Citigroup Inc.*, 801 F.3d 1268, 1275 (11th Cir. 2015).

## SUMMARY OF THE ARGUMENT

**I.** Aetna's complaint states a claim for vacatur of certain IDR determinations. The district court's dismissal of the claim rests on a misreading of the complaint and disregards the well-established legal standard for reviewing pleadings on a Rule 12(b)(6) motion. It must be reversed.

The NSA provides for judicial review of IDR decisions procured through fraud or where the IDR entity exceeds its authority. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II) (incorporating 9 U.S.C. § 10(a)(1), (4)). The district court recognized that Aetna properly alleged that Defendants engaged in fraud and did so with the particularity necessary to satisfy Rule 9(b)'s heightened pleading

requirement. Dkt. 105 at 6–7. But the court went on to dismiss the vacatur claim based on its mistaken conclusion that Aetna knew about Defendants' fraudulent scheme prior to the IDR proceedings. That pleading-stage factual assessment—which the court described as a "close call" made with "Aetna's 'heavy burden'" of proof in mind—was wholly improper. *Id*. at 8–9. The court misread the complaint to contain an "admission" that Aetna "knew" of Defendants' fraud when they terminated MBB's in-network contract in 2022 and deemed this "fatal to Aetna's position." *Id*. In fact, the complaint does *not* attribute termination of the contract to knowledge of fraud; to the contrary, it alleges Aetna did *not* have such knowledge until 2024 and explains the reasons for this, including the affirmative steps Defendants took to conceal their fraud. Dkt. 80 ¶¶ 170–87, 265. The district court erred when, rather than accepting these clear allegations, it drew inferences against Aetna, the non-moving party, to make a "close call" factual determination.

The district court also erred by dismissing this count without acknowledging or addressing Aetna's other ground for vacatur: that the IDR entities necessarily exceeded their powers when they decided claims that were not for "qualified" services furnished by out-of-network providers. 42 U.S.C. § 300gg-111(c)(1)(A), (c)(1)(B), (c)(2)(A).

**II.** The district court's dismissal of Aetna's remaining claims was also error. It reflected a misunderstanding of the nature of Aetna's claims and their relationship to the IDR process—or rather their lack thereof.

First, the court violated the principle of party presentation by dismissing the claims based on a preemption argument that Defendants never raised and that Aetna therefore had no opportunity to address. *Margolin v. Nat'l Ass'n of Immigr. Judges*, 146 S. Ct. 1285, 1288 (2026). Second, the court mistakenly believed that Aetna's state-law claims sought to recover payments made to MBB as a result of IDR determinations and thereby effectively vacate the IDR determinations. Dkt. 105 at 9. In fact, Aetna's state-law claims for damages concern payments Aetna made on fraudulent bills that were *not* disputed in any IDR and do not implicate that process. Preemption is plainly inapplicable here.

Similarly, Aetna's ERISA claim did not challenge any IDR determination or the IDR process. Rather, Aetna asked the district court to issue declaratory or injunctive relief to stop Defendants from continuing to submit bills for in-network services on an out-of-network basis—relief within the court's authority. In short, none of Aetna's "remaining claims" pose any conflict with the NSA, FAA or other federal law, and the order dismissing them should be reversed.

**III.** At a minimum, the district court should have granted Aetna leave to amend its complaint. *City of Miami*, 801 F.3d at 1277. Because dismissal of the claim

for vacatur turned on the court's understanding of Aetna's factual allegations, which the court concluded presented a "close call," Dkt. 105 at 9, it was error to hold that amendment would be futile. Likewise, if necessary, the court's apparent confusion as to the scope of the other claims could be clarified in an amended complaint.

## ARGUMENT

### I. The District Court Erred in Dismissing Aetna's Claim for Vacatur of IDR Determinations for In-Network Benefit Claims.

