

**UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT**

GUARDIAN FLIGHT LLC, ET AL.

Plaintiffs,

v.

AETNA LIFE INSURANCE COMPANY INC., AETNA
HEALTH INC. and AETNA HEALTH AND LIFE
INSURANCE COMPANY, and CITNA HEALTH AND
LIFE INSURANCE COMPANY

Defendants.

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Case No. 3:24-CV-00680(MPS)

JULY 19, 2024

AETNA’S MOTION TO DISMISS PLAINTIFFS’ SECOND AMENDED COMPLAINT

Pursuant to Rule 12(b) of the Federal Rules of Civil Procedure and Local Civil Rule 7(a), defendants Aetna Life Insurance Company, Aetna Health Inc., and Aetna Health and Life Insurance Company (“Aetna”) respectfully move to dismiss all causes of action asserted by Plaintiffs¹ in their Second Amended Complaint² (Dkt. 109) under Federal Rules 12(b)(1) and 12(b)(6). In support of the requested relief, Aetna states:

In compliance with L. Civ. R. 7(a), Aetna submits the accompanying memorandum of law demonstrating why dismissal of Plaintiffs’ claims with prejudice is appropriate. As set forth in the accompanying memorandum of law, Aetna is entitled to dismissal on numerous grounds, including, but not limited to, the following: (1) the No Surprises Act (“NSA”) does not provide a private right of action for the Court to “enforce” an Independent Dispute Resolution (“IDR”) award, much less convert such an award into a federal judgment; (2) Plaintiffs lack standing to “enforce” IDR awards under the Employee Retirement Income Security Act of 1974 (“ERISA”);

¹ “Plaintiffs” refers collectively to Guardian Flight LLC, REACH Air Medical Services LLC, CALSTAR Air Medical Services, Med-Trans Corp., Air Evac EMS, Inc., and AirMed International, LLC.

² Despite titling their Second Amended Complaint as a “Consolidated First Amended Complaint,” Plaintiffs have twice amended their pleadings in this Court. *See* Dkts. 101 and 109.

ORAL ARGUMENT REQUESTED

and (3) Plaintiffs' state-law claim under the Connecticut Unfair Trade Practices Act ("CUTPA") is preempted by the NSA or, alternatively, ERISA. Even if it weren't preempted, Plaintiffs have failed to plead a colorable claim for relief because the complained-of conduct does not constitute unfair claim settlement practices under the Connecticut Unfair Insurance Practices Act ("CUIPA").

Aetna, therefore, respectfully asks the Court to dismiss Plaintiffs' Second Amended Complaint with prejudice to refile and without leave to amend.

Respectfully submitted,

By: /s/ John B. Shely
Kevin P. Daly (ct30380)
Robinson & Cole LLP
280 Trumbull Street
Hartford, CT 06103
Tel. No.: (860) 275-8200
Fax No.: (860) 275-8299
E-mail: kpdaly@rc.com

JOHN B. SHELBY
Admitted Pro Hac Vice
Texas State Bar No.18215300
jshely@HuntonAK.com
M. KATHERINE STRAHAN
Admitted Pro Hac Vice
Texas State Bar No. 24013584
kstrahan@HuntonAK.com
DAVID HUGHES
Admitted Pro Hac Vice
Texas State Bar No. 24101941
DHughes@huntonAK.com
HUNTON ANDREWS KURTH LLP
600 Travis, Suite 4200
Houston, Texas 77002
Telephone: (713) 220-4200
Facsimile: (713) 220-4285

**ATTORNEYS FOR DEFENDANTS
AETNA HEALTH INC.,**

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

CERTIFICATE OF SERVICE

I hereby certify that on July 19, 2024, a copy of the foregoing document was filed electronically through the Court's CM/ECF system. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system or anyone unable to accept electronic filings as identified on the Notice of Electronic Filing.

/s/ David Hughes
David Hughes

**UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT**

GUARDIAN FLIGHT LLC, REACH AIR
MEDICAL SERVICES LLC, CALSTAR AIR
MEDICAL SERVICES, LLC, MED-TRANS
CORPORATION, AIR EVAC EMS, INC., and
AIRMED INTERNATIONAL, LLC,

Plaintiffs,

V.

AETNA LIFE INSURANCE COMPANY,
AETNA HEALTH, INC., AETNA HEALTH
AND LIFE INSURANCE COMPANY, and
CIGNA HEALTH and LIFE INSURANCE
COMPANY

Defendants.

[illegible]

Civil Action No. 3:24-cv-00680-MPS

Jury Trial Demanded

**CORRECTED MEMORANDUM IN SUPPORT OF AETNA'S
MOTION TO DISMISS PLAINTIFFS' SECOND AMENDED COMPLAINT**

Aetna¹ moves to dismiss Plaintiffs' Second Amended Complaint² ("SAC") (Dkt. 109) and respectfully shows as follows.

I. INTRODUCTION

As mentioned in Aetna’s pending motion to stay discovery, *see* Dkt. 114, this case represents for-profit, private-equity-owned emergency service providers’ frustration with legislation that has cut into their bottom line. Now, the same companies that, for years, willfully took advantage of patients, gouging them with surprise medical bills have flooded the No Surprises Act’s (“NSA”) Independent Dispute Resolution (“IDR”) process with an inordinate number of

¹ “Aetna” refers collectively to Aetna Health Inc., Aetna Life Insurance Co., and Aetna Health and Life Insurance Co. Aetna files 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. Based on Plaintiffs’ ascertainable allegations, Aetna Life Insurance Company is the relevant affiliate.

² Despite titling their SAC as a “Consolidated First Amended Complaint,” Plaintiffs have twice amended their pleadings in this Court. *See* Dkts. 101 and 109.

ORAL ARGUMENT REQUESTED

payment disputes. Understandably, this veritable tsunami of disputes has overwhelmed the handful of IDR entities tasked with hearing them and, predictably, bogged down the process itself, contributing directly to its litany of well-documented procedural flaws.³

As it relates to this case, the IDR process' procedural challenges can be grouped into three general categories: (1) notification issues—that is, payers not receiving prompt, timely, and clear notification of IDR awards (and in some instances of the disputes themselves); (2) administrative burdens; and (3) the volume of IDR disputes. While each category poses unique problems, they compound one another, amplifying the cumulative effect.

Despite these procedural challenges being entirely beyond Aetna's control, Plaintiffs' SAC doubles down in making inflammatory accusations about Defendants'⁴ alleged nefarious motives and intentions. But allegations regarding Aetna's supposed "practice and policy of failure to timely pay IDR awards" completely ignore that payers such as Aetna are not receiving adequate notice when IDR awards are issued. At the very least, notice-related issues hinder Aetna's ability to timely pay the awards. Often times, the lack of adequate notice outright prevents Aetna from doing so. Moreover, Plaintiffs' SAC conveniently fails to mention that Aetna has endeavored to pay IDR awards when properly notified. Indeed, mere months after Plaintiffs filed their original complaint, Aetna had fully paid all 51 IDR awards once properly identified by Plaintiffs. *See* Dkt. 1-1. What's more, throughout the course of this litigation, Plaintiffs' counsel has identified additional IDR awards that Plaintiffs contended were past due, which, until Plaintiffs' recent amendment, were not at issue in this case. Though not at issue, Aetna worked diligently to verify and, where

³ Even Plaintiffs' counsel has acknowledged that the IDR process suffers from procedural flaws, including an overwhelming number of submissions. *See* Theresa Schliep, *3 Years In, 'No Surprises' Gets Mixed Reviews From Providers*, Law 360 (Apr. 9, 2024), <https://www.law360.com/insurance-authority/articles/1796182/3-years-in-no-surprises-gets-mixed-reviews-from-providers> (quoting Plaintiffs' counsel).

