

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION**

**REACH AIR MEDICAL SERVICES, LLC, §
CALSTAR AIR MEDICAL SERVICES, LLC, §
GUARDIAN FLIGHT LLC, MED-TRANS §
CORP., and AIR EVAC EMS, INC., §
§**

Plaintiff,

VS.

**AETNA HEALTH, INC., AETNA LIFE
INSURANCE CO., and AETNA HEALTH
AND LIFE INSURANCE CO.,**

Defendants.

Civil Action No. 4:23-cv-00805

DEFENDANTS' MOTION TO DISMISS PLAINTIFFS' ORIGINAL COMPLAINT

Defendants Aetna Health, Inc., Aetna Life Insurance Co., and Aetna Health and Life Insurance Co. (collectively “Defendants”)¹ move to dismiss Plaintiffs’ REACH Air Medical Services (“REACH”), CALSTAR Air Medical Services, LLC (“CALSTAR”), Guardian Flight LLC (“Guardian Flight”), Med-Trans Corporation (“Med-Trans”), and Air Evac EMS, Inc. (“Air Evac”) (collectively “Plaintiffs”) original complaint (Dkt. 1) under Federal Rules of Civil Procedure 12(b)(1), 12(b)(3), and 12(b)(6).

I. INTRODUCTION

Plaintiff’s complaint identifies 51 Independent Dispute Resolution (“IDR”) awards that Plaintiffs allege Defendants have failed to pay within the 30-day window provided for under the

¹ Defendants file this motion to dismiss without waiver of any argument that Defendants Aetna Health and Life Insurance Company and Aetna Health Inc. are not proper parties to Plaintiffs' claims. Based on Plaintiffs' ascertainable allegations, Aetna Life Insurance Company is the relevant affiliate.

No Surprises Act (“NSA”). *See* Dkt. 1-2; *see also* 42 U.S.C. 300gg-111(c)(6). The IDR awards allegedly concern air-ambulance transports provided by one of the Plaintiffs to patients insured by Defendants. These air-ambulance flights took place in fourteen different states. The IDR awards were rendered by three different IDR entities located in Texas, Pennsylvania, and Illinois.

Since receiving the complaint, Defendants have worked diligently to resolve this matter. However, some of the IDR awards identified by Plaintiffs did not appear to involve Defendants (i.e., Aetna), while Defendants lacked sufficient information to verify the status of other IDR awards. And in some instances, Aetna has no record of *receiving* any such award (which is an issue beyond Aetna’s control in the new federal IDR process). Moreover, while counsel for the parties worked together behind the scenes, Plaintiffs identified additional IDR awards that were not mentioned in their complaint, which Plaintiffs claim Defendants have not paid. Defendants have worked earnestly to verify and, where appropriate, pay this latter group of IRD awards, as well. Of the 51 IDR awards identified by Plaintiffs in their complaint, only a few remain outstanding, which Defendants are committed to paying once properly verified.

The true hindrance to resolving this case is Plaintiffs’ request for pre- and post-judgment interest, costs, and attorney’s fees. For reasons explained below, Defendants maintain that Plaintiffs have failed to invoke the Court’s jurisdiction under any of the three causes of action pleaded. Specifically, (i) the NSA does not provide a private right of action for the Court to “confirm” an IDR award, much less “convert” such an award “into a federal judgment,” *see* Dkt. 1 at 6; (ii) Plaintiffs lack standing to enforce the IDR awards under the Employee Retirement Income Security Act of 1974 (“ERISA”); and (iii) the NSA preempts the various state-law prompt-pay statutes under which Plaintiffs attempt to recover. As for the latter legal theory, Defendants contend in the alternative that Plaintiffs have failed to state a claim under the state prompt-pay

statutes because recovery under those statutes is predicated on a contractual agreement between the parties, which is lacking in this case. Finally, even if one were to assume the NSA does permit this type of enforcement action—i.e., allow a court to “issue judgment for the total amount outstanding [IRD awards]”—it is beyond debate that the NSA does not permit Plaintiffs to recover pre- or post-judgment interest, costs, or attorney’s fees.

As a final hurdle, the Southern District of Texas is not the proper venue for resolving this dispute. Plaintiffs’ basis for filing suit in the Southern District of Texas is that a handful of the IDR awards at issue—almost all of which have since been resolved—were decided by Medical Evaluators of Texas ASO, LLC (“MET”), a dispute-resolution entity located in Houston.² That any IDR awards were issued in the Southern District of Texas is complete red herring, as the “event[] or omission[] giving rise to” Plaintiffs’ complaint is not *where* an award was issued. *See* 28 U.S.C. § 1391(b)(2). Rather, the singular event or omission giving rise to Plaintiffs’ complaint is Defendants’ alleged failure to timely pay the awards. Accordingly, venue is proper in the District of Connecticut—the judicial district where Defendants reside. *See id.* § 1391(b)(1).

