

**UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT**

GUARDIAN FLIGHT LLC, et al.,

Plaintiffs,

v.

**AETNA LIFE INSURANCE
COMPANY et al.,**

Defendants.

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

JURY TRIAL DEMANDED

**PLAINTIFFS' JOINT OPPOSITION TO DEFENDANTS'
MOTIONS TO DISMISS PLAINTIFFS' SECOND AMENDED COMPLAINT**

Plaintiffs Guardian Flight, LLC (“Guardian Flight”), REACH Air Medical Services, LLC (“REACH”), CALSTAR Air Medical Services, LLC (“CALSTAR”), Med-Trans Corporation (“Med-Trans”), Air Evac EMS, Inc. (“Air Evac”), and AirMed International LLC (“AirMed”) (collectively “Plaintiffs”) file this joint opposition to the motions to dismiss filed by Defendants Aetna Life Insurance Company, Aetna Health, Inc., and Aetna Health and Life Insurance Company (collectively “Aetna,” Docs. 121 and 127) and Cigna Health and Life Insurance Company (“Cigna,” Docs. 123 and 124), and would respectfully show the Court as follows:

INTRODUCTION

This lawsuit is about making sure that life-saving transports by air remain available across America. In the No Surprises Act (“NSA”), Congress devised a scheme whereby health plans and insurers are required to provide coverage for emergency out-of-network (“OON”) services received by patients when they would have been covered by an in-network provider. OON rates are either governed by state law, agreed upon during an open negotiation period, or resolved by a third party. If insurance companies like Defendants cannot be compelled by providers to actually

pay the OON rate required by statute, and can instead convert that money into billion-dollar profits and million dollar CEO compensation, the entire system collapses.

Plaintiffs provide life-saving transports every day. Transports like:

- A young boy injured in a wooded area flown to a pediatric hospital for trauma care (Dispute 135402, unpaid Aetna transport, one year past due);
- A woman pregnant with twins flown to a hospital with high-risk obstetric and neonatal ICU services (Dispute 932498, unpaid Cigna transport, five months past due);
- A young man injured on a dirt bike flown to a hospital with a trauma care unit (Dispute 152408, unpaid Aetna transport, one year past due); and
- A newborn baby flown to a children's hospital with specialized neonatal cardiothoracic services (Dispute 949661, unpaid Cigna transport, five months past due).

As of the time this brief is filed, Defendants collectively have failed to pay over \$4 million that is owed on the emergency air ambulance transports at issue herein. While Defendants were supposed to pay for these services within thirty (30) days of the payment dispute being resolved, they are on average 290 days past due. Payments for many more transports were made late, averaging 119 days. This is on top of a regulatory process that can take a year or more to determine the amount owed.

Plaintiffs do not want to be forced to close their doors at any base in any part of the country. To keep all of those doors open, the courthouse door must remain open to enforce the payment obligation that Congress said “shall be binding upon the parties involved.”

I. Defendants Mischaracterize the NSA's Legal and Factual Landscape

Defendants spend a good part of their briefs mischaracterizing the “background” of the NSA in an attempt to defend their well-documented violations of the federal law. Aetna suggests Plaintiffs and other providers are filing too many payment disputes, known as Independent Dispute Resolution (“IDR”) proceedings. Doc. 127 at 1-2. The reality is that filing payment disputes is

the only way for providers to receive fair payment because the NSA allows insurance companies to unilaterally determine the “initial payment” made to OON providers. *See* 42 U.S.C. § 300gg-112(a)(3)(a). The result has been that insurers like Defendants are taking advantage of the NSA, often paying far less for OON services than they did prior to its enactment. While Plaintiffs have filed the most air ambulance payment disputes, the Government Accountability Office (“GAO”) explains that all air ambulance payment disputes *combined* are only “a small portion” of the IDR disputes that have been initiated. *See* Report to Congressional Committees, “Roll Out of Independent Dispute Resolution Process for Out-of-Network Claims Has Been Challenging,” (“GAO Report”) at p. 12, available at <https://www.gao.gov/products/gao-24-106335>.

Defendants’ suggestion that providers are also filing too many ineligible claims is premised in part on a misunderstanding of data issued by the Centers for Medicare and Medicaid Services (“CMS”), which administers the IDR payment dispute process. As Plaintiffs have noted, the NSA has very tight deadlines that providers have to meet in order to get to a final payment determination. Eligibility “depends on compliance with applicable time periods and completion of a 30-business-day open negotiation period prior to submitting a dispute.” GAO Report at p. 10. If any time period is missed (deadline to initiate, deadline to pay administrative fee, etc.), CMS designates the dispute as “ineligible.” The fact that the ineligible claims rate is high proves the point that insurers make low initial payments, hoping that busy providers focused on patient care never make it to the end of the line and obtain an IDR award.¹

¹ Another reason for the high ineligibility rate is because eligibility for the federal IDR process also depends on the type of health plan. The NSA relegates some disputes to state surprise billing law proceedings. The information needed to know the type of health plan at issue is within the insurers’ knowledge and often not included on the explanations of payment sent to providers. This leaves providers without the information needed to know whether the federal or a state process applies.

And while much is made of the backlog of IDR claims, this in fact has benefitted big insurers like Defendants. It means that healthcare providers like Plaintiffs have millions of dollars tied up in IDR proceedings that are stalled. Hence, Defendants have *fewer IDR awards* to deal with (and to pay) than they otherwise should. This means they get to hold money that is owed to providers much longer. Far from being a defense to not timely paying IDR awards, the backlog of IDR proceedings should make it easier for insurance companies to timely pay the awards that have actually made it through the process.

Also noticeably absent from Defendants' cherry picked "background" briefing is the fact that when providers do make it all the way through the IDR process, they are winning most of the time. Indeed, Plaintiffs win the payment they seek on Defendants' transports well over 80% of the time. That means that IDR entities agree with Plaintiffs that Defendants are underpaying their transports and that the amount Plaintiffs seek is the appropriate payment. And when Plaintiffs prevail, they are awarded on average 150 percent more than the paltry initial payment made by Defendants. And despite the landslide of wins in Plaintiffs' favor, Defendants still do not pay the appropriate amount up front or offer a network contract at the IDR-certified appropriate rates. Instead, they continue to force Plaintiffs to go through IDR.

Despite their continued attempts to demonize the front-line first responders who are in the business every day of saving lives, it is insurance companies who are handsomely profiting from the NSA. Last year, Defendants each reported net income in excess \$5 billion dollars, with their respective CEOs each receiving in excess of \$20M in compensation.² It is literally raining profits

² See "Big Payers Ranked by 2023 Profit," available at <https://www.beckerspayer.com/payer/big-payers-ranked-by-2023-profit-beckers.html>; "UnitedHealth chief Andrew Witty was 2023's highest-paid payer CEO. Here's what his peers earned," available at <https://www.fiercehealthcare.com/payers/unitedhealth-ceo-andrew-witty-was-2023s-highestpaid-payer-ceo-heres-what-his-peers-earned> (Aetna is owned by CVS Health).

at big insurers like Aetna and Cigna, while emergency providers like Plaintiffs are left to seek scraps through the IDR process. Adding insult to injury, providers now have to sue to get the IDR awards paid, with big insurance taking the position that they can choose not to pay the awards and that courts are powerless to do anything about it.

Defendants spend much time claiming their violations of the NSA are because of “notification issues,” “administrative burdens” and “other considerations.” However, none of Defendants’ *factual* defenses to their failure to make timely payments matter at the motion to dismiss stage. Instead, Plaintiffs’ factual allegations must be taken as true. *Ellerbe v. Jasion*, 2015 WL 1064739, at *1 (D. Conn. Mar. 11, 2015) (Shea, J) (“When considering a motion to dismiss, the Court accepts as true all factual allegations in the complaint and draws inferences from these allegations in the light most favorable to the plaintiff.”). And to the extent it did matter, Defendants noticeably provide no evidence or verification of their counsels’ bare allegations. Indeed, it is the discovery process (with policy and procedure documents produced and witnesses under oath) that will determine the reason each IDR award at issue in this proceeding was not timely paid. This Court should disregard Defendants’ many factual allegations masquerading as legal argument.