⁴ "Defendants" refers collectively to Aetna and Cigna Health and Life Insurance Co. ("Cigna").

appropriate, pay the latter group of IDR awards. All that is to say, Plaintiffs’ feigned indignation about unpaid IDR awards rings hollow. When adequately notified, Aetna has endeavored to timely pay valid outstanding IDR awards and will continue to do so.

In truth, this case was never just about unpaid IDR awards. If it were, Plaintiffs would not have filed their original complaint *nine days* after Plaintiffs’ counsel first notified Aetna of unpaid IDR awards. The true hindrance to resolving this case is Plaintiffs’ relentless effort to recover more than they are owed for their services by way of punitive damages, costs, attorney’s fees, pre- and post-judgment interest, and equitable relief. For reasons explained below, 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 “enforce” IDR awards, much less convert such awards into a federal judgment, *see* Dkt. 109 at 8; (ii) Plaintiffs’ lack standing to “enforce” the IDR awards under the Employee Retirement Income Security Act of 1974 (“ERISA”), *see id.* at 9–12; and (iii) for various reasons, Plaintiffs have failed to plead a colorable claim under the Connecticut Unfair Trade Practices Act (“CUTPA”), *see id.* at 12–14.

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 to “enforce” an IDR award, much less convert such an award into a federal judgment. Plaintiffs’ attempt to shoehorn their enforcement claims under ERISA fares no better. As medical providers, Plaintiffs must demonstrate they have derivative standing to pursue a claim under ERISA. Plaintiffs ostensibly attempt to do so in their SAC, alleging, “Plaintiffs have been assigned all of their patients’ claims under ERISA” and, therefore,

“are entitled to enforce all of the NSA’s requirements with respect to ERISA health plans.” Dkt. 109 at 11. But one cannot assign a right they do not have. Here, the plan members whose medical claims were submitted to the IDR process have no right to payment or benefits. 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. 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.

Lastly, Plaintiffs’ state-law claim under CUTPA is preempted by the NSA or ERISA. But even if the claim weren’t preempted, Plaintiffs have failed to plead a viable claim for relief because the complained-of conduct does not constitute unfair claim settlement practices under the Connecticut Unfair Insurance Practices Act (“CUIPA”).

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. *See Lyndonville Sav. Bank & Trust Co., v. Lussier*, 211 F.3d 697, 700 (2d Cir. 2000). 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. *See Makarova v. United States*, 201 F.3d 110, 113 (2d Cir. 2000). 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. *See Rhulen Agency, Inc. v. Alabama Ins. Guar. Ass'n*, 896 F.2d 674, 678 (2d Cir. 1990).

There are two forms of Rule 12(b)(1) challenges to subject-matter jurisdiction: “facial attacks” and “factual attacks.” *Carter v. HealthPort Techs., LLC*, 822 F.3d 47, 56-57 (2d Cir. 2016). A facial attack challenges that the allegations in the complaint are insufficient on their face to invoke federal jurisdiction. “When a defendant raises a facial attack to subject matter jurisdiction, the court takes the allegations in the complaint as true and draws all inferences in favor of the non-movant.” *Russo v. City of Hartford*, 184 F. Supp. 2d 169, 178 (D. Conn. 2002).

In contrast, a factual attack disputes the truth of the allegations that, by themselves, would otherwise invoke federal jurisdiction. “When a court reviews a complaint under a factual attack for lack of subject matter jurisdiction, it must determine whether the factual predicate for subject matter exists.” *Id.* Under a factual attack, “there is no presumptive truthfulness to the facts alleged in the complaint,” and a court is free to weigh evidence properly before it to confirm the existence of its power to hear the case. *Id.* Because “[a] plaintiff asserting subject matter jurisdiction has the burden of proving by a preponderance of the evidence that it exists,” *Makarova*, 201 F.3d at 113, to survive a factual attack on the Court’s subject-matter jurisdiction, a plaintiff relying on derivative standing must put forth evidence of valid and enforceable assignments of benefits. *See Petruska v. Gannon Univ.*, 462 F.3d 294, 302 n.3 (3d Cir. 2006); *see also Tasini v. N.Y. Times Co.*, 184 F. Supp. 2d 350, 353 (S.D.N.Y. 2002) (“[I]n a factual challenge . . . no presumptive truthfulness attaches to the complaint’s jurisdictional allegations; rather, the burden is on the plaintiff to satisfy the Court, as fact-finder, of the jurisdictional facts.” (quotation omitted)).

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). Courts, however are “not bound to accept as true a legal conclusion couched as a factual allegation.” *Twombly*, 55 U.S. at 555. 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. *See Leonard v. GM L.L.C.*, 504 F. Supp. 3d 73, 83 (D. Conn. 2020).

IV. BACKGROUND

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

1. Background of Surprise Medical Bills

As it relates to this case, Aetna Life Insurance Company⁵ provides third-party claims administrative services to self-funded, employer-sponsored plans. In this role, Aetna enters into “network” contracts with healthcare providers that set 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.

⁵ Aetna Life Insurance Company is the only proper Aetna affiliate to this action.

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 cover and the amount the provider billed. By 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* House Committee on Education and Labor, BAN SURPRISE BILLING ACT, 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, when they have a choice, patients almost always choose in-network providers over out-of-network providers. Situations arise, however, where patients have little opportunity to seek treatment from an in-network provider (e.g., 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 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.⁶

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, -112, -131, & -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 payers 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 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).

⁶ H.R. Rep. No. 116-615, at 53 (2020).

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 Departments⁷ 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).⁸

C. Well-Documented Issues With the NSA’s IDR Process

As mentioned earlier, the IDR process suffers from many well-documented issues. For purposes of this case, these issues can be grouped into three general categories: (1) notification issues, (2) administrative burdens, and (3) the volume of IRD disputes.

The Volume of IDR Disputes. Since its inception, the NSA’s IDR process has been overwhelmed by the submission of an unexpected and inordinate number of payment disputes. Indeed, for CY 2022, the Departments anticipated providers and payers combined to submit roughly 22,000 payment disputes. Over 200,000 were submitted.⁹ Through June 2023, the total

⁷ “Departments” collectively refers to the Departments of Health and Human Services (“HHS”), Labor, and Treasury.

⁸ 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.

⁹ *See* U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-24-106335, ROLL OUT OF INDEPENDENT DISPUTE PROCESS FOR OUT-OF-NETWORK CLAIMS HAS BEEN CHALLENGING (Dec. 12, 2023) at 23, <https://www.gao.gov/assets/870/864587.pdf>.

number of disputes topped 490,000.¹⁰ The *vast majority* of these disputes—94.9%—were initiated by providers.¹¹

With regard to air-ambulance services specifically, Plaintiffs’ parent company, Global Medical Response (“GMR”), initiated over 40% of all air-ambulance disputes in 2022 (Q2 through Q4), totaling 4,188 submissions.¹² GMR nearly doubled their submissions through the first two quarters of 2023, accounting for 7,031 dispute submissions—roughly 50% of all air-ambulance disputes.¹³ What’s more, roughly 50% of the air-ambulance disputes resolved in 2022 were determined to be ineligible, directly contributing to the submission backlog.¹⁴

All that is to say, Plaintiffs’ allegation that Defendants are “mak[ing] low initial payments hoping that providers will be too busy to file IDR proceedings” is belied by the underlying data, which demonstrates that providers are reflexively—and arbitrarily—disputing out-of-network payments, even when the services at issue are ineligible for the NSA’s dispute-resolution process.