In sum, the Southern District of Texas is not a proper venue, and the case should be dismissed on that basis. Alternatively, Plaintiffs’ claims fail on their merits as a matter of law.

II. SUMMARY OF THE ARGUMENT

Plaintiffs have failed to establish that this Court has subject-matter jurisdiction over their dispute. Beginning with federal-question jurisdiction, Plaintiffs have not pleaded an action “arising under the Constitution, laws, or treaties of the United States.” 28 U.S.C. § 1331. First, the NSA does not provide a private right of action for the Court to “confirm” an IDR award, much less

² The remaining IDR awards were issued by dispute-resolution entities in Pennsylvania and Illinois.

“convert” such an award “into a federal judgment.” *See* Dkt. 1 at 6.

Furthermore, Plaintiffs’ attempt to shoehorn their enforcement claims under ERISA likewise does not vest the Court with subject-matter jurisdiction. As medical providers, Plaintiffs must demonstrate they have derivative standing to pursue a claim under ERISA. Plaintiffs ostensibly attempt to do so in their complaint, stating: “Plaintiffs have been assigned the right to payment and benefits from Aetna’s beneficiaries.” *Id.* at 7. But one cannot assign a right they do not have. Here, the plan members whose medical claims were submitted to the NSA’s IDR process have no “right to payment and benefits.” *See id.* To the contrary, the NSA was enacted to eliminate the harm caused by surprise out-of-network medical bills by removing the patient (i.e., plan member) from the equation and, instead, submitting disputes between out-of-network providers and insurers to arbitration under the IDR process. *See* 42 U.S.C. §§ 300gg-112, 300gg-131, 300gg-132. Because those plan members whose medical claims were submitted to IDR arbitration are not entitled “to payment and benefits,” the supposed assignments of their rights to such are meaningless. *See* Dkt. 1 at 7. Accordingly, Plaintiffs lack standing to sue under ERISA.

Plaintiffs’ third theory of recovery arises under fourteen different states’ “prompt-pay” statutes. *See* Dkt. 1 at 8. Those states, according to Plaintiffs, represent where the air-ambulance transports that give rise to the IDR awards at issue took place. *See id.* at 5. There are multiple problems with this legal theory. First, Plaintiffs have not sufficiently pleaded diversity jurisdiction.³ But even if one were to assume the Court has jurisdiction, Plaintiffs’ state-law

³ Plaintiffs’ complaint only provides that REACH, CALSTAR, and Guardian Flight are California (REACH and CALSTAR) and Delaware (Guardian Flight) limited liability companies with their principal places of business in California (REACH and CALSTAR) and Texas (Guardian Flight). *See* Dkt. 1 at 2. However, where an LLC maintains its principal place of business is irrelevant for determining its citizenship for diversity jurisdiction purposes. *See Warren v. Bank of Am., N.A.*, 717 F. App’x 474, 475 n.4 (5th Cir. 2018). Rather, the citizenship of a limited-liability entity is determined by the citizenship of its members. *See Harvey v. Grey Wolf Drilling*

prompt-pay claims fail as a matter of law because they are preempted by the NSA’s IDR process.

Finally, even if one were to assume Plaintiffs could bring the pleaded enforcement claims, the Southern District of Texas is not the appropriate venue to bring such an action. As explained, the “event[] or omission[] giving rise to” Plaintiffs’ complaint is not where the award was issued. *See* 28 U.S.C. § 1391(b)(2). Rather, the singular event or omission giving rise to Plaintiffs’ complaint is Defendants’ alleged failure to timely pay the awards. Accordingly, venue is proper in the District of Connecticut—the judicial district where Defendants reside. *See id.* § 1391(b)(1).

III. LEGAL STANDARDS

A. Rule 12(b)(1)

“Federal courts are courts of limited jurisdiction; without jurisdiction conferred by statute, they lack the power to adjudicate claims.” *In re FEMA Trailer Formaldehyde Prods. Liab. Litig.*, 668 F.3d 281, 286 (5th Cir. 2012). When challenged, the burden of establishing federal jurisdiction rests with the party asserting its existence. *See DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 342 n.3 (2006). Under Rule 12(b)(1), “a claim is properly dismissed for lack of subject-matter jurisdiction when the court lacks the statutory or constitutional power to adjudicate the claim.” *In re FEMA*, 668 F.3d at 286 (quotation omitted). “When a Rule 12(b)(1) motion is filed in conjunction with other Rule 12 motions, the court should consider the Rule 12(b)(1) jurisdictional attack before addressing any attack on the merits.” *Ramming v. United States*, 281 F.3d 158, 161 (5th Cir. 2001).