Aetna also conveniently omits the result of the first-ever federal government Qualified Payment Amount (“QPA”) audit against an insurer, which was an Aetna affiliate. That audit revealed that, for at least the first several months of 2022 (the audit period), Aetna was vastly underpaying emergency helicopter transports using a QPA, or median contracted rate, that was up to seventy-three percent (73%) too low. *See* Final Report: Federal Qualifying Payment Amount Audit of Aetna Health Inc., May 29, 2024 (“Aetna QPA Audit”), at p. 16, available at <https://www.cms.gov/files/document/qpa-final-report-aetna-tx.pdf>. Aetna not only bases its initial payments to providers on the QPA, it submits it in IDR proceedings. 42 U.S.C. § 300gg-

112(b)(5)(C)(i)(I). Accordingly, it is currently unknown how many IDR awards Aetna was able to win based on its fraudulent QPAs. Notably, the federal auditors had to make multiple requests for documentation and information from Aetna before the company finally admitted to its illegal practice. Aetna QPA Audit at pp. 14-15.

LEGAL STANDARD

I. Fed. R. Civ. P. 12(b)(1)

“A Rule 12(b)(1) motion challenging subject matter jurisdiction may be either facial or fact-based.” *Carter v. HealthPort Technologies, LLC*, 822 F.3d 47, 56 (2d Cir. 2016). When the jurisdiction challenge is facial, then it is “based solely on the allegations of the complaint or the complaint and exhibits attached to it[.]” *Id.* When the challenge is fact-based, however, a court “may consider affidavits and other materials beyond the pleadings to resolve the jurisdictional issue...” *J.S. ex. rel. N.S. v. Attica Cent. Sch.*, 386 F.3d 107, 110 (2d Cir. 2004) (internal citations omitted). But “[i]n adjudicating a motion to dismiss under Rule 12(b)(1), the court ‘accept[s] all of plaintiff’s factual allegations in the complaint as true and draw[s] inferences from those allegations in the light most favorable to the plaintiff.’” *Rodriguez v. United States Postal Service*, 2024 WL 2274074, at *2 (D. Conn. May 20, 2024) (quoting *Courtenay Communications Corp. v. Hall*, 334 F.3d 210, 213 (2d Cir. 2003)).

II. Fed. R. Civ. P. 12(b)(6)

At the motion to dismiss stage, to state a claim, a plaintiff must only allege “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). Facial plausibility exists “when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.” This means that a plaintiff need not plead facts that would “probably” establish a violation; all that is required is that the factual allegations, taken as true, demonstrate “more than a sheer possibility

that a defendant has acted unlawfully.” *Id.* at 678-79. Because of this, when a federal court reviews a complaint on a motion to dismiss, it “must accept as true all allegations in the complaint and draw all reasonable inferences in favor of the non-moving party.” *Vietnam Ass’n for Victims of Agent Orange v. Dow Chemical Co.*, 517 F.3d 104, 115 (2d Cir. 2008).

ARGUMENT AND AUTHORITIES

I. The NSA Requires Insurers to Cover Emergency Services and to Pay the OON Rate Directly to Providers

Many of Defendants’ legal arguments in their motions to dismiss, especially their arguments relating to ERISA standing, are premised on characterizations of the NSA that do not hold up against the actual statutory text. Accordingly, Plaintiffs first analyze the structure and language of the NSA itself.

With the NSA, Congress created a coverage mandate similar in kind to those added by the Affordable Care Act (“ACA”). Just as the ACA requires health plans and insurers to cover pre-existing conditions, the NSA requires coverage of emergency services provided by OON healthcare providers where in-network services are covered. Since there is no agreed rate for those services, the NSA next provides a mechanism to resolve disputes over the appropriate amount OON providers are owed for these covered services. In order to capture as many health plans as possible, including fully insured plans sold by insurance companies and self-funded plans administered by those same companies, Congress concurrently amended three different statutory schemes, including the Employee Retirement and Income Security Act (“ERISA”).³ This resulted

³ The relevant provisions occur in triplicate in the United States Code, because the Act amended three statutes: the Public Health Service Act (administered by the Department of Health and Human Services), ERISA (administered by the Department of Labor), and the Internal Revenue Code (administered by the Department of the Treasury). This brief primarily cites to the provisions in the Public Health Service Act, codified at Title 42 of the U.S. Code. The parallel provisions are codified at 29 U.S.C. § 1185e (ERISA) and 26 U.S.C. § 9816(c) (Internal Revenue Code).

in joint regulation by the Departments of Health and Human Services, Treasury and Labor (the “Departments”).

The NSA is comprised of two basic parts, one primarily applicable to emergency room (“ER”) facilities and providers, and the other to air ambulance providers. Both provisions are substantially similar, cross-reference one another, and incorporate each other’s provisions by reference. The first key part of the statutory scheme creates the coverage and payment mandates for emergency services:

(a) **Coverage** of emergency services

(1) In general

If a group health plan, or a health insurance issuer offering group health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—

(A) without the need for any prior authorization determination;

(B) ***whether the health care provider furnishing such services is a participating provider*** or a participating emergency facility, as applicable, with respect to such services;

42 U.S.C. § 300gg-111 (emphasis added); 42 U.S.C. § 300gg-112 (requiring coverage for OON air transports where in-network coverage exists)⁴. Stated differently, the NSA requires health plans, whether fully insured or self-insured, to cover OON emergency services if they cover in-network emergency services.

⁴ While the air ambulance section of the NSA does not reference the term “coverage,” it reaches the same result. The official website of the United States government defines “health coverage” as the “***legal entitlement to payment or reimbursement for your health care costs***, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP).” <https://www.healthcare.gov/glossary/health-coverage/> (emphasis added). There can be no doubt that after the NSA, OON air transports are now “covered” where in-network coverage exists.

Congress next addressed how covered services would be paid. For context, large employers typically “self-fund” their health plans rather than purchasing actual insurance. However, they still contract with large insurers to administer their health plans, including paying claims and resolving payment disputes. Employer-funded health plans also obtain access to the health insurer’s network of providers. The insurers, such as Defendants here, execute managed care agreements with network providers, meaning the insurer has the direct, contractual payment obligation to network providers for both insured and self-funded plans.

In essence, the NSA extended the payment obligation insurers have to their in-network providers to OON providers. The NSA provides the terms of payment for OON providers just as managed care agreements govern the terms for in-network providers. Accordingly, the NSA states:

3) *the group health plan or health insurance issuer*, respectively, *shall*—

[. . .]

(B) *pay a total plan or coverage payment*, in accordance with, if applicable, subsection (b)(6), *directly to such provider furnishing such services* to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (A), *equal to the amount by which the out-of-network rate* (as defined in section 300gg-111(a)(3)(K) of this title) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with paragraphs (1) and (2)).

42 U.S.C. § 300gg-112(a)(3)(B) (emphasis added); 42 U.S.C. 300gg-111(a)(1)(C)(iv) (same payment obligation for ER services). Congress was clear that OON emergency services must be covered where in-network coverage exists and that health plans and insurers *shall pay* a total plan or coverage payment *directly to* the OON provider. The amount to be paid is the OON rate minus any initial payment and the patient cost share.

Having created a coverage mandate and a direct payment obligation, Congress next turned to determining the amount to be paid. The OON rate is either: 1) the amount in an applicable state law; 2) the amount agreed upon during the open negotiation process; 3) the amount determined by an IDR entity in a payment dispute proceeding; or 4) the amount in an applicable All-Payer Model Agreement. *See* 42 U.S.C. 300gg-111(a)(3)(K). The IDR payment dispute program is administered by the Centers for Medicare and Medicaid Services (“CMS”).

Congress also determined what would be considered by IDR entities in payment disputes. *See* § 300gg-111(c)(5)(C); § 300gg-112(b)(5)(C) (“Considerations in determination”). It decided that that payment determinations would be made by independent third parties, or IDR entities, rather than HHS personnel. 300gg-111(c)(4); 300gg-112(b)(4). Finally, Congress explained that the OON rate determined by the IDR entity would be binding on the parties. The NSA states:

(E) *Effects of determination*

(i) In general

A determination of a certified IDR entity under subparagraph (A)-

(I) *shall be binding upon the parties involved*, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and

(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9.

[. . .]