Notification Issues. By way of background, in addition to Plaintiffs’ direct contributions to the problems they now complain about, payers such as Aetna regularly do not receive timely notice when an IDR award is issued. Notice-related issues are generally attributable to incomplete

¹⁰ See footnote 9, *supra*, at 2.

¹¹ See CMS, PARTIAL REPORT ON THE INDEPENDENT DISPUTE RESOLUTION (IDR) PROCESS OCTOBER 1 – DECEMBER 31, 2022 (Dec. 31, 2022) at 8 n.23, <https://www.cms.gov/files/document/partial-report-idr-process-octoberdecember-2022.pdf>; see also CMS, SUPPLEMENTAL BACKGROUND ON FEDERAL INDEPENDENT DISPUTE RESOLUTION PUBLIC USE FILES (AS OF FEBRUARY 15, 2024), <https://www.cms.gov/media/606896> (“The majority of disputes were initiated by a small number of initiating parties or their representatives.”).

¹² See CMS, INITIAL REPORT ON THE INDEPENDENT DISPUTE RESOLUTION (IDR) PROCESS APRIL 15 – SEPTEMBER 30, 2022 (Sept. 30, 2022) at 26, <https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf>; PARTIAL REPORT ON THE IDR PROCESS OCTOBER 1 – DECEMBER 31, 2022 at 26 (footnote 11, *supra*).

¹³ See CMS, FEDERAL IDR SUPPLEMENTAL TABLES FOR 2023 Q1, <https://www.cms.gov/media/606916> (under *Top Disputing Parties* tab for 2023 Q1); CMS, FEDERAL IDR SUPPLEMENTAL TABLES FOR 2023 Q2, <https://www.cms.gov/media/606921> (under *Top Disputing Parties* tab for 2023 Q2).

¹⁴ See INITIAL REPORT ON THE IDR PROCESS APRIL 15 – SEPTEMBER 30, 2022 at 27 (footnote 12, *supra*); PARTIAL REPORT ON THE IDR PROCESS OCTOBER 1 – DECEMBER 31, 2022 at 27 (footnote 11, *supra*).

or inaccurate information. For example, when sending notice of an award, IDR entities frequently fail to use the correct contact information provided at the beginning of the dispute-resolution process. In other instances, the contact information provided at the beginning of the dispute-resolution process is inaccurate, which causes notice-related issues down the road. The latter example is notable because the party who initiates the payment disputes (i.e., the provider) is responsible for providing the correct payer-contact information. Thus, if a provider fails to include the correct contact information when initiating the IDR process, then the provider—not the payer—is responsible for the payer not receiving notice of the IDR award. Worse yet, IDR entities have issued awards without ever notifying Aetna of the underlying payment dispute. Indeed, on multiple occasions, initiation notices were sent to the wrong individual or inbox, meaning Aetna was never aware of the IDR dispute.

Even when notice is properly issued, award notifications often lack essential details, such as the amount of the award or case reference numbers, which require additional time to clarify and address. By way of example, rather than using the claim ID assigned when a claim is first submitted, IDR entities will use a self-assigned claim number or alternative ID when notifying the parties, which delays Aetna's ability to verify the dispute and timely pay the award.

On top of notice-related errors, general inefficiencies or errors within the IDR entity's own administrative process can delay its notifying the parties of an award's issuance. Given the narrow timeframe payers have to process and pay IDR awards, any delay in receiving notice is significant.

Administrative Burdens. The administrative process involved in handling IDR awards can be cumbersome and time-consuming. After receipt of an IDR award, payers must review and verify the award's details. This takes time and is particularly challenging given the limited, and often incorrect details accompanying an award. Given the short turnaround to process and pay IDR

awards, any administrative burden can be significant. When viewed in conjunction with the overwhelming number of IDR disputes, these administrative burdens add up and significantly impact a payer's ability to timely process and pay IDR awards.

Other Considerations. On top of the issues mentioned above, uniform case-tracking tools for IDR disputes are practically non-existent, requiring payers (and providers) to configure *ad hoc* methods to monitor the deluge of payment-dispute proceedings. Moreover, providers—particularly at the inception of the IDR process—regularly send documentation to unattended e-mail addresses. In an effort to resolve this issue, Aetna has set up a dedicated mailbox for providers to send IDR-related communications.

In addition, multiple federal court decisions have vacated various parts of the NSA, the effects of which have significantly hampered—and in one instance, temporarily suspended¹⁵—the IDR process.¹⁶ Lastly, as further proof that Plaintiffs' complaints regarding late-paid IDR awards or "low initial payments" are industry-wide problems—as opposed to Aetna- or Cigna-specific issues—Plaintiffs (or their affiliates) have filed near-identical lawsuits, levying the same conspiratorial allegations against other payers. *See* Section V(A), *infra*.

V. ARGUMENT & AUTHORITIES

A. Plaintiffs Have Failed to State a Claim Under the NSA

A federal cause of action can come in two forms: express or implied. *See* *Nw. Airlines v. Transp. Workers Union*, 451 U.S. 77, 90 (1981). The NSA contains neither an express nor implied

¹⁵ In 2023, the Departments temporarily suspended the IDR process from August 25 to September 21 to make changes necessary to comply with a federal court's order.

¹⁶ *See, e.g., Tex. Med. Ass'n*, 587 F. Supp. 3d at 549 (vacating certain provisions of interim final rules requiring arbitrator to apply a rebuttable presumption in favor of insurers' QPA submissions); *Tex. Med. Ass'n v. United States Dep't of Health & Hum. Servs.*, 654 F. Supp. 3d 575, 595 (E.D. Tex. 2023) (vacating certain provisions of final rule that imposed restrictions on IDR arbitrators' discretion that did not appear in the statute); *Tex. Med. Ass'n v. United States Dep't of Health & Hum. Servs.*, 2023 WL 4977746, at *15 (E.D. Tex. Aug. 3, 2023) (vacating Departments' increase of administrative fees and restriction on batching medical claims).

private right of action for the Court to “enforce” an IDR award, much less convert such an award into a federal judgment. *See* Dkt. 109 at 8.

United States District Judge Jane J. Boyle of the Northern District of Texas recently dismissed identical claims to enforce IDR awards brought by Guardian Flight, LLC and Med-Trans Corporation—two of the plaintiffs in the underlying action—finding that “the NSA does not provide . . . an express or implied cause of action to enforce IDR awards.” *Guardian Flight, LLC v. Heath Care Servs. Corp.*, 2024 WL 2786913, at *3–4 (N.D. Tex. May 30, 2024). First, Judge Boyle correctly found that “the NSA does not contain any provisions expressly allowing Plaintiffs to file a lawsuit in federal court seeking to enforce an IDR award—thus, the NSA does not contain an express cause of action.” *Id.* at *3. Turning toward whether the NSA contains an implied cause of action, Judge Boyle correctly found that “no language in the NSA establish[es] that Congress intended to create a remedy for out-of-network providers” and, thus, “does not create a procedural mechanism for Plaintiffs to enforce their IDR awards in federal court.” *Id.*; *see Alexander v. Sandoval*, 532 U.S. 275, 286–87 (2001) (“The judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy. Statutory intent on this latter point is determinative. Without it, a cause of action does not exist and courts may not create one[.]” (citations omitted)).