Co., 542 F.3d 1077, 1080 (5th Cir. 2008). Further, where members of an LLC are themselves entities or associations, citizenship must be traced through however many layers of members there are until arriving at the entity that is not a limited-liability entity and identifying its citizenship status. *See Mullins v. TestAmerica, Inc.*, 564 F.3d 386, 397–98 (5th Cir. 2009). Because Plaintiffs have only identified the principal places of business for REACH, CALSTAR, and Guardian Flight, it is impossible to determine whether the Court has diversity jurisdiction over this dispute—that is, assuming Plaintiffs’ claims under the NSA and ERISA fail.

There are two forms of Rule 12(b)(1) challenges to subject-matter jurisdiction: “facial attacks” and “factual attacks.” *Paterson v. Weinberger*, 644 F.2d 521, 523 (5th Cir. 1981). “A facial attack consists of a Rule 12(b)(1) motion unaccompanied by supporting evidence that challenges the court’s jurisdiction based solely on the pleadings.” *Harmouche v. Consulate Gen. of Qatar*, 313 F. Supp. 3d 815, 819 (S.D. Tex. 2018). In considering a facial attack, the court “is required merely to look to the sufficiency of the allegations in the complaint because they are presumed to be true.” *Paterson*, 644 F.2d at 523. If those jurisdictional allegations are sufficient, the complaint stands. *See id.*

A factual attack, on the other hand, challenges the existence of subject-matter jurisdiction, irrespective of the pleadings. *See Harmouche*, 313 F. Supp. 3d at 819. “If a defendant makes a ‘factual attack’ upon the court’s subject matter jurisdiction over the lawsuit, the defendant submits affidavits, testimony, or other evidentiary materials.” *Paterson*, 644 F.2d at 523. No presumptive truthfulness attaches to the plaintiff’s allegations, and the existence of disputed facts will not preclude the trial court from evaluating for itself the merits of jurisdictional claims. *See Williamson v. Tucker*, 645 F.2d 404, 413 (5th Cir. 1981).

B. Rule 12(b)(6)

Rule 12(b)(6) allows for the dismissal of a complaint for the “failure to state a claim upon which relief can be granted.” Fed. R. Civ. P. 12(b)(6). To survive a motion to dismiss under Rule 12(b)(6), a plaintiff’s complaint must plead “enough facts to state a claim to relief that is plausible on its face.” *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). “A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). “When reviewing a Rule 12(b)(6) motion to dismiss, ‘the central issue is whether, in the light most

favorable to the plaintiff, the complaint states a *valid claim* for relief.” *Millsap Waterproofing v. U.S. Fire Ins. Co.*, 2021 WL 6063620, at *1 (S.D. Tex. Dec. 21, 2021) (quoting *St. Paul Mercury Ins. Co. v. Williamson*, 224 F.3d 425, 440 n.8 (5th Cir. 2000) (emphasis added)).

C. Rule 12(b)(3)

A party may move to dismiss for improper venue under Rule 12(b)(3). Courts have typically imposed the burden of proving that venue is proper on the plaintiff once a defendant has objected to the plaintiff’s chosen forum. *See Galderma Labs., LP v. Teva Pharm. USA, Inc.*, 290 F. Supp. 3d 599, 605 (N.D. Tex. 2017) (collecting cases); *see also Fernandez v. Soberon*, 2013 WL 2483345, at *2 (S.D. Tex. June 10, 2013) (“Once a defendant files a Rule 12(b)(3) motion challenging venue, the burden of sustaining venue lies with the plaintiff.”).

Under 28 U.S.C. § 1391, a civil action may be brought in: (1) a judicial district in which any defendant resides, if all defendants are residents of the state in which the district is located; (2) a judicial district in which a substantial part of the events or omissions giving rise to the claim occurred, or a substantial part of the property that is the subject of the action is situated; or (3) if there is no district in which any action may otherwise be brought as provided in this section, any judicial district in which any defendant is subject to the court’s personal jurisdiction with respect to such action. *See* 28 U.S.C. § 1391. “If a case falls within one of § 1391(b)’s districts, venue is proper; if it does not, venue is improper, and the case must be dismissed or transferred under § 1406(a).” *Atl. Marine Constr. Co. v. United States Dist. Court*, 571 U.S. 49, 50 (2013).

IV. BACKGROUND

A. Overview of the Healthcare Industry and the No Surprises Act

1. Background of Surprise Bills

As it relates to this case, Aetna Life Insurance Company (“Aetna”) provides third-party

claims administrative services to self-funded, employer-sponsored plans.⁴ In this role, Aetna enters into “network” contracts with healthcare providers setting the rates for services provided to Aetna’s members. Providers that do not have network contracts with Aetna are known as “out-of-network” providers. Because these providers do not have an agreement setting the rates for their services, Aetna generally pays these services according to the out-of-network benefits under a given member’s plan.