(6) *Timing of payment*

The ***total plan or coverage payment required pursuant to subsection (a)(1) or (b)(1)***, with respect to a qualified IDR item or service ***for which a determination is made*** under paragraph (5)(A) or with respect to an item or service for which a payment amount is determined under open negotiations under paragraph (1), ***shall be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made.***

42 U.S.C. § 300gg-111(c)(5)(E) (emphasis added); 300gg-112(b)(5)(D). Here, for the second time, Congress explained that the “plan or coverage payment . . . shall be made directly to the nonparticipating provider or facility.” And it created a 30-day payment deadline.

Accordingly, this lawsuit concerns payment of covered services under health plans that are insured or administered by Defendants. Congress twice told them that they are required to directly pay Plaintiffs the amounts owed for those services, all of which went through the IDR process to resolve the amount of covered benefits that are owed. For each transport at issue, Plaintiffs have legally binding payment determinations that either were not paid or were paid late.

II. IDR Awards are Enforceable in Court

Defendants move to dismiss Plaintiffs’ claim under the NSA for payment of the OON rate that has been determined in IDR proceedings, arguing there is no express or implied cause of action in the statute. Docs. 124 at 8-12, 127 at 12-15. In support of their motions, they rely primarily on an unpublished decision by a federal judge in Texas that *created* conflicting authority on IDR award enforcement. *Id.* The Texas court is wrong, and this Court should not follow its error.

Prior to the Texas decision, a Blue Cross Blue Shield (“BCBS”) affiliate had successfully obtained enforcement and confirmation of an IDR award in New Jersey federal court. *See GPS of New Jersey M.D., P.C. v. Horizon Blue Cross & Blue Shield*, No. 22-CV-6614, 2023 WL 5815821 (D.N.J. Sept. 8, 2023) (confirming IDR award). However, because it was on the losing side of the IDR process in Texas, another BCBS affiliate took the opposite position. *See Guardian Flight, LLC v. Health Care Serv. Corp.*, 3:23-CV-01861-B, 2024 WL 2786913 (N.D. Tex. May 30, 2024) (dismissing IDR enforcement action).⁵ Plaintiffs have appealed the ruling in *Health*

⁵ Health Care Service Corporation is a Blue Cross Blue Shield Association licensee that operates Blue Cross companies in Illinois, Montana, New Mexico, Oklahoma and Texas. The decision in the Texas Blue Cross Case was issued in the Northern District of Texas whereas this case was transferred from the Southern District of Texas.

Care Serv. Corp. to the Fifth Circuit. *See Guardian Flight, LLC et al. v. Health Care Serv. Corp.*, No. 24-10561 (5th Cir. 2024). But regardless of how that litigation turns out, neither of the decisions procured by BCBS affiliates in opposite parts of the country is binding on this Court.

A. This Court Can Enforce IDR Awards Under the NSA or the FAA

As explained above, the NSA mandates coverage of OON emergency services where in-network coverage exists and requires payment be made directly to the healthcare provider at the OON rate. 42 U.S.C. § 300gg-112(a)(3)(B); 42 U.S.C. 300gg-111(a)(1)(C)(iv). Payment disputes are resolved by a third party IDR entity. The NSA states that this determination “*shall be binding upon the parties involved*” and that the “*total plan or coverage payment*” owed by the insured or self-funded health plan “*shall be made directly to the nonparticipating provider* or facility not later than 30 days after the date on which such determination is made.” 42 U.S.C. § 300gg-111(c)(5)(E); 42 U.S.C. § 300gg-112(b)(5).

First, Defendants confuse the distinct concepts of “judicial review” and “judicial enforcement.” When discussing judicial review, the NSA adopts the standards to vacate awards in the Federal Arbitration Act (“FAA”). Accordingly, Defendants argue that absent grounds to vacate an award, “the NSA does not offer a path of any kind into court.” Doc. 127 at 13. However, limiting the reasons that IDR awards can be *challenged* in court is not the same as limiting *enforcement* in court.

The FAA applies to contractually agreed arbitrations and states that “any party to the arbitration may apply . . . for an order confirming the award.” 9 U.S.C. § 9. The Administrative Dispute Resolution Act (“ADRA”) allows agencies to use “a dispute resolution proceeding for the resolution of an issue in controversy, and that relates to an administrative program” so long as the parties agree to it. 5 U.S.C. § 572(a). A “dispute resolution proceeding” is statutorily defined as “any process in which an alternative means of dispute resolution is used to resolve an issue in

controversy in which a neutral is appointed and specified parties participate.” *Id.* at 571. Notably, IDR proceedings fit neatly under this definition. The ADRA goes on to state:

A final award is binding on the parties to the arbitration proceeding, and ***may be enforced pursuant to sections 9 through 13 of title 9***. No action brought to enforce such an award shall be dismissed nor shall relief therein be denied on the grounds that it is against the United States or that the United States is an indispensable party.

Id. at §580(c). In other words, the ADRA extends a district court’s power under the FAA to enforce final awards in private arbitrations to final awards issued in dispute resolution proceedings related to administrative programs. Notably, the NSA uses very similar language to that used in the ADRA for final, enforceable awards (“binding on the parties” vs. “binding upon the parties involved”).

As explained in *Horizon Blue Cross*, FAA case law states that “language that indicates [an] award will be final and binding implicitly ***permits Federal court intervention to compel compliance***.” *Horizon Blue Cross*, 2023 WL 5815821 at *10 (emphasis added). And because the NSA “provides that any determination of the IDR entity is binding on the parties and is only subject to judicial review” in limited circumstances, “that language indicates the decision is to be ‘final and binding,’ and ***gives the court the authority to confirm the award***.” *Id.* (emphasis added). In other words, once the regulatory process is complete and a binding payment obligation is issued, federal courts enforce the award no differently than it enforces private obligations between the parties resulting from arbitrations or final awards in alternative dispute resolution proceedings related to an administrative program. *See also New Jersey Bldg. Laborers’ Statewide Ben. Funds v. Newark Bd. of Educ.*, 2013 WL 5180433, at *3 (D.N.J. Sept. 13, 2013) (“language that indicates the award will be final and binding implicitly permits Federal court intervention to compel compliance”).

Accordingly, this Court can enforce IDR Awards under the NSA and FAA in accordance with same reasoning used in the *Horizon Blue Cross* case. Stated differently, the use of the phrase “final award binding on the parties,” and in particular the word “binding,” provides authority either directly under the NSA or through the FAA to confirm the awards.⁶ Defendant Cigna’s argument that the *Horizon Blue Cross* case assumed without argument that the FAA applied is wrong. The court carefully traced its authority under both the NSA and FAA to enforce awards that are “binding” between the parties.

This is essentially the same conclusion reached by a D.C. federal judge in a very similar context in *Cheminova A/S v. Griffin LLC*, 182 F. Supp. 2d 68 (D.D.C. 2002), which concerned judicial enforcement of arbitration decisions made pursuant to the Federal Insecticide, Fungicide, and Rodenticide Act (“FIFRA”). *Id.* at 70. FIFRA covers registrations to sell pesticides, which are regulated by the Environmental Protection Agency (“EPA”). Under FIFRA, a new registrant can rely on the environmental study performed by a prior registrant so long as the prior registrant is provided appropriate payment. *Id.* at 70-71. Rather than statutorily define the appropriate payment, FIFRA implemented a private arbitration process to make that determination. *Id.* at 71-72. *Cheminova* concerned the enforceability of a FIFRA arbitration award with striking similarities to the challenge made here to the enforceability of NSA IDR awards.

The party losing the FIFRA payment dispute, like Defendants here, moved to dismiss the enforcement proceeding, arguing that neither FIFRA, the Federal Arbitration Act (“FAA”) nor the Administrative Dispute Resolution Act (“ADRA”) provided authority for judicial enforcement of

⁶ Plaintiffs do not contend that the entirety of the FAA applies to proceedings to enforce IDR awards. As Defendants note in their briefs, Plaintiffs have contested such a wholesale approach in other proceedings. Plaintiffs do, however, believe that the FAA provides the court with the legal authority and power to enforce IDR awards, which are “binding” obligations between the parties that relate to an administrative program.

FIFRA awards. *Id.* at 70. Like here, FIFRA limited the scope of judicial review of FIFRA awards, *id.* at 77, and did “not explicitly provide for judicial confirmation” of them, *id.* at 72. Similarly, the losing party argued that FIFRA “provides only an administrative remedy for a registrant’s failure to comply with an award.” *Id.* at 73.