It is beyond debate that the NSA contains no express cause of action. As for an implied cause of action, the NSA’s express terms limit judicial review of IDR awards to the four well-known grounds for vacatur under the Federal Arbitration Act (“FAA”). *See* 42 U.S.C. § 300gg-111(c)(5)(E)(II) (“A determination of a certified IDR entity . . . shall not be subject to judicial review, except in cases described in paragraphs (1) through (4) of section 10(a) of Title 9 [9 U.S.C. § 10(a)].”). Absent one of those four grounds, the NSA does not offer a path of any kind into court,

let alone an implied right of action for remedies relating to the *payment* of IDR awards. Although Congress borrowed from § 10(a) of the FAA, it notably did not incorporate any other provisions, including the provision that enables parties to confirm arbitration awards. As Judge Boyle aptly noted, this demonstrates that Congress did not intend to create a private cause of action under the NSA:

The FAA expressly provides parties with a procedural mechanism to vacate, modify, or confirm arbitration awards in federal court. If Congress intended to create such a procedural mechanism under the NSA, it simply could have incorporated one more section of the FAA, yet Congress did not do so. The Court interprets this omission in the NSA to mean that Congress did not intend to create a remedy under the NSA. ***Therefore, not only is there no “statutory intent” to create a private remedy, but the NSA also includes language strongly suggesting that Congress did not intend to create a private remedy.***

Health Care Servs., 2024 WL 2786913, at *4 (emphasis added and citations omitted).

Other aspects of the NSA’s framework demonstrate that Congress did not intend to create an implied cause of action to enforce IDR awards through the courts. For example, Congress vested HHS with extensive regulatory oversight to ensure compliance with the NSA’s provisions, *see* 42 U.S.C. §§ 300gg-111(a)(2) and (c)(4), which further evinces Congress’s intent that HHS, not the courts, ensure that health plans make payment on duly authorized awards. Indeed, as part of its oversight duties, HHS created 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.¹⁷

Based on the NSA’s manifest lack of an “enforcement” mechanism for Plaintiffs to petition the Court to convert IDR awards into a federal judgment, Aetna requests the Court dismiss

¹⁷ *See CMS, 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]”).

Plaintiffs' claims under the NSA.¹⁸ *See Health Care Servs.*, 2024 WL 2786913, at *5 (“Because the NSA does not provide a private cause of action, Plaintiffs cannot state a claim under the NSA.”).

B. ERISA

1. Factual Attack on Plaintiffs' Standing

To bring any lawsuit, a plaintiff must have constitutional standing to do so, which means, among other things, that the plaintiff must have suffered a concrete injury due to the defendant's conduct.

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 Plaintiffs, 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 Rojas v. Cigna Health & Life Ins. Co.*, 793 F.3d 253, 258 (2d Cir. 2015).

In their SAC, Plaintiffs attempt to invoke “derivative standing” under ERISA, meaning their standing 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 to

¹⁸ As a throwaway alternative argument, Plaintiffs contend they are entitled to enforce the IDR awards under the FAA. *See* Dkt. 109 at 8. This argument merits little discussion. “Neither the NSA nor the FAA says that the FAA bears on the NSA outside of the four explicitly incorporated paragraphs,” all of which concern the *vacatur* of an IDR award. *Med-Trans Corp. v. Cap. Health Plan, Inc.*, --- F. Supp. 3d ---, 2023 WL 7188935, at *5 (M.D. Fla. Nov. 1, 2023). Ironically, these same Plaintiffs fought tooth and nail to avoid application of any FAA requirements when attempting to *vacate* IDR awards. *See Guardian Flight LLC v. Aetna Health, Inc., et al.*, Case No. 4:22-cv-03805 (S.D. Tex. 2022), Docket Entry 15 at 8 (“[T]he [NSA] adopted the legal standard applicable to one small part of a single section of the [FAA § 10(a)] because, otherwise, no part of the FAA would apply to IDR determinations.”). It is beyond disingenuous for Plaintiffs to now argue to this Court that they can enforce IDR awards under FAA § 9.

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); *see Brown v. Sikora & Assocs., Inc.*, 311 F. App'x 568, 571 (4th Cir. 2008) (“***When assignees of ERISA benefits have been found to have derivative standing, [the assignees] could have sued the actual ERISA participants***, who would then have clearly had standing to sue for the unpaid ERISA benefits.” (emphasis added)).

The critical distinction to the 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 **only** pursue negotiations with the health plan, 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)).

It is black-letter law that an assignee acquires no greater rights than his assignor. *See Rojas v. Cigna Health & Life Ins. Co.*, 793 F.3d 253, 258-59 (2d Cir. 2015). Put differently, “the assignee of a claim has standing to assert the injury in fact suffered by the assignor”—nothing more. *Vt.*

Agency of Nat. Res. v. U.S. ex rel. Stevens, 529 U.S. 765, 768, 120 S. Ct. 1858, 1860 (2000); *Feldman’s Med. Ctr. Pharmacy, Inc. v. Carefirst, Inc.*, 902 F. Supp. 2d 771, 781 (D. Md. 2012) (“An assignee stands in the shoes of its assignor and only has standing to assert whatever rights the assignor possessed.” (cleaned up)). It necessarily follows that an assignee “cannot recover under the assignment any more than the assignor could recover.” *CardioNet, Inc. v. Cigna Health Corp.*, 751 F.3d 165, 178 (3d Cir. 2014).

Here, the assignors (i.e., plan participants) could not sue Aetna for payment of the IDR awards. That is because any claimed right to payment stems from the NSA, *not* the plan participants’ rights under ERISA. Thus, the alleged “assignments”—which purport to assign a right the plan members do not possess—cannot confer derivative standing for Plaintiffs to sue Defendants for unpaid benefits under ERISA.¹⁹ Indeed, as Judge Boyle explained, under the NSA, plan members are no longer financially responsible for balance billing and, thus, incur no financial injury from a dispute between a provider and insurer with regard to payment of IDR awards. *See Health Care Servs.*, 2024 WL 2786913, at *5. Accordingly, because plan members “suffered no concrete injury from [Aetna’s] allegedly failing to pay IDR awards to Plaintiffs,” *id.*, an assignment from the plan members is insufficient to establish Article III standing. *See id.* at *6 (“Plaintiffs lack standing to assert their ERISA claim because the [Aetna] beneficiaries did not suffer any concrete injury.”); *see also LaSala v. Needham & Co.*, 2006 WL 452024, at *4 (S.D.N.Y. Feb. 24, 2006) (“Logically . . . a valid assignment of a claim must transfer not just the authority to initiate a lawsuit, but also an actual interest in the outcome of the suit.”); *W. R. Huff*

¹⁹ *See Rojas*, 793 F.3d at 259 (“If an assignee seeking relief in court stands in the place of an assignor, there has been a substitution rather than an expansion of the parties.” (quotation omitted)); *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”).

Asset Mgmt. Co., LLC v. Deloitte & Touche LLP, 549 F.3d 100, 108 (2d Cir. 2008) (explaining that “an assignment of claims confers legal title or ownership of *those* claims” (emphasis added)).

In sum, because the plan participants have no interest in the payment of IDR awards to Plaintiffs and, therefore, suffered no concrete injury, Plaintiffs lack derivative standing to pursue the pleaded ERISA claims on behalf of the plan members. *See La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys.*, 461 F.3d 529, 535 (5th Cir. 2006) (“The assignment of benefits from the patient to the [provider] results solely in the transfer of the cause of action provided by § 502(a) from the patient to the [provider]. The assignee takes what the assignor had; no more, no less.”).