Prior to the NSA’s enactment, out-of-network providers were free to “balance bill” patients for the difference between what their health insurance would pay and the amount the provider billed. In contrast, in-network provider contracts generally prohibit (or limit) them from balance billing patients. “Balanced bills” pose a substantial burden on patients because out-of-network charges are often arbitrary and egregiously high, *see* H.R. Rep. No. 116-615, at 52 (2020) (“These unexpected medical bills can result in financial ruin”), and reflect “prices that are set to be discounted and not paid.” George A. Nation III, *Healthcare and the Balance-Billing Problem*, 61 VILL. L. REV. 153, 153 (2016); *see also* *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 508 (Pa. Super. Ct. 2003) (noting that billed charges “cannot be considered the value of the benefit conferred because that is not what people in the community ordinarily pay for medical services”).

For this reason, patients almost always choose in-network providers over out-of-network providers—that is, when they have a choice. Situations arise, however, where patients have little opportunity to seek treatment from an in-network provider (i.e., emergency services) or receive services in a setting that leads them to believe they are receiving in-network services when they are, in fact, not (e.g., services provided by an out-of-network doctor at an in-network facility). In

⁴ Aetna Life Insurance Company is the only proper Aetna-affiliate to this action.

these situations, a balance bill from a provider will often come as a “surprise” to the unwitting patient. To make matters worse, providers of these types of services are particularly well-situated to charge excessive prices, as Congress explained:

Economists generally regard the practice of surprise medical billing as arising from a failure in the health care market, which causes [certain] providers to have little or no incentive to contract to join a health plan’s network due to a number of unique circumstances. These providers face highly inelastic demands for their services because patients lack the ability to meaningfully choose or refuse care, such as during an emergency or when ancillary services are provided of which a patient may not even be aware. They also often hold substantial market power, resulting in one or only very few providers available to provide critical items or services in a geographic area. These circumstances enable some providers to charge amounts for their services that exceed the marginal cost of producing those services and resulting in compensation far above what is needed to sustain their practice.⁵

With this background, the NSA was enacted to eliminate the harm from these surprise medical bills. It does so by limiting the amount the patient pays and setting up a dispute-resolution framework between the provider and payer to arrive at a payment amount that reflects what would be paid under realistic market conditions. *See* 42 U.S.C. §§ 300gg-111, 300gg-112, 300gg-131, 300gg-132. Critically, *the patient (i.e., member) is completely removed from the IDR process.*

B. The NSA’s Independent Dispute Resolution Framework

The NSA sets forth a detailed process for out-of-network providers (i.e., Plaintiffs) and payors to resolve payment disputes arising from surprise medical bills. Beyond eliminating the ability to “balance bill” patients, the process’s primary goal is to “tether payment rates for surprise out-of-network bills directly to market-based prices, curbing cost growth relative to the status quo.” H.R. Rep. No. 116-615, at 57 (2020).

Under the NSA’s framework, insurers must first issue an initial payment or notice of denial of payment to a provider within 30 days after the provider submits a bill for an out-of-network

⁵ H.R. Rep. No. 116-615, at 53 (2020).

service. 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv), -111(b)(1)(C). If the provider disagrees with the insurer’s determination, the provider may initiate a 30-day open-negotiation period with the insurer over the claim. *See id.* § 300gg-111(c)(1)(A). If the parties cannot resolve the dispute through negotiation, the parties may then proceed under the NSA’s IDR process. *See id.* § 300gg-111(c)(1)(B). Either party may invoke the IDR process, and the parties may continue to negotiate even after it has been invoked. *See id.* § 300gg-111(c)(2)(B).

The parties must agree upon an IDR entity “not later than the last day of the 30 business day period following the date of the initiation of the [IDR] process.” *Id.* § 300gg-111(c)(4)(F). If the parties cannot agree on an IDR entity, the Departments⁶ must select an IDR entity. *See id.* § 300gg-111(c)(4)(F)(ii). IDR arbitration is “baseball style,” meaning the “provider and insurer each submits a proposed payment amount and explanation to the arbitrator,” and the arbitrator “must select one of the two proposed payment amounts.” *Tex. Med. Ass’n v. United States HHS*, 587 F. Supp. 3d 528, 534 (E.D. Tex. 2022). “Not later than 30 days after the date of selection of the certified IDR entity . . . the certified IDR entity shall” notify the parties of its determination. 42 U.S.C. § 300gg-111(c)(5)(A)(ii). IDR awards are binding subject to limited exceptions, *see id.* § 300gg-111(c)(5)(E)(i), and payment of an IDR award “shall be made . . . not later than 30 days after the date on which such determination is made.” *Id.* § 300gg-111(c)(6).⁷

V. ARGUMENT & AUTHORITIES

A. The Southern District of Texas is Not a Proper Venue

The Southern District of Texas is not the proper venue for resolving this dispute. More

⁶ “Departments” collectively refers to the Departments of Health and Human Services (“HHS”), Labor, and Treasury.