The *Cheminova* court concluded that FIFRA awards were fully enforceable in federal court for multiple reasons. First, the court explained that FIFRA used the term “binding” in describing FIFRA proceedings and further mandated that the awards were “final and conclusive.” *Id.* at 73. It next explained that per Second Circuit case law, a party who has fully participated in a dispute resolution proceeding that is “final, conclusive and binding” upon it implicitly agrees that federal court intervention may be sought to compel compliance. *Id.* at 74 (citing *Kallen v. District 1199, Nat’l Union of Hosp. and Health Care Employees*, 574 F.2d 723, 726 (2d Cir. 1978) (holding that participation in arbitration pursuant to collective bargaining agreement provision stating that arbitrator’s award would be “final, conclusive, and binding” was sufficient to establish consent to enter judgment on an arbitration award)). The court noted that “the use of these [statutory] terms in an agreement between private parties is tantamount to consent to judicial enforcement” and that their use in FIFRA “should not convey a different meaning.” *Id.* at 74.

The *Cheminova* court next explained that “the purposes of the statute would be defeated” if FIFRA awards “are not judicially enforceable,” noting that the purpose of the FIFRA sections at issue was “to guarantee compensation” to a party for compelled use of its data. *Id.* at 74. It noted that “[w]ithout judicial enforcement, there would be no assurance that” the prevailing party would be paid,” and that the “the absence of judicial enforcement would frustrate Congress’s attempt to streamline” the registration process. *Id.* at 74-75. Such a decision would turn the FIFRA proceeding into “a relatively meaningless exercise, thereby gutting the very purpose of the Act”

and making an award of compensation illusory. *Id.* at 75. The court concluded that absent judicial enforcement, “FIFRA’s data-compensation scheme could be rendered meaningless.” *Id.* at 76.

Similarly here, judicial enforcement is necessary to effectuate the NSA’s express goals, and the purposes of the NSA would be defeated if IDR awards were not judicially enforceable. The IDR process determines the amount the insurer must pay the provider for the emergency services that were rendered. Congress was clear that insurers must pay – under federal law – those amounts within thirty days. The award “shall be binding upon the parties involved.” 42 U.S.C. § 300gg–111(c)(5)(E)(i)(I). If this language was included in a private agreement between the parties, there would be no doubt that the resulting award could be enforced in court. As the *Cheminova* court noted, the result should be no different merely because the language is in a statute. *Id.* at 74.

The FAA, ADRA, NSA and FIFRA all share the same statutory goals and principles of outsourcing binding determinations to private third parties, limiting the ability to obtain judicial review of final awards, and making final awards binding upon the parties. The only way IDR awards can be binding upon the parties as required by federal law is through judicial enforcement.²

B. There is No Regulatory Enforcement Mechanism

Defendants argue that the Departments are somehow solely responsible for enforcing IDR awards. The argument lacks any statutory support whatsoever. While CMS operates a “help desk” that accepts complaints, as the GAO reported, providers “receive little to no response when submitting complaints to CMS,” have “not seen a resolution on any submitted complaints,” and have been “discouraged” by CMS “from continuing to contact the help desk.” GAO Report at p.

² Defendant Cigna relies primarily on the *Health Care Serv. Corp.* decision to argue that the FAA does not apply. However, the court in *Health Care Serv. Corp.* did not address *Cheminova*, *Horizon Blue Cross* or the ADRA. It likewise ignored and did not address how an award can be “binding upon the parties” yet not enforceable by them.

37. One provider who was not paid an IDR award and complained to CMS, after waiting months for a response, was directed “to their state department of insurance for assistance.” *Id.* The state department of insurance responded that they “did not have any information on enforcement of the IDR process.” *Id.* And CMS and DOL say they have “limited ability to increase their enforcement efforts due to budget constraints.” *Id.* at 38. It is against this backdrop that Plaintiffs arrive at this Court to enforce their awards.

Defendant Cigna argues the “help desk” is Plaintiffs’ exclusive remedy, Doc. 124 at 10, because the Departments have “extensive rulemaking authority” and “regulatory oversight.” *Id.* However, the NSA only contains an audit provision for determining whether QPAs are properly calculated. 42 U.S.C. § 300gg-111(a)(2) (“Audit process and regulations for qualifying payment amounts.”). To date, two and one-half years after the NSA became effective, only one such audit report has been publicly released – the Aetna QPA Audit that revealed fraudulent QPAs. And the only complaint process listed in the NSA concerns complaints relating to QPA calculations, not IDR award enforcement. *Id.* at 300gg-111(a)(2)(B) (authorizing “a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i),” which are the requirements relating to calculating QPAs).⁸ The simple fact is that the NSA contains no regulatory enforcement procedure for IDR awards, a fact strongly supporting judicial enforcement. If the phrase “binding upon the parties involved” has any meaning, it must be that parties can enforce awards themselves.

⁸ The recent Aetna QPA Audit reveals how little regard CMS has for providers who have been cheated in the IDR process. Despite the fact Aetna admitted to using false QPAs, none of the remedies required by CMS concerned underpaid providers or the IDR proceedings that may have been tainted by the fraudulent practice. Instead, CMS was solely concerned with consumers who may have paid a higher deductible due to the QPA not being properly calculated. *See Aetna QPA Audit* at pp. 7-10.

It is clear that Congress decided to create a federal binding payment obligation between private parties – the emergency services provider and the insurer who controls the payment of health plan benefits. Interpreting federal statutes with mandatory dispute resolution proceedings that result in final, binding awards in such a way as to bar the prevailing party from judicial enforcement would eviscerate these statutory schemes. The *Cheminova* and *Horizon Blue Cross* courts recognized that, and this Court should do so too.

III. The NSA Created a Private Right of Action for Payment of the OON Rate, Which Includes Payments Based on IDR Awards

Like substantive federal law itself, private rights of action must be created by Congress. Courts “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.” *Alexander v. Sandoval*, 532 U.S. 275, 287 (2001). While “statutory intent is determinative,” legal context matters “to the extent it clarifies text.” *Id.* Here, the text, structure and legal context of the NSA evinces Congress’s intent to create both a private right and a private remedy, and thus a private right of action to enforce the NSA’s payment provision. Congress also separately evinced its intent because the statute provides no alternative enforcement mechanism.

The foundational requirement in the NSA is that health plans and insurers pay the OON rate directly to the healthcare provider. The statute states:

(3) *the group health plan or health insurance issuer*, respectively, *shall—*

[. . .]

(B) *pay a total plan or coverage payment*, in accordance with, if applicable, subsection (b)(6), *directly to such provider furnishing such services* to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (A), *equal to the amount by which the out-of-network rate* (as defined in section 300gg111(a)(3)(K) of this title) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with paragraphs (1) and (2)).

42 U.S.C. § 300gg-112(a)(3)(B) (emphasis added). As noted above, the OON rate is determined one of four ways, including through an IDR proceeding. *Id.* at § 300gg111(a)(3)(K) (defining the OON rate). Whichever amount is used, Congress clearly and unequivocally created a direct payment obligation of the OON rate by insurers like Defendants to providers like Plaintiffs.

Next, the NSA addresses the IDR dispute resolution process. There again, the text and structure implies a private remedy between private parties. The “Timing of Payment” provision states that payment “*shall* be made *directly* to the nonparticipating provider *not later than 30 days* after the date on which such [IDR] determination is made.” 42 U.S.C. § 300gg-112(b)(6) (emphasis added). The NSA goes on to make clear that the determinations are not advisory. The statute states that “[a] determination of a certified IDR entity...*shall be binding* upon the parties involved...” 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I) (emphasis added).

Taken together, these directives create a direct payment obligation between private parties that is binding on them and must be paid. These provisions clearly evince Congress’s intent to create both a private right and a private remedy. Indeed, the outsourcing of the IDR process – in which none of the Departments participate in the substance of any payment determination – further evinces a desire by Congress to effectuate private resolutions between private parties. The NSA keeps the agencies out of the process as much as possible.