Aetna seeks vacatur of MBB's improperly obtained IDR determinations on two grounds. First, the determinations are the product of fraudulent misrepresentation of in-network claims as eligible for IDR under the NSA. The district court erred by purporting, at the pleading stage, to resolve the factual question of whether Defendants' fraud was discoverable before or during the IDR process, disregarding Aetna's allegations to the contrary and drawing inferences in Defendants'—rather than Aetna's—favor. Second, Aetna's claim for vacatur is also supported by allegations that the IDR entities exceeded their powers when they issued determinations as to payment amounts for services not eligible for IDR. The district court erred in dismissing Aetna's claim without considering this basis for relief.

### A. Aetna adequately pleaded a claim for vacatur based on fraud.

The NSA establishes that an IDR determination is not binding on the parties where there is a "fraudulent claim" or "misrepresentation of facts … to the IDR entity," 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I), and the Act's limitation on judicial review does not apply in a case in which the decision "was procured by … fraud." 9 U.S.C. § 10(a)(1); *see* 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II).

This Court has applied the FAA's three-part test to determine whether an IDR determination should be vacated for fraud: (1) "[T]he 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." *Bonar v. Dean Witter Reynolds, Inc.*, 835 F.2d 1378, 1383 (11th Cir. 1988) (applied in *Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc.*, 160 F.4th 1110, 1121 (11th Cir. 2025)). Only the first of these three elements—the fraud itself—must be alleged with "particularity." Fed. R. Civ. P. 9(b) (requiring a plaintiff to "state with particularity the circumstances constituting fraud"); *see Reach Air Med. Servs.*, 160 F.4th at 1121 (holding plaintiff seeking to vacate NSA IDR determination failed to allege fraud with sufficient detail to satisfy Rule 9(b)). The remaining elements—including the

requirement that the fraud at issue was not discoverable earlier with reasonable diligence—are *not* subject to a heightened pleading standard. Fed. R. Civ. P. 8.[11]

The district court expressly held that Aetna satisfied its obligation under Rule 9(b) to allege "with particularity the circumstances constituting [Defendants'] fraud." Dkt. 105 at 6. As the district court recognized (*id*. at 6, 8), Aetna addressed the "precise statements" underlying Defendants' fraud—including details about the time and place, as well as content and manner, in which the fraudulent statements misled Aetna—and allegations of how Defendants "gained by the alleged fraud." *Otto Candies, LLC v. Citigroup Inc.*, 137 F.4th 1158, 1178 (11th Cir. 2025) (discussing Rule 9(b) standard).

Aetna's allegations detailed how, beginning in July 2022, Defendants engaged in a practice of fraudulently submitting claims for reimbursement as if the services were furnished by an out-of-network provider when they were actually in-network (*i.e.*, covered by a contract between Aetna and the provider who furnished the

[11] The district court noted that plaintiffs bear a "heavy burden of demonstrating that vacatur is appropriate … by proving the existence of one or more of four statutorily enumerated causes for reversal." Dkt. 105 at 7 (quoting a summary judgment ruling, *Wiand v. Schneiderman*, 778 F.3d 917, 925 (11th Cir. 2015)). It is only the first of the three elements—the fraud itself—that *Bonar* says must be proven by "clear and convincing evidence." 835 F.2d at 1383. But as discussed below, whatever the burden of proof for the remaining elements, the *pleadings* are subject to the "familiar Rule 12(b)(6) standard explicated by the Supreme Court in *Twombly* and *Iqbal*." *Thomas Davis v. Miami-Dade Cnty.*, No. 23-12480, 2024 WL 4051215, at *1 (11th Cir. Sept. 5, 2024) (reversing where the court relied on the "evidentiary framework" to "assess the sufficiency of [plaintiff's] complaint").