⁷ Notification and process limitations in the newly-implemented federal scheme are the root cause of these issues—procedural matters that fall squarely within the Departments’ purview.

specifically, Plaintiffs’ basis for filing suit in the Southern District of Texas is that a handful of the 51 IDR awards were decided by MET, a dispute-resolution entity located in Houston. However, the “event[] or omission[] giving rise to” Plaintiffs’ complaint is not *where* the award was issued. *See* 28 U.S.C. § 1391(b)(2).

Alleged “omissions”—in the context of § 1391(b)—occur where the non-action happens. *See Cottman Transmission Sys. v. Martino*, 36 F.3d 291, 295 (3d Cir. 1994). For example, in *Cottman*, the Third Circuit held that the “omission” of a failure to remit payments, for purposes of determining venue, occurred at the situs of the payor. *See id.* (omission of failure to remit payment occurred in Michigan where payor was located, even though the result of the omission (i.e., non-receipt of payment) occurred in Pennsylvania); *see also Am. Motorists Ins. Co. v. Roller Bearing Co. of Am., Inc.*, 2001 U.S. Dist. LEXIS 1623, at *17–18 (S.D.N.Y. Feb. 20, 2001) (finding defendant’s alleged failure to pay under insurance policies at issue occurred in Connecticut, where defendant’s principal place of business was located); *cf., RAIT P’ship, L.P. v. Fieldstone Lester Shear & Denberg LLP*, 2009 U.S. Dist. LEXIS 95399, at *19–21 (D. Del. Oct. 14, 2009) (finding defendants’ “omission”—the failure to file a UCC financial statement with the Delaware Secretary of State—occurred in Florida and Virginia, where the defendants resided). Here, the singular event or omission giving rise to Plaintiffs’ complaint is Defendants’ alleged failure to timely pay the awards. Accordingly, venue is proper in the District of Connecticut—the judicial district where Defendants reside based Plaintiffs’ own allegations. *See id.* § 1391(b)(1).

To the extent Plaintiffs intend to argue that the Southern District of Texas is a proper venue because the FAA permits “a motion to confirm, vacate, or modify an arbitration award to be brought . . . where the award was made,” *Cortez Byrd Chips, Inc. v. Bill Harbert Const. Co.*, 529 U.S. 193, 195 (2000), such an argument rests on the faulty premise that the NSA incorporates any

portion of the FAA, aside from its limited grounds for judicial review.⁸ *See* 42 U.S.C. § 300gg-111(c)(5)(E)(II) (providing that IDR awards “shall not be subject to judicial review” except for cases described in 9 U.S.C. § 10(a)). Section 10(a), in turn, concerns attempts to vacate an arbitration award. Plainly, Plaintiffs do not ask the Court to vacate any of the IDR awards.⁹

B. Plaintiffs Have Failed to State a Claim upon Which Relief May Be Granted

1. No Surprises Act

The NSA does not provide a private right of action for the Court to “confirm” an IDR award, much less “convert” such an award “into a federal judgment.” *See* Dkt. 1 at 6. Rather, Congress has vested HHS with extensive regulatory oversight to ensure compliance with the NSA’s provisions, including rulemaking authority and annual audit requirements of health plans, 42 U.S.C. §§ 300gg-111(a)(2), as well as control over the certification (and decertification) of all IDR entities. *See id.* § 300gg-111(c)(4). Moreover, HHS has an online portal for providers to submit complaints—such as the very complaint Plaintiffs make in this case regarding Defendants’ alleged failure to timely pay IDR awards—and has the authority to perform complaint-based audits and enforce the NSA’s provisions.¹⁰ Critically, the NSA’s express terms limit judicial review of IDR awards to the four well-known grounds for vacatur under the Federal Arbitration Act. *See id.* § 300gg-111(c)(5)(E)(II). This limitation on judicial intervention further evinces Congress’s intent that HHS, not the courts, ensure health plans make payment on duly authorized IDR awards.

⁸ In fact, in a different case pending before this Court, Plaintiffs’ counsel attempted to distinguish the NSA from the FAA by arguing that the NSA’s text never uses the term “arbitration.” Case No. 4:22-cv-03805, Docket Entry 43-1 at 36:11–36:13, 41:11–41:14.

⁹ Even if this were the case, there is no basis to join complaints regarding unrelated awards on unrelated medical claims to a single action in Texas.