Recently, the Supreme Court in *Maine Cmty. Health v. United States* considered whether “shall pay” language in § 1342 of the Affordable Care Act “established a money-mandating obligation.” 590 U.S. 296, 301 (2020). In finding that it did, the Court noted that mandatory ““shall pay”” language often reflects congressional intent to create both a right and a remedy, and that the analysis is “precisely” the same as the analysis regarding whether a statute “displays an intent to

create not just a private right but also a private remedy. *Id.* at 323-24, n. 12 (2020) (internal quotations omitted). No “magic words explicitly inviting suit” are required. *Id.*

Moreover, Congress is acutely aware of the understanding and definition of the term “binding.” Circuit courts have consistently held that binding awards carry with it the implicit agreement that it is enforceable in court. *See e.g., Kallen v. Dist. 1199, Nat. Union of Hosp. & Health Care Emp., RWDSU, AFL-CIO*, 574 F.2d 723, 726 (2d Cir. 1978) (a party can “hardly avow that an award will be ‘final, conclusive and binding’ upon it without implicitly agreeing that federal court intervention may be sought to compel compliance”); *see also Specialty Healthcare Mgmt., Inc. v. St. Mary Par. Hosp.*, 220 F.3d 650, 656 n.20 (5th Cir. 2000) (“consent to binding arbitration may properly imply consent to confirmation”); *id.* at 658 (Garza, J., dissenting) (“Any reasonable person would believe that an agreement to ‘binding’ arbitration means that any resulting damages would be enforceable and collectable. Otherwise, why agree to arbitrate?”); *Lander Co. v. MMP Invs., Inc.*, 107 F.3d 476, 480 (7th Cir. 1997) (“[t]o agree to binding arbitration is to agree that if your opponent wins the arbitration he can obtain judicial relief if you refuse to comply with the arbitrator’s award.”). Because of this, the NSA’s text clearly evinces an intent by Congress to provide both a private right and private remedy for providers to enforce the NSA’s payment obligation in federal court.

As noted above, Defendants’ argument that complaining to the CMS “help desk” is the sole remedy available lacks any statutory support. There is nothing in the NSA that creates a regulatory enforcement process.² And as the GAO Report explained, provider complaints to the

² With respect to Defendants’ argument that Plaintiffs have not asserted that they exhausted their administrative remedies, receipt of an IDR award is the completion of the regulatory process. There is nothing else in the NSA left to do. Plaintiffs not only assert exhaustion through completion of the IDR process, they specifically list the IDR awards at issue in exhibits to the complaint.

“help desk” go unanswered, with some being referred to state departments of insurance who know nothing about the statute. GAO Report at p. 37. The reality is that without judicial enforcement, there is no “binding” obligation between the parties.

Defendants cite three unpublished opinions to argue Plaintiffs have no private right of action under the NSA. The first, *Los Robles Emergency Physicians Medical Group v. Stanford-Franz*, 2024 WL 2106951 (C.D. Cal. Feb. 8, 2024), is cited only by Cigna and is irrelevant. That case concerned a patient’s claim that her medical provider overbilled her for services. *Id.* at *1. The provider claimed the patient “hijacked” the provider’s name in retaliation for the alleged overbilling “via registration of a website, creation of corporate entities, and redirection of [provider’s] mail.” *Id.* When the provider sued the patient, she counter-claimed with numerous theories, including violation of the NSA’s balance billing protections. *Id.* at *2. The court, noting there was “no established law on the issue,” concluded that a patient had no private right of action under the NSA to essentially enforce the balance billing prohibition. *Id.* In support of its conclusion, the court noted the “extensive dispute resolution process between insurers and medical providers” in the NSA. *Id.* *Los Robles* has nothing to do with the enforceability of an IDR award or a private right of action *by a provider* for the OON rate *who went through* the “extensive dispute resolution process” and obtained an IDR award.

Next, also cited only by Cigna, is *FHMC LLC v. Blue Cross and Blue Shield of Arizona*, 2024 WL 1461989 at *3 (D. Ariz. Apr. 4, 2024). There, a provider attempted to *skip the IDR process* and sue for alleged underpayments that were not made in accordance with the NSA’s initial payment deadline. *Id.* at *3 Indeed, plaintiffs conceded in their briefs and at oral argument that they had the option to “initiate IDR for all their unpaid or underpaid claims” but had not done

so. *Id.* The *FHMC* court ruled that there was “no implied private right of action *in such circumstance.*” *Id.* (emphasis added).

The final case, cited by both Defendants, is the *Health Care Serv. Corp.* case previously discussed. As noted above, that court simply ignored controlling authority on ERISA standing as well as contrary authority, such as *Horizon Blue Cross* (which enforced an IDR award). For all of the reasons stated in this brief, the *Health Care Serv. Corp.* court is simply wrong. And while Defendant Cigna narrowly focuses solely on the “Timing of Payment” provision, Doc. 124 at 12-13, Plaintiffs’ statutory interpretation relies on much more.

The NSA’s structure, terms and legal context all point to Congress’ intent to create a private right of action for payment of the OON rate, and any interpretation to the contrary would undermine the statutory scheme. Without a private right of action, there is no means for providers to enforce the NSA’s language stating that IDR determinations are “binding” and that insurers “shall pay” the OON rate set by those awards within thirty days. Only a private right of action comports with the statutory scheme and fulfills its purpose of eliminating patient balance billing liability in exchange for a direct payment of health plan benefits to OON providers, with payment disputes being efficiently resolved so providers are quickly paid. *See* 42 U.S.C. §§ 300gg-111(c)(3)(A), 300gg-111(c)(4)(E). For these reasons, the NSA provides a private right of action which Plaintiffs have stated a claim thereunder, and Defendants’ Motion should be denied.

IV. Plaintiffs Have Derivative Standing Under ERISA to Sue for Plan Benefits and Payment of IDR Awards

Defendants move to dismiss Plaintiffs’ derivative ERISA claims on the erroneous grounds that a patient lacks standing to compel its insurer to pay plan benefits for the OON services received. This is not a new argument. Insurers have argued for many years that unless and until patients are balance billed, they have no financial risk of loss and thus they and their assignees

lack ERISA standing. As explained below, this argument has been met with universal rejection, and the NSA has strengthened, not weakened, patient standing.

At the outset, Plaintiffs note that with respect to health plans governed by ERISA, the term “plan benefit” is equivalent to the coverage provided under a health insurance agreement. A “covered service” in an insurance policy is a “plan benefit” in ERISA parlance. Accordingly, an ERISA claim for plan benefits is for payment of medical expenses that are covered by the plan. As noted above, ERISA now requires coverage for OON emergency services where in-network services are covered. All of the health plans at issue herein had such coverage as they otherwise would have been ineligible for the IDR process and no IDR award would exist.

A. Plaintiffs Have Valid Assignments of All Claims Relating to Payment, Including ERISA Claims

With respect to Defendants’ factual challenge to Plaintiffs’ standing to assert ERISA claims, Plaintiffs have valid assignments from their patients as required to maintain derivative standing. *See I.V. Servs. of Am., Inc. v. Trs. Of Am. Consulting Eng’rs Coluncil Ins. Trust Fund*, 136 F.3d 114, 117 n.2 (2d Cir. 1998) (“[T]he assignees of beneficiaries to an ERISA-governed insurance plan have standing to sue under ERISA.”). As the attached declaration and exemplar document demonstrates, all of the Plaintiffs use the same assignment of benefits form and it is standard practice to obtain the patient or legal guardian’s signature for each transport. *See Ex. A.* Those assignments include assignment of “all right to (and related or associated with)” payable benefits, including the right to file lawsuits, recover attorney’s fees, and “all rights, statutory or contractual, to any additional recovery such as treble damages, punitive damages, or penalties.” Plaintiffs have obtained valid, legally enforceable assignments of their patients’ ERISA claims and Defendants’ challenge on this ground should be denied.

B. Patients Have Standing to Sue for Plan Benefits and Payment of IDR Awards

Defendants next argue that Plaintiffs lack standing because the patients from whom they received assignments lack standing to sue for health plan benefits or payment of IDR awards. They are wrong on both accounts.

First, as mentioned above, insurance companies have been making a version of this argument for years. In fact, Defendant Cigna made this argument in an OON payment dispute with a Texas hospital in 2015. *See North Cypress Medical Center Operating Co., Ltd. v. Cigna*, 781 F.3d 182 (5th Cir. 2015). While it prevailed at the district court level, the decision was reversed by the Fifth Circuit. *Id.* at 207 (reversing dismissal of ERISA claims).