service), and then fraudulently initiating IDR proceedings to dispute the sufficiency of Aetna's payments on those claims. Dkt. 105 at 8. Aetna specified, for example, that Defendants' fraudulent scheme depended on misrepresentations MBB made in the IDR notices it submitted each time it initiated an IDR process. Dkt. 80 ¶ 117 (explaining that each time MBB attested that "the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) within the scope of the Federal IDR process").[12] Aetna further explained that it did not know of the fraud at the time, and specifically pleaded that it later discovered those statements were false for tens of thousands of claims where the services were not "qualified" because they were not furnished by a "nonparticipating" or out-of-network provider, as required by the NSA. 42 U.S.C. §§ 300gg-111(c)(1)(A)–(B), (2)(A), (3)(G)(1); *see* Dkt. 80 ¶¶ 118, 162; *id.*, Ex. A (alleging thousands of IDR decisions obtained by fraudulently submitting in-network benefit claims). The complaint offered specific examples of physicians at practices with contracts with Aetna whose services were falsely billed on an out-of-network basis by using the TIN of MBB, and where, after Aetna's initial payment, Defendants sought more money through IDR proceedings. *See, e.g.*, *supra* note 8. Finally, Aetna identified multiple ways in which the fraudulent scheme benefited Defendants. Dkt. 80. ¶¶ 60, 66–67, 82–84, 94–96, 116–33, 144–46, 157–

[12] Given the false representations at issue, there was no question in the district court's ruling that the fraud alleged "materially related to an issue in the arbitration." *Bonar*, 835 F.2d at 1383.

59. The district court stressed that Defendants' fraud "resulted in IDR awards that injured Aetna by causing Aetna to incur arbitration fees and to pay at a rate higher than it would have if the claims were submitted as being performed by in-network providers." Dkt. 105 at 8.

The district court then turned to whether the fraud was "discoverable upon the exercise of due diligence prior to or during arbitration." *Id*. Aetna adequately alleged that it was not. *See, e.g.*, Dkt. 80 ¶¶ 6, 59, 265 (alleging that, despite reasonable inquiries, the insurer did not discover Defendants' fraudulent submissions until late 2024). As the district court acknowledged, the complaint described multiple steps Defendants took to "shield the true origins of their claims." Dkt. 105 at 8–9. Among other things, Defendants sought to make it difficult to discern physicians' medical group affiliations, providing false or incomplete answers to questions and even creating sham agreements between doctors and MBB. Dkt. 80 ¶¶ 179–80, 184–85. And they initiated improper IDRs in bulk batches of thousands of claims to inundate Aetna with more disputes than it could reasonably investigate. *Id*. ¶¶ 120, 196. The volume of batched submissions—reaching four to five thousand claims at a time—required Aetna to rely on MBB's attestations in the IDR notices that the benefit claims were "qualified" for IDR. *Id*. ¶¶ 117, 120, 161 196.[13] These factual allegations

[13] As described *supra* pp. 7–9, the NSA imposes a series of rapid deadlines on the IDR process, providing Aetna only days to assess claims. That MBB submitted its

should have sufficed. *See Bonar*, 835 F.2d at 1383 (citing *Karppinen v. Karl Kiefer Mach. Co.*, 187 F. 2d 32, 35 (2d Cir. 1951)). After all, "[r]easonable diligence does not require parties to assume the other side is lying." *France v. Bernstein*, 43 F.4th 367, 380 (3d Cir. 2022); *see also NuVasive, Inc. v. Absolute Med., LLC*, 71 F.4th 861, 879 n.11 (11th Cir. 2023) (explaining that where a person "took an oath affirming that there was no one in the room with [the witness] and no one was communicating with him," it was reasonable to "believe, in reliance on this oath, that no one was coaching him").

The district court held otherwise. In doing so, the court misapplied the relevant legal standard and read admissions into the complaint that Aetna did not make. It is axiomatic that a plaintiff's well-pleaded allegations control at the Rule 12 stage. *Pereda*, 666 F.3d at 1272. The district court thus erred by seeking to resolve the fact-dependent question of discoverability at the pleading stage, rather than accepting Aetna's factual allegations as true and construe them "in the light most favorable to the plaintiff," as required on a Rule 12(b)(6) motion. *Id*.