¹⁰ *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, *Providers: Submit a Billing Complaint*, <https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint> (portal allowing providers to “report a violation of the [NSA]”).

Based on the NSA’s manifest lack of an “enforcement” mechanism for Plaintiffs to petition the Court to “confirm” the IDR awards and “convert” them “into a federal judgment,” Defendants request the Court dismiss Plaintiffs’ claims under the NSA.

2. ERISA

i. Factual Attack on Plaintiffs’ Standing

A plaintiff must have “constitutional, prudential, and statutory standing” to bring a civil action under ERISA. *Leuthner v. Blue Cross & Blue Shield of Ne. Pa.*, 454 F.3d 120, 125 (3d Cir. 2006). ERISA allows a “participant [in] or beneficiary” of an ERISA plan to bring a civil action to “recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B). It is well-established that healthcare providers, such as Guardian Flight, are *not* “beneficiaries” or other enumerated parties under ERISA and, therefore, lack standing in their own right to sue under the civil enforcement provisions of ERISA. *See LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores, Inc.*, 298 F.3d 348, 351 (5th Cir. 2002).

In their complaint, Plaintiffs allege they “have been assigned the right to payment and benefits from [Defendants’] beneficiaries.” Dkt. 1 at 7. Plaintiffs apparently attempt to invoke “derivative standing” under ERISA, meaning that standing (i.e., the right to sue) is derived from another source. *See Brown v. Bluecross Blueshield of Tenn., Inc.*, 827 F.3d 543, 546 (6th Cir. 2016) (stating, “[d]erivative standing confers upon the holder of a valid assignment standing to sue in place of the assignor”). Courts fashioned this *limited* exception of derivative standing to the general rule that healthcare providers cannot sue under ERISA based on the following rationale:

If provider-assignees cannot sue the ERISA plan for payment, they will bill the participant or beneficiary directly for the insured medical bills, and the participant or beneficiary will be required to bring suit against the benefit plan when claims go unpaid. On the other hand, if provider-assignees can sue for payment of benefits,

an assignment will transfer the burden of bringing suit from plan participants and beneficiaries to providers, who are better situated and financed to pursue an action for benefits owed for their services.

Cagle v. Bruner, 112 F.3d 1510, 1515 (11th Cir. 1997) (cleaned up).

The critical distinction to any alleged “derivative” standing in *this* case is that the NSA *prohibits* air-ambulance providers such as Plaintiffs from balance-billing the plan member (i.e., participant) for the out-of-network services; instead, the providers can pursue negotiations, and ultimately the IDR process, for the amounts in excess of plan benefits directly from the plans. *See Haller v. U.S. Dep’t HHS*, 2022 WL 3228262, at *7 (E.D.N.Y. Aug. 10, 2022) (“When Congress enacted the No Surprises Act, it permitted health care providers to recover payment directly from insurers for out-of-network services, which is a new public right. Out-of-network providers’ claims against insurers do not arise under state common law, but instead depend upon the will of Congress and flow from a federal statutory scheme.” (cleaned up)).

Put differently, any claimed right to payment of the IDR awards stems from the NSA, not any plan participant’s rights under ERISA. Thus, it follows that the alleged “assignments”—which, here, purport to assign a right the plan members do not possess—cannot confer derivative standing for Plaintiffs to sue Defendants. *See Lone Star OB/GYN Assocs. v. Aetna Health, Inc.*, 579 F.3d 525, 529 n.3 (5th Cir. 2009) (“where the basis of the suit is entirely independent of the ERISA plan, and thus of the plan member, an assignment of benefits from the patient cannot confer standing”); *see also Paragon Office Servs., LLC v. UnitedHealthGroup, Inc.*, 2012 WL 1019953, at *6 (N.D. Tex. Mar. 27, 2012) (explaining that the “crucial question” is whether plaintiffs are seeking benefits under the terms of the health plan or rights that derive from a basis independent of the agreement). Because Plaintiffs cannot sue under the alleged assignments, Plaintiffs’ ERISA claims fail for lack of subject-matter jurisdiction. *See Fed. R. Civ. P. 12(b)(1)*.

ii. Facial Attack on Plaintiffs' Standing

Alternatively, even if Plaintiffs could rely on derivative standing, the law requires that Plaintiffs first demonstrate they have a valid assignment. *See ABC Servs. Grp., Inc. v. Health Net of Cal., Inc.*, 2022 U.S. Dist. LEXIS 117207, at *19 (C.D. Cal. June 13, 2022) (“Plaintiff’s claim that they have valid assignments is a legal conclusion that the Court is not required to accept without adequate factual support.”). This, Plaintiffs cannot do.