In *North Cypress*, Cigna argued that there was no injury in fact because patients were not billed for the amounts allegedly due from the insurance plans and thus had no financial stake in the litigation. The court disagreed, explaining:

Cigna argues that its refusal to pay based on the full charges [the provider] reported did not cause patients any injury because they were never at imminent risk of out-of-pocket expenses; that [the provider] did not bill patients for the amounts Cigna did not pay and never intended to do so. The district court agreed with Cigna, and found the patients—and thus [the provider]—lacked standing. We cannot agree.

...

In purchasing her Cigna plan she agreed to pay for coverage at out-of-network providers like [this one], and Cigna is failing to uphold the bargain by paying for covered services. ERISA is designed “to protect contractually defined benefits” and has a “repeatedly emphasized purpose” of doing so.

North Cypress Medical Center Operating Co., Ltd. v. Cigna, 781 F.3d 182, 192–193 (5th Cir. 2015) (emphasis added). In other words, patients have standing under ERISA to sue their health plans and insurers for non-payment of healthcare providers regardless of whether the patient will ever be balance billed for the services provided. And this right may be assigned to OON providers like Plaintiffs, which is what was done here.

The *North Cypress* decision does not stand on its own. As the Sixth Circuit has explained:

Every circuit court to consider this issue agrees that a plaintiff in [the patient’s] shoes does not need to suffer financial loss. The Fifth, Ninth, and Eleventh Circuits have each held that the ***denial of plan benefits*** is a concrete injury for Article III standing ***even when patients were not directly billed for their medical services.***

Springer v. Cleveland Clinic Emp. Health Plan Total Care, 900 F.3d 284, 287 (6th Cir. 2018) (emphasis added). At least five circuits have held that denial of plan benefits, *i.e.* not paying OON providers the amounts owed for services provided the ERISA beneficiary, is a concrete injury for Article III standing even when patients are not billed for the medical services and stand no prospect of financial loss. *See Mitchell v. Blue Cross Blue Shield of N.D.*, 953 F.3d 529, 536 (8th Cir. 2020) (explaining that plan participants “are injured not only when an underpaid healthcare provider charges them for the balance of a bill” but also “when a plan administrator fails to pay a healthcare provider in accordance with the terms of their benefits plan”); *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1291 (9th Cir. 2014); *HCA Health Servs. of Ga., Inc. v. Emp’rs Health Ins. Co.*, 240 F.3d 982, 991 (11th Cir. 2001), *overruled on other grounds by Doyle v. Liberty Life Assurance Co. of Bos.*, 542 F.3d 1352 (11th Cir. 2008).

Defendants attempt to circumvent this clear authority by arguing that Congress created a “right to payment” from insurers like them that is untethered to the ERISA health plans they administer. Doc. 127 at 17. Defendants contend that because the “right to payment stems from the NSA, not the plan participants’ rights under ERISA,” patients no longer have standing to sue for payment of their OON care. *Id.* This argument is factually and legally wrong. As discussed above, the NSA created the obligation for a health plan or insurer to directly pay *ERISA plan benefits* to the provider who provided services that ERISA health plans must now cover.

The Court should not overlook the fact that Defendants make their standing argument without reference to the actual terms of the NSA. Instead, they cite another court’s characterization

of the NSA’s terms, made in the context of a constitutional attack on the validity of the NSA itself. *See Id.* at 16 (citing a constitutional attack on the NSA itself). The reason is because their argument cannot withstand scrutiny under the statute’s actual terms.

First and foremost, the NSA *is part of ERISA*. It is not some separate or standalone obligation. The NSA amended three different statutory schemes, one of which was ERISA. *See* 29 U.S.C. §§ 1185e (Preventing surprise medical bills) and 1185f (Ending surprise air ambulance bills). All of the requirements of “the NSA” are requirements of ERISA, as amended. That is also why the civil enforcement provisions of ERISA now apply to the NSA. *See* 29 U.S.C. § 1132(a)(3) (Civil enforcement) (stating a beneficiary can enforce the requirements of subtitle I, which includes the amendments added by the NSA).

Second, the NSA does not create an independent payment obligation untethered to ERISA or ERISA regulated health plans. As explained above, the NSA created a *coverage* mandate similar in kind to those added by the Affordable Care Act (“ACA”). *See* (explaining that “the plan or issuer shall cover emergency services” for OON providers); 29 U.S.C. § 1185f (air ambulance providers). It is notable that the NSA is part of § 1185 of ERISA, which contains other coverage mandates such as requiring ERISA health plans to cover certain reconstructive surgeries. *Id.* at 1185b (“Required coverage for reconstructive surgery following mastectomies”). The provision applying the requirements of the Affordable Care Act to ERISA plans are likewise located here. *Id.* at 1185d (“Additional market reforms”).

The NSA amendments to ERISA go on to explain that health plans and insurers cannot require prior authorization of OON emergency medical services or apply patient cost-sharing differently than if the service had been provided by someone in network. *Id.* at 1185e (a)(1)(C). As noted above, ERISA now requires ERISA health plans to “pay a *total plan or coverage*

*payment . . . directly to such provider furnishing” the emergency services “equal to the amount by which the” IDR award exceeds patient cost-sharing “imposed **under the plan or coverage.”** *Id.* at 1185f(a)(3)(B) (emphasis added). The NSA amended ERISA to require a direct payment obligation **of ERISA plan benefits** to healthcare providers like Plaintiffs. Payment of air ambulance transports by OON providers is now a benefit of every ERISA health plan providing in-network coverage for transports as a matter of law.*

Simply stated, payment of OON emergency care is now a plan benefit under every ERISA health plan that covers in-network emergency services. This lawsuit includes self-funded health plans that Defendants insure and/or administer. Doc. 109 (“SAC”) at ¶ 19. The patient (ERISA beneficiary) has the same concrete interest in getting the benefit of its bargain under his or her ERISA health plan after the NSA was enacted. Or as the Eighth Circuit explained it:

Plan participants are injured not only when an underpaid healthcare provider charges them for the balance of a bill; they are also ***injured when a plan administrator fails to pay a healthcare provider in accordance with the terms of their benefits plan.***

Mitchell v. Blue Cross Blue Shield of N.D., 953 F.3d 529, 536 (8th Cir. 2020). That is precisely the case here. Each health plan, as now required by the NSA amendments to ERISA, promised payment for OON emergency care to each patient that was transported by air ambulance. All the IDR award did was liquidate the amount of that OON payment obligation.

Patients, particularly those in rural America, likewise have a concrete interest in air ambulance providers being paid for transports to assure the availability of these life-saving services. SAC ¶ 33. As alleged in their complaint, air ambulance companies have already shuttered bases in response decreased payments due to the NSA (citing news stories). *Id.* ¶ 34. One large provider of emergency room physicians filed bankruptcy due to payments being slashed by insurers like Defendants after the NSA went into effect. *Id.* ¶ 35. This is not speculation – it is reality. Patients

cannot receive the benefit of their health care bargains if there is no provider to provide the service they have been promised and which the NSA mandates.

Patients are injured when plan administrators, like Defendants here, fails to pay plan benefits to their providers. Plaintiffs, as assignees of their patients, have standing to assert a claim for payment of ERISA plan benefits for the emergency services that were provided. *See* 29 U.S.C. 1132(a)(1)(B). They also have a claim under ERISA’s civil enforcement section to enforce ERISA’s requirement, as amended by the NSA, that payments be made directly to them based on the OON rates determined in IDR awards. *See* 29 U.S.C. § 1132(a)(3)

V. Plaintiffs are Entitled to Enforce ERISA and Obtain Equitable Relief as it relates to Payment of Services

ERISA provides a beneficiary the right to sue “to enjoin any act or practice which violates any provision of [ERISA subchapter I],” “to obtain other appropriate equitable relief,” “to redress such violations,” or “to enforce any provisions of [ERISA subchapter I] *or* the terms of the plan.” 29 U.S.C. § 1132(a)(3) (Civil enforcement) (emphasis added). In their operative complaint Plaintiffs state that they “seek civil enforcement against Defendants of the NSA’s requirement to pay IDR awards within thirty days.” SAC at ¶ 36. Plaintiffs further seek all of the equitable relief the Court deems appropriate, a decision on the merits that is not yet ripe. *Id.* at p. 15 (prayer).