The district court was explicit that it thought the answer was "a close call"—which, contrary to federal pleading standards, it resolved in Defendants' favor. Dkt. 105 at 8. In doing so, the court claimed to be "mindful" of the ultimate evidentiary

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IDR notices containing this attestation not only to Aetna, but also HHS, lent an added expectation of legitimacy. Dkt. 80 ¶ 256; *see* 45 C.F.R §§ 149.510(b)(2)(i), (b)(2)(iii)(A)(6).

standard—what it called Aetna's "heavy burden." *Id*. But this was error, improperly conflating pleading and evidentiary standards. As this Court has recognized, the "evidentiary framework" does not alter the "familiar Rule 12(b)(6) standard" that must be used to assess the sufficiency of these allegations. *Thomas Davis*, 2024 WL 4051215, at *1; *see, e.g.*, *Surtain v. Hamlin Terrace Found.*, 789 F.3d 1239, 1246 (11th Cir. 2015) (reversing district court's conclusion that a party failed to "plead a valid claim for relief" based on the "evidentiary standard" rather than applying the "*Iqbal/Twombly* plausibility standard"); *Durham v. Kelley*, 82 F.4th 217, 227 (3d Cir. 2023) ("Standards of pleading are not the same as standards of proof."); *see also supra* p. 24 & note 11.

Moreover, the district court's conclusion—that it could "not excuse Aetna's failure to raise" Defendants' fraud in the IDR disputes—was improper factfinding that relied heavily on an "admission" the court incorrectly attributed to Aetna. Dkt. 105 at 9. The court claimed (without citation) that Aetna's complaint "states that it terminated its contract with MBB because MBB was submitting in-network claims from providers across the state that were not employees of MBB." *Id*. at 8; *see id.* at 8–9 (repeating the erroneous assertion that Aetna "admi[tted] that it knew" Defendants were abusing MBB's TIN, and that this was "fatal to Aetna's position").

In fact, Aetna's complaint makes no such "admission." Aetna alleged it terminated MBB's contract in July 2022 after MBB's claim submissions increased

in volume. Dkt. 80 ¶¶ 6, 54–56, 59. The complaint does *not* allege that Aetna was aware at that time that MBB was submitting claims on behalf of other providers who were not MBB employees or could infer fraud. Instead, the complaint expressly alleges that it was not until "late 2024" that Aetna identified the fraudulent nature of MBB's IDR submissions. *Id*. ¶ 265. The district court nevertheless drew the conclusion that Aetna had discovered MBB's fraud when Aetna terminated its contract with MBB and that Aetna's failure to raise the fraud during arbitration could not be "excuse[d]." Dkt. 105 at 8–9. That inference, drawn in Defendants' favor, was error. *See, e.g.*, *Randall v. Scott*, 610 F.3d 701, 705 (11th Cir. 2010) (repeating the familiar refrain that, on a motion to dismiss, the court must "draw all reasonable inferences in the plaintiff's favor").

Given Defendants' alleged efforts to conceal MBB's fraudulent practices and affirmative misrepresentations, Aetna plausibly pleaded that the fraud was not discoverable through reasonable diligence—and nothing more was required at this stage. The district court committed reversible error when it misread the complaint to include a "fatal" admission and drew inferences against Aetna. Dkt. 105 at 9; *see, e.g.*, *Randall*, 610 F.3d at 705; *Thomas v. Bradshaw*, No. 20-13471, 2022 WL 333244, at *4 (11th Cir. Feb. 4, 2022) (applying "standard set out under Federal Rule of Civil Procedure 12(b)(6)" and holding dismissal improper where "the district

court misconstrued [plaintiffs' complaint] and narrowed the allegations contained therein").