2. 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.²⁰

Plaintiffs have not plausibly pleaded the existence of valid assignments of rights that would enable them to assert claims under ERISA. *See, e.g., Michael E. Jones. M.D., P.C. v. UnitedHealth*

²⁰ Even if Plaintiffs plausibly alleged that they have valid assignments, they have failed to show that they have exhausted their administrative remedies under ERISA before bringing these claims. “[F]ederal courts—including this Circuit—have recognized a firmly established federal policy favoring exhaustion of administrative remedies in ERISA cases.” *Paese v. Hartford Life & Accident Ins. Co.*, 449 F.3d 435, 443 (2d Cir. 2006) (quotation omitted). A plaintiff must pursue “those administrative [processes] provided for in the relevant plan or policy.” *Kennedy v. Empire Blue Cross & Blue Shield*, 989 F.2d 588, 594 (2d Cir. 1993). “[C]ourts routinely dismiss ERISA claims brought under Section 502(a)(1)(B) on a 12(b)(6) motion to dismiss where the plaintiff fails to plausibly allege exhaustion of remedies.” *Gordon Surgical Grp., P.C. v. Empire HealthChoice HMO, Inc.*, --- F. Supp. 3d ---, 2024 WL 1134682, at *3 (S.D.N.Y. Mar. 14, 2024) (quotation omitted); *see Kesselman v. Rawlings Co., LLC*, 668 F. Supp. 2d 604, 608–09 (S.D.N.Y. 2009) (collecting cases). Here, because Plaintiffs’ SAC does not so much as mention whether they have exhausted their administrative remedies, dismissal of their ERISA claims is required for this additional reason. *See Ruderman v. Liberty Mut. Grp., Inc.*, 2021 WL 827693, at *3 (N.D.N.Y. Mar. 4, 2021) (“Courts uniformly require an ERISA plaintiff to plead that she has exhausted her administrative remedies before bringing suit in federal court.” (collecting cases)), *aff’d*, 2022 WL 244086 (2d Cir. Jan. 27, 2022); *Abe v. New York Univ.*, 2016 WL 1275661, at *5 (S.D.N.Y. Mar. 30, 2016) (dismissing claim under Section 502(a)(1)(B) where “no facts suggest[ed] any effort to exhaust the remedies available through [plaintiff’s] ERISA administrative plan”).

Grp., Inc., U.S. Dist. LEXIS 150725, at *11 (S.D.N.Y. Aug. 19, 2020) (dismissing complaint because, *inter alia*, the complaint failed to identify a single patient, the terms of the underlying assignments, or allegations that the assignments were consistent with the terms of the ERISA plans at issue). In total, Plaintiffs allege that they “have been assigned all of their patients’ claims under ERISA.” Dkt. 109 at 9. This is wholly insufficient to pursue a derivative ERISA claim. *See Am. Psychiatric Ass’n v. Anthem Health Plans, Inc.*, 821 F.3d 352, 361 (2d Cir. 2016) (“[S]imply asserting that claims under ERISA . . . have been assigned by the patients to Dr. Savulak is insufficient by itself to give Dr. Savulak a cause of action under the statute.”). For example, Plaintiffs could have included the actual terms of the supposed assignments—information that presumably is readily available—but did not, leaving the Court with only Plaintiffs’ bare legal conclusions as to the alleged assignments’ validity and effect. Considering that this is Plaintiffs’ *third* attempt at pleading their claims—and given that Aetna’s motion to dismiss Plaintiffs’ original complaint similarly challenged the purported assignments’ validity, *see* Dkt. 12 at 6—Plaintiffs’ failure to attach a single copy of the supposed assignment form or, at a minimum, reference the assignment language is puzzling.

“A plaintiff asserting subject matter jurisdiction has the burden of proving by a preponderance of the evidence that it exists.” *Makarova*, 201 F.3d at 113. Once a defendant raises a challenge to the validity of an assignment (i.e., asserts a facial attack on the Court’s subject-matter jurisdiction), the burden is on the plaintiff to demonstrate a valid assignment from a beneficiary exists to maintain a cause of action for unpaid benefits under ERISA. *See, e.g., Karkare v. Aetna Life Ins. Co.*, 2023 U.S. Dist. LEXIS 56958, at *4 (E.D.N.Y. Mar. 31, 2023). Accordingly, in responding to Aetna’s motion to dismiss, the burden is on Plaintiffs to prove that subject-matter

jurisdiction exists. *See Hobbs v. Blue Cross Blue Shield*, 276 F.3d 1236, 1242 (11th Cir. 2001) (“Without proof of an assignment, the derivative standing doctrine does not apply.”).

3. Equitable Relief

Setting aside the issues discussed in the preceding subsections, Plaintiffs cannot pursue equitable relief via a derivative-standing ERISA claim. *See* Dkt. 109 at 12 (“Plaintiffs further seek equitable relief [under ERISA] enforcing prospectively Defendants’ obligation to pay awards within thirty days, and all other appropriate equitable relief to redress such violations, such as the filing of quarterly reports with the court certifying compliance for an appropriate period.”).

“The notion that an assignment to a healthcare provider of the right to reimbursement for services rendered by that provider automatically gives the provider standing as a beneficiary to assert a full array of claims under the ERISA statute is a facile one.” *Premier Health Ctr., P.C. v. UnitedHealth Grp.*, 292 F.R.D. 204, 218 (D.N.J. 2013). Indeed, an assignment of benefits from a patient for services rendered by a given healthcare provider cannot logically imply the right to assert ERISA claims for equitable relief on behalf of that patient for services she *may* receive from providers at some point in the future. *See Franco v. Conn. Gen. Life Ins. Co.*, 818 F. Supp. 2d 792, 811 (D.N.J. 2011) (finding that assignments to receive reimbursement “in no way can be construed as tantamount to assigning the right enforce his or her rights under the plan”); *cf.*, *MCI Healthcare, Inc. v. United Health Grp., Inc.*, 2019 WL 2015949, at *5 (D. Conn. May 7, 2019) (“even if the Assignment of Benefits form is a legal assignment of the right to payment [for services rendered] and the right to sue under ERISA for non-payment, it does not encompass the right to pursue injunctive relief”); *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1292 (9th Cir. 2014) (finding argument that assignment encompassed ERISA breach-

of-fiduciary-duty claims was “divorced from context,” as “[t]he entire focus of the [a]ssignment [wa]s payment for medical services”).

Plaintiffs’ equitable-relief argument also fails under common-law principles. Again, an assignee acquires no greater rights than his assignor. Here, plan participants could not sue Aetna for “equitable relief enforcing prospectively Defendants’ obligation to pay awards within thirty days” or any “other . . . equitable relief to redress such violations[.]” Dkt. 109 at 12; *see Rojas*, 793 F.3d at 259. Plaintiffs’ grievance regarding the *future* payment of IDR awards is uniquely their own; it is not derivative of Aetna’s plan participants. Accordingly, dismissal of Plaintiffs’ ERISA claims to the extent they seek equitable relief is appropriate for this additional reason.

C. Plaintiffs’ CUTPA Claim Based on Alleged Violations of the Connecticut Unfair Insurance Practices Act (CUIPA).

Plaintiffs have failed to allege a colorable claim under the CUTPA because said claim is preempted by the NSA. Alternatively, Plaintiffs’ purported CUTPA claim is preempted by ERISA. Even if, *arguendo*, Plaintiffs’ CUTPA claim is not preempted, Plaintiffs’ allegations fail to state a claim for unfair claim settlement practices in violation of CUIPA.