In the Fifth Circuit, a challenge to an assignment’s validity in an ERISA case constitutes a facial attack to subject-matter jurisdiction “because [the defendant] has challenged the underlying facts supporting the complaint . . . rather than merely challenging the allegations on their face.” *Cell Science Sys. Corp. v. La. Health Serv.*, 804 F. App’x 260, 263–64 (5th Cir. 2020). Once a defendant raises a facial challenge to the Court’s subject-matter jurisdiction, the burden is on the plaintiff to prove that subject-matter jurisdiction exists by a preponderance of the evidence and must submit facts through an evidentiary method. *See New Orleans & Gulf Coast Ry. Co. v. Barrois*, 533 F.3d 321, 327 (5th Cir. 2008); *see, e.g., Bond Pharmacy v. Advanced Health Sys.*, 2021 WL 4955447, at *3 (S.D. Miss. Oct. 25, 2021) (dismissing ERISA claims under Rule 12(b)(1) because once a defendant raises a facial challenge to an ERISA assignment’s validity, the plaintiff must produce evidence of the alleged assignment agreements).

3. State-Law Prompt-Pay Claims

With no federal claims to support this Court’s jurisdiction, Plaintiffs are left with their alleged violations of various states’ prompt-pay statutes. To begin, Plaintiffs—which are limited liability companies—have not identified their respective members; thus, there is no basis for diversity jurisdiction. *See* footnote 3. But even if one were to assume the parties are completely diverse, Plaintiffs cannot succeed on their state-law prompt-pay claims.

According to Plaintiffs' complaint, the IDR awards at issue involve air-ambulance transports in (1) California; (2) Colorado; (3) Florida; (4) Georgia; (5) Illinois; (6) Indiana; (7) Kansas; (8) Missouri; (9) North Carolina; (10) Ohio; (11) Oklahoma; (12) Tennessee; (13) Texas; and (14) Wyoming. *See* Dkt. 1 at 8. Plaintiffs' skeletal allegations do not flesh out the notion that IDR awards are enforceable under state prompt-pay statutes. Regardless, their claims fail.

State-law prompt-pay penalties conflict with the NSA's IDR process and regulations and, therefore, are preempted. "The United States Constitution gives Congress the power to preempt state law." *America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1329 (11th Cir. 2014). There are three forms of preemption that are frequently discussed in judicial decisions: (1) express preemption; (2) conflict preemption; and (3) field preemption. *See Woodard-Hall v. STP Nuclear Operating Co.*, 473 F. Supp. 3d 740, 745 (S.D. Tex. 2020).

Here, because the NSA's text does not expressly preempt Plaintiffs' claims, our discussion begins (and ends) with conflict preemption. Under conflict preemption, state laws that conflict with federal laws are preempted. *See Darcangelo v. Verizon Communs., Inc.*, 292 F.3d 181, 186 (4th Cir. 2002). Here, the NSA's regulations provide a specific and orderly mechanism for the parties to negotiate and, if negotiations are unsuccessful, submit a claim to the IDR process. The timeline of these negotiations and, if necessary, dispute-resolution proceedings conflict with the penalties imposed by the various state prompt-pay statutes—penalties that hinge on whether a claim that the insurer¹¹ initially denies (or partially denies) is later determined to be payable.

Generally speaking, state prompt-pay statutes are structured to provide certain remedies for the prompt payment of claims submitted to an insurer covered under the state *insurance* laws

¹¹ Notably, these are self-funded and not *insured* plans, meaning the prompt-pay laws do not apply for this reason, as well.

(which Aetna is *not*, in this context, because it administers self-funded plans). Under a prompt-pay statute at issue, for example, an insurer has between 21 to 45 days after a claim is submitted to determine whether to: (1) pay the claim; (2) partially pay and partially deny the claim and notify the provider in writing of the reason for partial denial; or (3) deny the claim and notify the provider in writing of the reason for denial. If an insurer fails to comply with these requirements, or if the insurer denies (or partially denies) a claim that is determined to be payable, the various statutes impose a range of penalties. *See, e.g.*, TEX. INS. CODE § 1301.137(a) (imposing penalties when “a clean claim submitted to an insurer is payable and the insurer does not determine . . . that the claim is payable and pay the claim on or before the date the insurer is required to make a determination or adjudication of the claim.”); *see also id.* § 843.342 (similar provisions)

The NSA similarly provides that a health plan covered by the Act (again, these are self-funded plans administered by Aetna in its role as a third-party administrator) must, within 30 days after receiving a bill for out-of-network services, either pay the claim or send the provider a notice of denial. 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv), -111(b)(1)(C). However, that is where the similarities end. The NSA does not impose any penalties if an insurer’s initial determination differs from the ultimate amount determined to be payable. Rather, under the NSA, if a provider disagrees with the insurer’s determination, the provider may initiate a 30-day open-negotiation period. *See id.* § 300gg-111(c)(1)(A). At this point, an insurer could, after receiving additional information on the claim, decide to increase its payment determination or pay the claim in full. Under the state prompt-payment statutes, however, an insurer would be subject to penalties based on its initial determination to deny (or partially deny) the claim. The NSA yields no such result. On the contrary, the open-negotiation period is specifically designed for providers and insurers to come together and resolve their payment disagreements.