### B. Aetna also properly argued for vacatur because the IDR entities exceeded their authority.

Aetna raised a second, independent basis for vacating the IDR decisions: that the IDR entities exceeded their authority under the NSA by deciding payment disputes over services rendered by providers with applicable in-network contracts with Aetna. *See* Dkt. 80 ¶¶ 11, 113, 126, 140, 153, 262–64, 266; Dkt. 90 at 18–20 (MTD Opp.). The NSA recognizes this as grounds for vacatur, 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II) (incorporating 9 U.S.C. § 10(a)(4)), and the district court erred by failing to address this argument.

This Court has explained that in Section 10(a)(4) cases—where vacatur is authorized because "the arbitrators exceeded their powers," 9 U.S.C. § 10(a)(4)—a court's "review is quasi-jurisdictional: a check to make sure that the arbitration agreement granted the arbitrator authority to reach the issues it resolved." *Gherardi v. Citigroup Glob. Mkts., Inc.*, 975 F.3d 1232, 1238 (11th Cir. 2020); *see, e.g.*, *Szuts v. Dean Witter Reynolds, Inc.*, 931 F.2d 830, 831–32 (11th Cir. 1991) (vacating arbitration award where panel did not abide by requirements imposed by arbitration agreement); *PoolRe Ins. Corp. v. Organizational Strategies, Inc.*, 783 F.3d 256, 262 (5th Cir. 2015) (explaining that judicial deference ceases when "the arbitrator exceeds the express limitations of his … mandate"). As particularly relevant here,

this Court has concluded that vacatur under Section 10(a)(4) is warranted where an arbitrator exceeds its authority by resolving a type of claim not covered by the arbitration agreement. *Reach Air Med. Servs. LLC*, 160 F.4th at 1120 (observing that vacatur is proper where arbitrators "award relief on a statutory claim when the arbitration agreement allows only for arbitration of contractual claims" (citing *Paladino v. Avnet Comput. Techs.*, 134 F.3d 1054, 1061 (11th Cir. 1998))).

The NSA incorporates the same rule when an IDR entity exceeds its limited statutory authority. The Act authorizes an IDR entity to determine the rate for a "qualified IDR item or service," which the Act defines as an "item or service furnished … by a nonparticipating provider or a nonparticipating facility." 42 U.S.C. § 300gg-111(c)(2)(A)–(B). And a nonparticipating provider or facility is one that "does not have a contractual relationship" with the insurer for the service. *Id.* § 300gg-111(a)(3)(G)(i). This sets the metes and bounds of the IDR entity's authority.[14]

Conversely then, when a contractual relationship exists between the insurer and the provider who furnished the service at issue, the IDR entity lacks statutory authority to decide the rate for the service if it is covered by their contract. Here,

[14] Indeed, regulations issued after the district court's decision stress that a "certified IDR entities are *statutorily prohibited* from making payment determinations for items and services that are not subject to the [NSA.]" 91 Fed. Reg. 33900, 33933 (June 4, 2026) (emphasis added).

Aetna alleged that IDR entities repeatedly did just that—they determined rates for items or services that were not "qualified" because they were covered by a contract that existed between Aetna and an in-network provider who furnished the service. In short, the IDR entities exceeded their statutory authority each time they determined the rates for in-network services. Aetna is entitled to reversal of its vacatur claim on this basis.

## II. The District Court Erred in Holding Aetna's Other Claims, Which Do Not Seek Vacatur of any IDR Determination, Preempted by the NSA.

### A. The district court's preemption ruling violated the principle of party presentation.

The district court dismissed Aetna's "remaining claims" (a combination of state law and federal ERISA claims) based on a preemption theory that Defendants did not raise and Aetna had no opportunity to address. This contravened the principle of party presentation, which requires the parties to "frame the issues for decision." *United States v. Sineneng-Smith*, 590 U.S. 371, 375 (2020). A judgment may be reversed where a lower court "transgresse[s] the party-principle" by deciding issues the parties did not raise below. *Margolin*, 146 S. Ct. at 1288. Where, as here, a court reaches a decision based on a new theory "without giving either side a chance to address its theory," that "departure from the principle of party presentation constitute[s] an abuse of discretion." *Id*. (internal quotation omitted). That alone is sufficient to warrant reversal of the court's dismissal of the remaining counts.