1. Plaintiffs’ CUTPA Claim is Preempted by the NSA.

State-law CUTPA penalties conflict with the NSA’s regulations and IDR process; thus, the NSA preempts Plaintiffs’ CUTPA claim. “A fundamental principle of the Constitution is that Congress has the power to preempt state law.” *Crosby v. Nat’l Foreign Trade Council*, 530 U.S. 363, 372 (2000). 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, the NSA’s text does not expressly preempt Plaintiffs’ CUTPA claim, so we turn to conflict preemption. Conflict preemption occurs where a (i) party’s compliance with both federal

and state regulations is a physical impossibility or (ii) the challenged state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress. *See Arizona v. United States*, 567 U.S. 387, 399 (2012). “Congress’s intent to preempt state law is implied to the extent that federal law actually conflicts with state law.” *Whistler Invs., Inc. v. Depository Tr. & Clearing Corp.*, 539 F.3d 1159, 1164 (9th Cir. 2008).

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 are in direct conflict with Plaintiffs’ attempt to fashion a CUTPA claim based on conduct identified in the amended complaint,²¹ some of which would necessarily occur *before* the mandatory open-negotiation period or dispute-resolution proceedings take place.

For example, Plaintiffs accuse Aetna of “making low initial payments,” which supposedly “force providers” to participate in the IDR process. *See* Dkt. 109 at 13. Setting aside the abject lack of support for this conclusory and baseless allegation, a finding that an initial payment amount violates CUTPA would subvert the NSA’s careful dispute-resolution framework. Indeed, the NSA provides that health plans covered by the NSA 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 (or partial denial). *See* 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv), -111(b)(1)(C). The NSA does not impose any penalties if the 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

²¹ Plaintiffs’ SAC is light on details. As it relates to their CUTPA claim, Plaintiffs identify the following alleged conduct to ostensibly support their CUTPA claim: (1) “making low initial payments that force providers to file IDR proceedings to obtain a fair payment”; (2) “not paying IDR awards within thirty days as required by federal law”; (3) “not including interest on late payments when made”; (4) “not investing in compliance programs, systems and personnel needed to assure timely payment of IDR awards”; and (5) “not attempting in good faith to effectuate prompt, fair and equitable settlements” during the open-negotiation period. Dkt. 109 at 13.

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 Plaintiffs’ ill-conceived CUTPA theory, however, Plaintiffs would have the Court impose penalties based on an insurer’s initial payment determination. The NSA allows no such result. On the contrary, the NSA’s open-negotiation period is specifically designed for providers and insurers to come together and resolve their payment disagreements without threat of Plaintiffs’ advocated-for extortion-esque penalties based on an insurer’s initial payment determination. *See In re Methyl Tertiary Butyl Ether Prods. Liab. Litig.*, 725 F.3d 65, 97 (2d Cir. 2013) (conflict preemption exists, *inter alia*, “when state law penalizes what federal law requires”). In addition, to even consider whether an insurer’s initial claim payment constitutes an unfair trade practice under CUTPA would necessarily require courts to supplant the IDR entities tasked with evaluating and deciding the appropriate rate for out-of-network medical services. *Cf. Birdsong v. Nurture, Inc.*, 275 F. Supp. 3d 384, 393 (E.D.N.Y. 2017) (finding conflict preemption where state-law claim based upon products not being “organic” directly conflicted with role of certifying agent Congress charged with making such determinations). Such a result directly contravenes the NSA’s prohibition on judicial intervention save for the FAA’s four vacatur grounds. *See Whistler Invs.*, 539 F.3d at 1164 (“Congress’s intent to preempt state law is implied to the extent that federal law actually conflicts with state law.”).

If the parties cannot resolve their dispute through negotiations, they 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’s text or legislative history suggests that an insurer is subject to penalties—state law or otherwise—if payment is not made within 30 days of an award’s issuance. Yet, Plaintiffs advocate for penalizing insurers who (i) pay IDR awards outside the 30-day window or (ii) do not *sua sponte* add interest to late-claim payments. *See* Dkt. 109 at 14. Such an outcome would impose judicially created penalties where the governing statutory scheme tolerates no such interpretation.

Congress meticulously designed the IDR process to provide a means of dispute resolution at minimal cost. *See* 87 Fed. Reg. 52618, 56637 (Aug. 26, 2022); 86 Fed. Reg. 55980, 59996 & 56001 (Oct. 7, 2021). Application of CUTPA penalties based on Aetna’s purported “failure” not to pay awards within 30 days of the awards’ issuance or decision not to unilaterally add interest on payments made outside the 30-day window would frustrate the NSA’s purpose by imposing punitive fines where Congress saw fit not to do so. Moreover, as explained, the root cause of the underlying dispute is notice- and process-related issues vis-à-vis the IDR process itself. *See* Section IV(C), *supra*. Regardless of the cause, procedural matters such as these fall squarely within the Departments’ Congressionally assigned administrative responsibility to oversee the IDR process. *Cf. Guardian Flight, LLC v. Aetna Health Inc.*, --- F. Supp. 3d ---, 2024 WL 484561, at *7 (S.D. Tex. Jan. 5, 2024) (finding that complaints regarding the accuracy of party submissions to the IDR entities “are better suited for the . . . Departments to address”).

All said, judicial intervention by way of a CUTPA claim based on the conduct alleged would directly conflict with congressional policies underpinning the NSA, thereby undermining

the NSA’s provisions and purpose. *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 prompt-pay penalties).

2. Alternatively, ERISA Preempts Plaintiffs’ CUTPA Claim.

District courts in this circuit have consistently found that ERISA preempts a CUTPA claim where that claim arises out of action taken in connection with an ERISA-governed plan. *See, e.g., Cote v. Durham Life Insurance Co.*, 754 F. Supp. 18, 22 (D. Conn. 1991) (dismissing CUTPA claim, writing, “This district has consistently held that statutory claims are preempted by ERISA”); *see also D’Amore v. Stangle & Denigris*, 1994 U.S. Dist. LEXIS 20691, at *15–17 (D. Conn. Oct. 18, 1994) (collecting cases).

ERISA supersedes “any and all State laws insofar as they relate to an employee benefit plan.” 29 U.S.C. § 1144(a). “A law ‘relates to’ an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.” *Paneccasio v. Unisource Worldwide, Inc.*, 532 F.3d 101, 114 (2d Cir. 2008) (quotation omitted); *see Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 718 (2d Cir. 1993) (“The term ‘relate to’ is to be accorded its broad common-sense meaning, thereby giving effect to the ‘deliberately expansive’ language chosen by Congress.” (quotations and internal citation omitted)).

Plaintiffs are trying to use CUTPA to enforce alleged rights under ERISA-governed plans. Plainly, such a claim “relates to” those members’ plans. *See, e.g.*, Dkt. 109 at 13 (“Defendants’ unreasonably low initial payments are unfair and not good faith attempts to effectuate equitable settlements.”). In fact, the plans are an essential part of Plaintiffs’ claim, without which the alleged liability would not exist. *See Michael E. Jones. M.D., P.C. v. UnitedHealth Group, Inc.*, 2020 WL 4895675, at *5 (S.D.N.Y. Aug. 19, 2020) (“A claim under state law is not independent of ERISA

if the terms of a benefit plan are ‘an essential part’ of the claim, and liability would exist only because of the administration of an ERISA-regulated benefit plan.”).

Put simply, Plaintiffs cannot impose state-law penalties on the administration of an ERISA plan. Because the viability of Plaintiffs’ claim “relates directly to the administration of the ERISA plan, and the liability of the parties is dependent upon the existence of the ERISA plan and rights conferred by it,” Plaintiffs’ CUTPA claim is preempted by ERISA and, therefore, must be dismissed. *Case v. Hosp. of St. Raphael*, 38 F. Supp. 2d 207, 209 (D. Conn. 1999).