If the parties cannot resolve the dispute through negotiations, the parties may then proceed to IDR arbitration. *See id.* § 300gg-111(c)(1)(B). Either party may invoke the IDR process. Once a certified IDR entity is agreed upon—or selected by HHS—the insurer and provider each submit a proposed payment amount and explanation to the IDR entity, which must select one of the two proposed payment amounts within 30 days. *See id.* § 300gg-111(c)(5)(A)(ii). As for the IDR award itself, the NSA only provides that payment “shall be made . . . not later than 30 days after the date on which such a determination is made.” *Id.* § 300gg-111(c)(6).

Nothing in the NSA suggests an insurer is subject to penalties under state law if payment is not made within 30 days of an award’s issuance; Plaintiffs are grasping for straws. More troubling, under Plaintiffs’ pleaded theory, Defendants would face monetary penalties for any IDR award that is more than its initial payment determination, ***which would begin to accrue on the date of the initial determination***—i.e., before the open-negotiation period even begins.

Congress specifically designed the IDR process to provide an “efficien[t]” and streamlined means of dispute resolution at a minimal cost.” 42 U.S.C. § 300gg-111(c)(3)(A); *id.* § 300gg-111(c)(4)(E); *see also Requirements Related to Surprise Billing, Part II (Interim Final Rules)*, 86 Fed. Reg. 55, 980, at 59,996 and 56,001 (Oct. 7, 2021) (underscoring the IDR’s purpose of “efficiency” and “predictability”). The application of state prompt-pay statutes’ penalties would frustrate the NSA’s purpose and completely undermine the NSA’s dispute-resolution framework by imposing punitive fines on insurers for their good-faith participation. Such a result would directly conflict with congressional policies behind the NSA. *Cf., Hous. Methodist Hosp. v. Humana Ins. Co.*, 266 F. Supp. 3d 939, 959–60 (S.D. Tex. 2017) (finding ERISA’s claim-processing regulations preempted statutory penalties under the Texas Prompt Payment Act).

To the extent Plaintiffs argue that the IDR awards themselves are subject to the prompt-pay statutes—that is, penalties begin to accrue 30 days *after* the IDR award is issued—such a result finds no support in the text of the prompt-pay statutes themselves. Indeed, under the pleaded prompt-pay statutes, penalties begin to accrue from the moment an insurer *denies* a claim that is later determined to be payable. But Defendants do not deny that the IDR awards are payable.

More importantly, this legal theory requires that the Court overlook the prompt-pay statutes’ definition of the term “clean claim”¹² and instead adopt Plaintiffs’ novel—and textually unsupported—interpretation of the term to include IDR determinations. Again using Texas as an example, a “clean claim” is one that is submitted *by a physician or provider*. See TEX. INS. CODE §§ 843.336, 1301.131. The idea that an IDR award, which is *issued by an IDR entity*, is equivalent to a claim submitted by a provider to an insurer not only defies common sense but also runs contrary to the NSA’s own terms, which contemplate that the first domino to fall in the IDR process is an out-of-network provider’s submission of a claim to an insurer. That is, a claim cannot be submitted to the IDR process unless and until a provider first submits a claim that is denied.¹³ See 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv), -111(b)(1)(C).

VI. CONCLUSION

For the reasons explained above, Defendants request the Court dismiss Plaintiffs’ claims with prejudice to refiling, unless, of course, the Court dismisses the claims under Rule 12(b)(3).

¹² Specifically, Plaintiffs argue: “IDR determinations qualify as ‘clean claims’ and are require to be paid within the timeframe allowed for electronic claims.” Dkt. 1 at 8.

¹³ If more is needed, prompt-pay claims require contractual privity between the insurer and provider. See, e.g., *Christus Health Gulf Coast v. Aetna, Inc.*, 397 S.W.3d 651, 654 (Tex. 2013). “As there is no contract between Aetna and [Plaintiffs], Aetna could not have violated the statute.” *Id.*; see also GA. CODE ANN. § 33-24-59.14(b)(1) (explaining prompt-pay requirements apply to “benefits under a health benefit plan . . . payable by the insurer or administrator”).

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was filed electronically on May 10, 2023. Notice of this filing will be sent by operation of the Court's electronic filing system to all parties indicated on the electronic filing receipt.

/s/ M. Katherine Strahan
M. Katherine Strahan