### B. Aetna's state law and federal ERISA claims are not preempted.

The district court claimed that "[t]he NSA adopts the ferocity of the FAA in defending arbitration awards," and suggested that it thus preempts state-law claims "that would otherwise frustrate its purpose." Dkt. 105 at 9. Without the benefit of briefing by the parties, the district court mistakenly described Aetna's "remaining claims" as an "attempt to end-around the NSA and FAA strictures," and held them preempted. *Id*. The court both misunderstood the contours of preemption under the FAA and the nature of Aetna's non-vacatur claims. *Id*. at 9–10.

The Supreme Court has held that the FAA preempts state law rules that prohibit the arbitration of particular types of claims or discriminate against arbitration agreements. *See, e.g.*, *Marmet Health Care Ctr., Inc. v. Brown*, 565 U.S. 530, 533 (2012); *Preston v. Ferrer*, 552 U.S. 346, 353 (2008). Even assuming some such rule could be attributed to the NSA and its IDR process, Aetna's state-law claims do nothing of the sort.

As explained in the complaint, these claims concern payment disputes that did *not* go through the NSA's dispute resolution process: Aetna seeks to recover excess amounts it paid as a result of fraudulent bills that were "not submitted to IDR." Dkt. 80 ¶ 16; *see id*. ¶¶ 188, 200, 203, 214, 219, 226, 228, 234–36, 238, 249.[15] Thus,

[15] The state-law claims address overpayments such as the following: MBB billed for an ultrasound by Dr. Nouri on an out-of-network basis, and Aetna paid $752 based

contrary to the district court's assertion, these claims do not "challenge" any IDR determinations or "discard[]" the IDR process established by Congress. Dkt. 105 at 9.[16]

Aetna's only other remaining claim—a forward-looking federal ERISA claim—does not seek to challenge or collaterally attack any IDR determination or process. It seeks to prevent Defendants from continuing to fraudulently bill Aetna for in-network claims on an out-of-network basis. *See* Dkt. 80 ¶ 277. The district court erred when it stated that it was "not empowered to take a preliminary review" of "claims yet to be submitted to the IDR." Dkt. 105 at 9–10. Aetna alleged an ongoing harm, Dkt. 80 ¶ 275, that poses "a real and immediate—as opposed to a merely conjectural or hypothetical—threat of future injury." *Houston v. Marod Supermarkets, Inc.*, 733 F.3d 1323, 1329 (11th Cir. 2013) (emphasis omitted). The

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on that false representation. Dkt. 80 ¶ 70. Had it been billed correctly using the TIN for Dr. Nouri's in-network practice, Aetna would have owed just $78.89. *Id*. ¶ 69. No IDR process was initiated, and thus no IDR determination is at issue. *Id.* ¶ 77 (alleging Aetna "paid MBB more than $118,000 on at least 610 claims for services rendered by Dr. Nouri billed under MBB's TIN on an out-of-network basis independent of the NSA IDR process"). Aetna seeks damages under state law because Defendants unlawfully induced Aetna to pay excess out-of-network rates.

[16] Congress, of course, did not mandate IDR as the exclusive means for resolving payment disputes; it made the IDR process a mechanism either party may elect to use to resolve disputes over payment amounts. *See* 42 U.S.C. § 300gg-111(c)(1)(A), (B) (providing either party "may" initiate open negotiations or IDR); *see also* Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980, 55984 (Oct. 7, 2021) ("Federal IDR provisions *may* be used to determine the out-of-network rate.") (emphasis added).

district court did not identify any provision of the NSA or FAA that precludes prospective relief in those circumstances, and there is none. The district court's dismissal of these claims must be reversed.