3. Alternatively, Plaintiffs Have Failed to State a Viable Claim for Relief.²²

In their SAC, Plaintiffs allege that Aetna “used and employed unfair methods of competition and unfair or deceptive acts or practices in the conduct of trade or commerce.” Dkt. 109 at 13. Plaintiffs go on to list a few practices they allege constitute unfair trade practices under CUTPA before arguing that the *same conduct* also violates CUIPA. Specifically, Plaintiffs contend that “[t]hese practices also constitute engaging in unfair settlement practices in violation of Conn. Gen. Stat. §38a-816(6)(F) for not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.” *Id.* In support of their CUIPA allegations, Plaintiffs identify three categories of conduct they claim are unfair settlement practices:

- (1) “Defendants’ unreasonably low initial payments are unfair and not good[-]faith attempts to effectuate equitable settlements”;
- (2) “During the Open Negotiation Period, Defendants are not attempting in good faith to effectuate prompt, fair and equitable settlements”; and
- (3) “[O]nce an IDR determination issues, and the precise amount owed by [Defendants] is unquestionably clear, they do not promptly, fairly and equitably

²² As a threshold matter, the health plans at issue are largely, if not all, self-funded plans administered by Aetna in its role as a third-party administrator. In other words, they do not concern *insured* plans.

settle the claim by paying the amount in the award (less any initial payment already made).”

Id.

CUTPA prohibits the use of “unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce,” Conn. Gen. Stat. § 42-110b, while CUIPA governs “unfair methods of competition” in the insurance trade. *See id.* § 38a-815. Although CUIPA does not provide a private cause of action, a CUTPA claim may be premised on a violation of CUIPA. *See Mead v. Burns*, 199 Conn. 651, 509 A.2d 11 (1986).

Importantly, CUIPA “defines what constitutes” unfair business practices in the insurance industry. *Artie’s Auto Body, Inc. v. Hartford Fire Ins. Co.*, 317 Conn. 602, 623 (2015). As the Connecticut Supreme Court explained, the legislature’s intent was for CUIPA to provide “the exclusive and comprehensive source of public policy with respect to general insurance practices” in a manner designed to “occupy the field of defining unfair insurance practices.” *State v. Acordia, Inc.*, 310 Conn. 1, 36–37, 73 A.3d 711 (2013). Accordingly, “unless an insurance related practice violates CUIPA or, arguably, some other statute regulating a specific type of insurance related conduct, it cannot be found to violate any public policy and, therefore, it cannot be found to violate CUTPA.” *Id.* at 37.

As it relates to this case, “[a] plaintiff cannot circumvent the requirements of CUIPA by alleging a CUTPA claim where the claim is related to the insurance industry.” *Ne. Mgmt. Grp., Inc. v. Underwriters at Lloyd’s London*, 2014 Conn. Super. LEXIS 211, at *12 (Super. Ct. Jan. 29, 2014); *see Tucker v. Am. Int’l Grp., Inc.*, 179 F. Supp. 3d 224, 229 (D. Conn. 2016) (“[A] plaintiff may not bring a cause of action under CUTPA based on conduct which does not also violate CUIPA where the alleged conduct relates to the insurance industry.” (quotation omitted)).

Here, the same practices Plaintiffs allege “constitute engaging in unfair settlement practices” under CUIPA are those that they argue support their allegation that Aetna has “used and employed unfair methods of competition and unfair or deceptive acts or practices in the conduct of trade or commerce.” Dkt. 109 at 13. In other words, Plaintiffs rely on the same conduct to allege that Aetna engaged in unfair settlement practices (CUIPA) and unfair trade practices (CUTPA). This, Plaintiffs cannot do.²³ Instead, to succeed in pursuing their CUTPA claim, Plaintiffs must plead and prove that the complained-of conduct violates CUIPA. *See, e.g., Ne. Mgmt. Grp.*, 2014 Conn. Super. LEXIS 211, at *12.

²³ *See Acordia*, 310 Conn. at 31 (“[I]f a plaintiff brings a claim pursuant to CUIPA alleging an unfair insurance practice, and the plaintiff further claims that the CUIPA violation constituted a CUTPA violation, the failure of the CUIPA violation is fatal to the CUTPA claim.”); *Artie’s Auto Body*, 317 Conn. at 624 (“a plaintiff cannot bring a CUTPA claim alleging an unfair insurance practice unless the practice violates CUIPA”); *see also Mead v. Burns*, 199 Conn. 651, 666, 509 A.2d 11, 19 (1986) (“it would be . . . anomalous to permit a CUTPA claim to override a CUIPA regulatory pattern [rather] than to require a private litigant . . . to comply with [CUIPA’s] statutory requirements”).

i. **Plaintiffs’ CUTPA Claim Fails Because the Complained-of Conduct Does Not Constitute Unfair Claim Settlement Practices.**²⁴

Section 38a-816(6) identifies a number of “unfair settlement claims practices.” *See* Conn. Gen. Stat. § 38a-816(6). Under § 38a-816(6), a plaintiff must plead and prove that an insurer committed one of the enumerated unfair claim settlement practices “with such frequency as to indicate a general business practice.” Subsection (F) provides that it is an unfair claim settlement practice to “not attempt[] in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.” Conn. Gen. Stat. § 38a-816(6)(F). As mentioned, Plaintiffs contend the following alleged conduct violates subsection (F):

- (1) “Defendants’ unreasonably low initial payments are unfair and not good[-]faith attempts to effectuate equitable settlements”;
- (2) “During the Open Negotiation Period, Defendants are not attempting in good faith to effectuate prompt, fair and equitable settlements”; and

²⁴ Additionally, because Plaintiffs are not a party to the underlying health plans, they cannot bring a direct claim for violations of CUIPA. Under Connecticut law, “the right to assert a private cause of action for CUIPA violations through CUTPA does not extend to third parties absent subrogation or a judicial determination of the insured’s liability.” *Carford v. Empire Fire & Marine Ins. Co.*, 94 Conn. App. 41, 53, 891 A.2d 55, 62 (2006). As neither scenario applies, Plaintiffs’ CUIPA-based claim must fail. Further, to the extent Plaintiffs argue their assignment of claims is equivalent to subrogation rights, Plaintiffs only allege they “have been assigned all of their patients’ claims under ERISA.” Dkt. 109 at 9.

Aetna is aware that this Court has previously found that *Carford*’s holding does not apply to claims brought by health care providers against insurers under § 38a-816(6)(F). *See Murphy Med. Assocs., LLC v. United Med. Res., Inc.*, 2024 WL 1072731, at *4 (D. Conn. Mar. 12, 2024). However, the Court’s expansive interpretation of § 38a-816(6) conflicts with Connecticut state courts, which have found in near unanimity that “*Carford* directly applies” to claims for unfair claim settlement practices brought under § 38a-816(6). *Grand Prix Motors, Inc. v. Greene*, 2021 WL 4287349, at *8 (Conn. Super. Ct. Sept. 1, 2021) (“Here, *Carford* directly applies as the plaintiff is bringing the claim under § 38a-816(6), for unfair claim settlement practices.”); *see also Asmus Elec., Inc. v. G.M.K. Contractors, LLC*, 2005 WL 758126, at *5 (Conn. Super. Ct. Feb. 25, 2005) (“The majority of [Connecticut] superior courts” have found that claims for unfair claim settlement practices “are actionable for insureds only, not for third-party claimants.” (second quotation omitted)).