Defendants challenge Plaintiffs’ request for equitable relief under ERISA. First, Plaintiffs’ ERISA claim to compel payment of outstanding IDR awards is not a claim for equitable relief. Plaintiffs do not seek an injunction with respect to this claim – they seek a money judgment. The civil enforcement provision of ERISA allows Plaintiffs, as assignees, to “enforce any provisions of” ERISA subchapter I which, as noted above, includes the terms of the NSA. That means that Plaintiffs can directly enforce the NSA, including the obligation that Defendants pay them the

OON rate owed on every air ambulance transport in this proceeding that concerns an ERISA regulated health plan (which Aetna claims is most “if not all”).

Defendants’ strained attempt to try to separate payment for IDR awards from the terms of ERISA regulated health plans is really a distinction without a difference. Whether Plaintiffs obtain a money judgment through a claim for plan benefits under § 1132(a)(1)(B) or by enforcing the plan’s obligation to pay IDR awards under § 1132(a)(3), the result is the same.¹⁰ As noted above, patients are injured when the administrator of their health plan (Aetna) does not live up to the benefit of its bargain and violates ERISA by not paying the required OON rate on air ambulance transports that the law requires. To the extent Aetna seeks dismissal of this claim as seeking “equitable relief,” it should be denied.

Defendants argue that Plaintiffs cannot seek equitable relief because it is not within the scope of their patient assignment. *See* Doc. 127 at 20-21. In support, they cite *Franco v. Connecticut Gen. Life Ins. Co.*, 818 F. Supp. 2d 792 (D.N.J. 2013). There, the court found no derivative standing under ERISA and stated that assignments to receive reimbursement “in no way can be construed as tantamount to assigning the right [to] enforce his or her rights under the plan.” 818 F. Supp. 2d 792, 811 (D.N.J. 2013). However, the Third Circuit reversed on appeal, concluding derivative standing existed. *See Franco v. Connecticut Gen. Life Ins. Co.*, 647 Fed. App’x. 76, 82 (3d Cir. 2016). The court also rejected Cigna’s argument in that case (made again here) that the assignments were not pled with sufficient specificity. As the Third Circuit explained:

The Provider Plaintiffs have pled that they have received from CIGNA insureds “an assignment of benefits,” (J.A. 395), or “a claim assignment ... through which [the Provider Plaintiff] is paid directly by CIGNA.” (J.A. 398.) These averments

¹⁰ As mentioned above at footnote 4, “health coverage” is the legal requirement to pay for a healthcare expense. If ERISA requires its regulated health plans to pay for OON air ambulance transports, it is “covered” and thus a “plan benefit” regardless of what the plan says.

are sufficient to plead the existence of a valid assignment to support derivative standing.

Id. at 82. The Third Circuit also noted it had previously rejected Aetna’s argument that assignments are insufficient to confer derivative standing unless they “explicitly include not just the right to payment but also the patient’s legal claim to that payment.” *Id.* at 81 (citing *North Jersey Brain & Spine Center v. Aetna, Inc.*, 801 F.3d 369, 372 (3d. Cir. 2015)).

Defendants next cite *Spinedex*, which as noted above, is a Ninth Circuit case where the court found derivative standing for a provider to pursue an ERISA claim for payment of benefits. 770 F. 3d at 1291. Defendants cite it for the proposition that an assignment for payment of benefits does not confer derivative standing to pursue a breach of fiduciary duty claim under ERISA. *Id.* at 1292. But Plaintiffs assert no such claim here. Instead, Plaintiffs are attempting to enforce compliance with ERISA’s requirement that OON providers like Plaintiffs ***be paid*** the OON rate, and that it be done by the required deadline. SAC ¶ 39. As explained below, Plaintiffs’ assignments are broad enough to encompass these payment-related obligations.

Lastly, Defendants cite *MCI Healthcare, Inc. v. United Health Group, Inc.*, for the proposition that an assignment of payment for services rendered does not “encompass the right to pursue injunctive relief.” 2019 WL 2015949, at *5 (D. Conn. May 7, 2019) (emphasis added). In *MCI Healthcare*, the assignment at issue simply stated “I, [patient’s name], am requesting that my Insurance company ***submit any payment*** related to my care at this rendering facility to the Mountainside Treatment Center.” *Id.* at 1 (emphasis added). As seen in Exhibit A¹¹, Plaintiffs assignments are nothing like the one at issue in *MCI Healthcare*.

¹¹ The court may consider the language of the assignment in deciding whether a claim has been stated. *See, e.g., Sira v. Morton*, 380 F.3d 57 (2d Cir. 2004) (explaining that a complaint is deemed to include any written instrument attached to it as an exhibit, materials incorporated in it by reference, and documents that, although not incorporated by reference, are integral to the complaint).

Plaintiffs here obtained broad assignments. They each state:

[Patient] . . . requests that *payment of authorized...benefits be made* on the patient's behalf *directly to [Plaintiff]* for any medical services provided to the Patient by [Plaintiff] *now or in the future*, and, *...assigns all rights to (and related or associated with) such payments to Supplier*, including...the right to file...litigation...*relating to a claim for payment*, as well as all rights to recover expenses or fees incurred for pursuing the claim and *all rights, statutory or contractual, to any additional recovery* such as treble damages, punitive damages, or penalties

Ex. A (emphasis added). These assignments are very broad and encompass all rights to payment of plan benefits in response to IDR awards “now or in the future.” The assignments also include all rights “related or associated with” payment of plan benefits for existing or future services, authorizes litigation “relating to” payment of plan benefits, assigns “all rights, statutory or contractual” to any additional recovery, and specifically includes treble damages, punitive damages and penalties.

There can be little doubt that Plaintiffs have the ability to enforce ERISA, as amended by the NSA, to compel payment of the OON rate that is owed on the transports at issue in this litigation. And enforcing timely payment of plan benefits *prospectively* in response to IDR awards is clearly “related or associated with” payment of authorized plan benefits for services provided “now” (at the time of the transport) or “in the future.” The scope of equitable relief that Plaintiffs seek does not go beyond the scope of Plaintiffs’ assignments.

VI. Plaintiffs’ CUTPA Claim is not Preempted

A. The NSA and CUTPA can Coexist

Defendants attempt to dismiss Plaintiff’s CUTPA claims by asserting they are preempted because they conflict with the NSA’s provisions and purpose. Doc. 127 at 21-25. This is incorrect. CUTPA complements, rather than conflicts, with the objectives and mandates of the NSA and therefore is not preempted by it.

Every preemption analysis begins with the presumption that Congress did not intend to displace state law. *New York Pet Welfare Ass'n, Inc. v. City of New York*, 850 F.3d 79, 86 (2d Cir. 2017) (citing *Wyeth v. Levine*, 555 U.S. 555, 565, 129 S.Ct. 1187, 173 L.Ed.2d 51 (2009)). 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. *Arizona v. United States*, 567 U.S. 387, 399 (2012). "What constitutes a sufficient obstacle is a matter of judgment, to be informed by examining the federal statute as a whole and identifying its purpose and intended effects." *Marentette v. Abbott Lab's, Inc.*, 886 F.3d 112, 117 (2d Cir. 2018). "[F]ederal law does not preempt state law under obstacle preemption analysis unless 'the repugnance or conflict is so direct and positive that the two acts cannot be reconciled or consistently stand together.'" *In re Methyl Tertiary Butyl Ether (MTBE) Prod. Liab. Litig.*, 725 F.3d 65, 102 (2d Cir. 2013) (citation omitted). The party asserting that federal law preempts state law bears the burden of establishing preemption. *Id.* at 96 (citing *Wyeth v. Levine*, 555 U.S. 555, 569 (2009)).

First, Defendants do not argue that it is "physically impossible" to comply with both CUTPA and the NSA. Instead, they appear to rely on obstacle preemption. However, they have not come close to the high bar required of a party asserting such preemption. To the contrary, both the NSA and CUTPA can consistently stand together. In fact, the NSA directly recognizes this by deferring to state surprise billing laws where applicable. *See* 42 U.S.C. §§ 300gg–111(a)(1)(c), –111(a)(3)(I), –111(a)(3)(K).¹² Here, the CUTPA claim is premised on Defendants' *violations* of

¹² The NSA provider requirements essentially adopt obstacle preemption, stating that they "shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent that such requirement or prohibition ***prevents the application of a requirement or prohibition***" of the federal surprise billing requirements. 42 U.S.C. § 300gg–134(c) (emphasis added).

the NSA as part of an overall scheme to avoid its payment obligations and maximize its corporate profits. *See, e.g., Centatiempo v. Bank of America, N.A.*, 333 Conn. 769, 792 (2019) (explaining that a CUTPA claim can be based on the violation of federal law).