## III. At a Minimum, It Was Error to Dismiss with Prejudice, and Aetna Should Be Granted Leave to Amend.

Having misconstrued Aetna's allegations and claims, the district court dismissed with prejudice, incorrectly concluding that "amendment would be futile." Dkt. 105 at 10. "A district court's discretion to dismiss a complaint without leave to amend is severely restricted by Fed. R. Civ. P. 15(a), which directs that leave to amend shall be freely given when justice so requires." *Bryant v. Dupree*, 252 F.3d 1161, 1163 (11th Cir. 2001) (cleaned up). "Generally, 'where a more carefully drafted complaint might state a claim, a plaintiff must be given at least one chance to amend the complaint before the district court dismisses the action with prejudice.'" *Id.*; *see also Garcia v. Chiquita Brands Int'l, Inc.*, 48 F.4th 1202, 1220 (11th Cir. 2022) (same).

Here, as discussed *supra*, Aetna's detailed allegations and carefully delineated claims should have survived Defendants' pleading-stage motion without amendment. But if more were needed, then Aetna should have been given—and must now be afforded—an opportunity to clarify the factual bases for it claims, including that Aetna had not uncovered MBB's fraud when it terminated MBB's contract and, despite reasonable efforts, was unable to determine the fraudulent

nature of the IDR submissions at issue until after the determinations were issued.[17]

In short, because the district court's decision turned on its misapprehension of Aetna's allegations and claims, this Court should reverse outright. At a minimum, however, the court's erroneous finding of "futility" must be rejected and the case remanded with instructions for the district court to grant Aetna leave to amend. *City of Miami*, 801 F.3d at 1277.

## CONCLUSION

For all these reasons, Aetna respectfully requests that this Court reverse the district court's judgment and remand for further proceedings.

[17] An amended pleading could also confirm that, as a matter of fact, Aetna's other (non-vacatur) claims do not challenge IDR determinations in this case. But this clarification ought to be wholly unnecessary as this is already stated explicitly in the complaint. *See* Dkt. 80 ¶¶ 16, 188, 200, 203, 214, 219, 226, 228, 234–36, 238, 249.

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Respectfully submitted,

**DLA PIPER LLP (US)**

/s/ Samantha L. Chaifetz

Samantha L. Chaifetz
DLA Piper LLP (US)
500 Eighth Street, NW
Washington, DC 20004
(202) 799-4000
samantha.chaifetz@us.dlapiper.com

Ardith Bronson
DLA Piper LLP (US)
200 South Biscayne Blvd.
Suite 2500
Miami, FL 33131
(305) 423-8562
ardith.bronson@us.dlapiper.com

Colin McGrath
DLA Piper LLP (US)
2000 Avenue of the Stars
Suite 400 North Tower
Los Angeles, CA 90067
(310) 595-3000
colin.mcgrath@us.dlapiper.com

*Counsel for Plaintiffs-Appellants Aetna Health Inc., et al.*

## CERTIFICATE OF COMPLIANCE

This Brief complies with the typeface and style requirements of Federal Rule of Appellate Procedure 32(a)(5) and (6) because this Brief was prepared in a proportionally spaced typeface using Microsoft Word using 14-point Times New Roman.

This Brief complies with the type-volume requirements of Federal Rule of Appellate Procedure 32(a)(7)(B)(i) because, excluding the parts of this Brief exempted by Federal Rule of Appellate Procedure 32(f) and Eleventh Circuit Rule 32-4, this Brief contains 8,622 words.

Dated: July 17, 2026

*/s/* Samantha L. Chaifetz
Samantha L. Chaifetz

*Counsel for Plaintiffs-Appellants Aetna Health Inc., et al.*

## CERTIFICATE OF SERVICE

I hereby certify that I electronically filed this document with the Clerk of Court using CM/ECF on July 17, 2026, which will automatically generate and serve Notices of Electronic Filing on all entitled parties.

Dated: July 17, 2026

*/s/* Samantha L. Chaifetz
Samantha L. Chaifetz

*Counsel for Plaintiffs-Appellants Aetna Health Inc., et al.*