In a decision issued the same day as *Murphy Medical*, Superior Court Judge John B. Farley reiterated that “all constraints imposed on claims settlement practices by CUIPA in § 38a-816(6) are aimed at the protection of insureds **and do not impose on insurers direct obligations to third-party claimants.**” *Levin v. Travelers Prop. Cas. Co.*, 2024 WL 1172214, at *8 (Conn. Super. Ct. Mar. 12, 2024) (emphasis added). In a footnote citation after discussing *NEMS PLLC v. Harvard Pilgrim Health Care of Connecticut Inc.*—the decision on which *Murphy Medical* relied—Judge Farley aptly noted, “[d]espite numerous amendments to the statute after *Carford*, [the *Carford*] court’s construction of § 38a-816 has stood for eighteen years without any legislative action.” *Id.* at *8 n.9. In sum, Aetna respectfully submits that providing a private right of action for third-party claimants against an insured of another does not fall within CUTPA’s policy of protecting consumers.

- (3) “[O]nce an IDR determination issues, and the precise amount owed by [Defendants] is unquestionably clear, they do not promptly, fairly and equitably settle the claim by paying the amount in the award (less any initial payment already made).”

Dkt. 109 at 13 (citing Conn. Gen. Stat. § 38a-816(6)(F)).

First, Plaintiffs’ allegations of a CUIPA violation are entirely conclusory. Merely reciting the statutory elements is insufficient to state a plausible claim. *See, e.g., Bilyard v. Am. Bankers Ins. Co.*, 2021 WL 4291173, at *4 (D. Conn. Sept. 21, 2021) (dismissing CUTPA claim where plaintiff “largely offered conclus[ory allegations] and reiterations of the statutory language”); *50 Waterville St. Tr., LLC v. Vermont Mut. Ins. Co.*, 2021 WL 2530777, at *3 (D. Conn. June 21, 2021) (dismissing CUTPA claim based on CUIPA where allegations were “little more than threadbare recitals of the elements of a cause of action” (cleaned up)); *O’Neill v. Riversource Life Ins. Co.*, 2010 WL 3925988, at *3 (D. Conn. Sept. 29, 2010) (same); *Van Dorsten v. Provident Life & Acc. Ins. Co.*, 554 F. Supp. 2d 285, 288–89 (D. Conn. 2008) (same).

Setting aside the wholly conclusory nature of Plaintiffs’ allegations, it cannot be said that “liability has become reasonably clear” until the IDR entity issues a determination. *See Tucker v. Am. Int’l Grp., Inc.*, 2015 WL 403195, at *27 n.48 (D. Conn. Jan. 28, 2015) (“The requirement that the insurer settle when the insured’s liability is ‘reasonably clear’ means that the existence of liability has to be substantially certain.” (cleaned up)). Accordingly, neither of the first two categories of conduct, as a matter of law, can support an unfair-settlement-practices claim.

Regardless, under the NSA, a payer has 30 days to make an initial payment on a claim. *See* 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv), -111(b)(1)(C). Plaintiffs do not dispute that Aetna has complied with its obligation to make an initial claim payment within 30 days of the claim submission, which only serves to demonstrate that Aetna is proceeding in compliance with its

statutory obligations. More importantly, it is not reasonable to infer that “liability has become reasonably clear” during the initial 30-day period following Plaintiffs’ submission of a claim.

As to the second category of alleged conduct—that Aetna is “not attempting in good faith to effectuate prompt, fair and equitable settlements” during the open-negotiation period—Plaintiffs’ SAC contains no factual allegation to support such a claim. Instead, the first (and only) time Plaintiffs mention either Defendants’ conduct during the open-negotiation period is when listing the conduct they contend violates § 38a-816(6)(F). *See* Dkt. 109 at 13. Plaintiffs’ isolated, conclusory allegation regarding Aetna’s supposed conduct during the open-negotiation period is objectively insufficient to plead a CUTPA claim based on a CUIPA violation. If more is needed, Plaintiffs also fail to include any basis for the Court to infer that this conduct occurs “with such frequency as to indicate a general business practice.” Conn. Gen. Stat. § 38a-816(6)(F).

Regarding the third category, Plaintiffs have not adequately alleged that Aetna has not attempted in good faith to pay the IDR awards once issued. As extensively discussed, notice-related issues have significantly hampered Aetna’s ability to pay IDR awards within 30 days of their issuance. *See* Section IV(C), *supra*. More importantly, Plaintiffs do not allege that Aetna was notified of or otherwise had adequate knowledge of the IDR determinations. *Cf. Ainsworth v. Amica Mut. Ins. Co.*, 2018 WL 4425991, at *9 (D. Conn. Sept. 17, 2018) (requiring allegation of knowingly false reason for denying coverage in declining to dismiss claim pursuant to Conn. Gen. Stat. § 38a-816(6)(F)). Without alleging that Aetna had knowledge of these IDR awards, Plaintiffs cannot state a plausible claim that Aetna did “not attempt[] in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear” as required by Conn. Gen. Stat. § 38a-816(6)(F). *See MCI Healthcare, Inc. v. United Health Grp., Inc.*, 2019 WL 2015949, at *9 (D. Conn. May 7, 2019) (dismissing CUTPA claim based on conclusory allegations

that defendant's conduct violated CUIPA); *Falit v. Provident Life & Accident Ins. Co.*, 2010 WL 2710478, at *2 (D. Conn. July 7, 2010) (same); *see also Kavanagh v. Zwilling*, 578 F. App'x 24, 24 (2d Cir. 2014) ("We do not accept as true conclusions unsupported by the facts alleged, legal conclusions, bald assertions, or unwarranted inferences."); *cf. S. Home Care Servs., Inc. v. Visiting Nurse Servs.*, 2015 WL 4509425, at *11 (D. Conn. July 24, 2015) ("liability depends on actual knowledge of the particular contractual provision alleged to have been violated" (quotations omitted)). Indeed, it is axiomatic that Aetna could not have acted in bad faith if it was unaware of an award's issuance. However, to be sure, when adequately notified, Aetna has endeavored to timely pay valid outstanding IDR awards and will continue to do so.

ii. CUIPA Is the Exclusive Vehicle to Pursue CUTPA Violations Based on Insurance-Related Conduct.

To the extent Plaintiffs attempt to plead a CUTPA claim based on conduct not mentioned in the preceding subsection, their claim must fail. *See generally* Dkt. 109 at 13–14. As discussed, "conduct by an . . . insurance company that is related to the business of providing insurance can violate CUTPA *only* if it violates CUIPA." *Acordia*, 310 Conn. at 27 (emphasis added).

VI. CONCLUSION

For the reasons set forth above, Aetna respectfully requests that the Court dismiss Plaintiffs' claims with prejudice to refiling.

Respectfully submitted,

By: /s/ John B. Shely
 JOHN B. SHELBY
 Texas State Bar No. 18215300
jshely@HuntonAK.com
 Attorney-in-Charge
 M. KATHERINE STRAHAN
 Texas State Bar No. 24013584
kstrahan@HuntonAK.com

DAVID HUGHES
Texas State Bar No. 24101941
DHughes@huntonAK.com
HUNTON ANDREWS KURTH LLP
600 Travis, Suite 4200
Houston, Texas 77002
Telephone: (713) 220-4200
Facsimile: (713) 220-4285

**Attorneys for Defendants
Aetna Health Inc.,
Aetna Life Insurance Co., and
Aetna Health and Life Insurance Co.**

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was filed electronically on July 23, 2024. 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/ David Hughes
David Hughes