Defendants argue that the NSA dispute resolution process is “in direct conflict” with Plaintiffs’ CUTPA claim because some of relevant conduct occurs before the IDR award setting the payment amount is issued. Doc. 127 at 22. However, merely because the NSA does not mandate the amount an insurer initially pays on a claim does not mean that an insurer can implement an unfair, bad faith process that takes advantage of the discretion it has. Most state laws, like Connecticut (discussed below), prohibit insurers from not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. Congress is presumed to have known this when it decided not to separately address the initial payment obligation. That decision does not give Defendants a free pass to act in bad faith by making unfair and inequitable settlements where liability clearly exists.

Plaintiffs do not seek to “impose penalties based on an insurer’s initial payment determination” or “subvert” the NSA’s dispute resolution process. *See id.* at 22-23. Plaintiffs do not allege that the mere fact Defendants’ payment is lower than what is later found to be payable constitutes an unfair and deceptive trade practice in violation of CUTPA. Rather, Plaintiffs allege that both Defendants engaged in similar “low pay, late pay or no pay” schemes which result in “Plaintiffs not receiving fair compensation until many months, and sometimes years, after the emergency transport occurred,” or at all. SAC ¶ 1. Thus, Defendants’ suggestion that state law may not penalize unfair or deceptive trade practices employed by insurers prior to an IDR award being issued is simply wrong and would allow insurers to engage in the type of unfair, bad faith conduct that CUTPA is intended to deter. Notably, the intent of the NSA’s dispute resolution

process was to encourage network contracting between the parties by providing them with independent, third party determinations of the value of OON services. GAO Report at pp. 31-32. Defendants, in violation of CUTPA, have turned the NSA's goal on its head.

A determination of whether Defendants' "low pay, late pay or no pay" scheme is prohibited by CUTPA would not supplant the IDR entities' role of deciding the appropriate rate for OON medical services. Doc. 127 at 23. The analysis of Defendants' unfair schemes will necessarily rely on many facts other than the IDR entities' determinations that their initial payments were lower than what was appropriate. Those additional facts will include their respective patterns and practices of violating the NSA by not timely paying awards, evidence relating to inadequate compliance measures, and countless documents and tactics that only discovery will reveal. Indeed, the recent Aetna QPA Audit results revealed one of the ways Aetna was implementing its "low pay, late pay or no pay" scheme that is likely different than the methods used by Cigna to reach the same result. Only discovery will reveal the details of these unfair practices.¹³

Nor would consideration of Defendants' conduct "directly contravene[] the NSA's prohibition on judicial intervention save for the FAA's four vacatur grounds." Doc. 127 at 23. The NSA does not provide a general "prohibition on judicial intervention" as suggested by Defendants. The NSA prohibits judicial review of an IDR entity's determination of the appropriate OON rate for a specific transport except in the four cases outlined in the FAA. *See* 42 U.S. Code §§ 300gg-(c)(5)(E)(i)(II). Plaintiffs are not asking this Court to reconsider the validity of any of the determination at issue in this lawsuit. Indeed, Plaintiffs' CUTPA claim is premised on the finality and enforceability of those determinations.

¹³ Moreover, Defendants' objections to the specific evidence Plaintiffs offer and arguments they make in support of their CUTPA claims are better addressed in pre-trial motions or trial objections. Defendants' IDR practices are discoverable even if not ultimately admissible. *See* F.R.C.P. 26(b)(1).

Defendants also argue that imposing penalties for their failure to adhere to the NSA's mandate to make payment within 30 days of an award's issuance would frustrate the NSA's purpose of "provid[ing] a means of dispute resolution at minimal cost" by "imposing punitive fines where Congress saw fit not to do so." Doc. 127 at 24. However, the Supreme Court has also already rejected the theory that Congress's failure to impose penalties for noncompliance with a federal statute requires preemption of state law allowing for such penalties.

In *English v. General Elec. Co.*, the Supreme Court refused to equate Congress's decision not to provide general authorization to award punitive damages in the Energy Reorganization Act with an intent to preempt state actions that permit the recovery of exemplary damages. *Eng. v. Gen. Elec. Co.*, 496 U.S. 72, 88–89 (1990). The Court found that "the District Court failed to follow this Court's teaching that '[o]rdinarily, state causes of action are not pre-empted solely because they impose liability over and above that authorized by federal law.'" *Id.* (citing *California v. ARC America Corp.*, 490 U.S. 93, 105 (1989)). There is no preemption here.

B. ERISA does not Preempt Plaintiffs' CUTPA Claim

There can be no doubt that ERISA does not preempt Plaintiffs' CUTPA claim with respect to Aetna's fully insured business, which is not governed by ERISA. *See Murphy Medical Associates, LLC v. Cigna Health and Life Insurance Company*, 2022 WL 10560321, at *2 (D. Conn. Oct. 18, 2022) (reconsidering broad dismissal of plaintiffs' CUTPA claim and allowing leave to amend because plaintiffs clarified that their claims "related to both ERISA and non-ERISA plans."); *Murphy Medical Associates, LLC v. United Medical Resources Inc.*, 2023 WL 2687466, at * 6 (D. Conn. Mar. 29, 2023) (granting leave to amend CUTPA claim to identify any non-ERISA plans). Plaintiffs allege that the transports at issue concerned both fully insured health plans and ERISA-governed health plans. SAC ¶ 19.

ERISA also does not preempt Plaintiffs' CUTPA claim with respect to ERISA-governed plans. Defendants initially argue that Plaintiffs, as assignees, cannot pursue an ERISA claim because "any claimed right to payment stems from the NSA, *not* the plan participants' rights under ERISA." Doc. 127 at 17. As discussed above, this makes no sense as the NSA amended and is now part of ERISA. Then, twisting itself in knots to avoid the consequences of their own conduct, Defendants later argue that ERISA preempts Plaintiffs CUTPA claim because "such a claim 'relates' to members' plans." *Id.* at 25. Defendants cannot have it both ways.

If Aetna is correct that Plaintiffs cannot assert a claim under ERISA for plan benefits, then Plaintiffs' CUTPA claim cannot be said to "relate to" ERISA-governed plans, and thus is not preempted. *See Gianetti v. Blue Cross and Blue Shield of Connecticut, Inc.*, 2008 WL 1994895, at *3 (D. Conn. May 6, 2008) (finding ERISA preemption for CUTPA claim but noting that ERISA preemption of state law claims was appropriate because Plaintiff had standing to sue under ERISA); *see also Weisenthal v. United Health Care Ins. Co. of N.Y.*, 2007 WL 4292039, at *4 (S.D.N.Y. Nov. 29, 2007) (holding that ERISA preempted plaintiff health care provider's state law claims after finding the plaintiff had standing to sue). This is because Plaintiffs' allegations for their CUTPA claim premised on violations of the NSA and the Connecticut Unfair Insurance Practices Act ("CUIPA"), would not derive from any ERISA-governed plan benefit.

However, if Plaintiffs do have derivative standing under ERISA to recover plan benefits to pay IDR awards (as Plaintiffs contend), their CUPTA claim is still not preempted. When determining whether ERISA preempts, the Second Circuit has instructed that courts "must start with the presumption that Congress does not intend to supplant state law." *Stevenson v. Bank of New York Co., Inc.*, 609 F.3d 56, 59 (2d Cir. 2010) (internal citations and quotations omitted). As the Supreme Court has explained, "not every state law that affects an ERISA plan" is preempted.

Rutledge v. Pharmaceutical Care Management Ass'n, 592 U.S. 80, 87 (2020). Instead, ERISA is “primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits.” *Id.* at 86. ERISA is especially unlikely to preempt a law where the “law merely affects costs.” *Id.* at 87. Further, a statute that is neutral and “applies equally” to non-ERISA plans counsels against preemption. *Id.* at 88.

Here, applying CUTPA to NSA violations is neutral towards ERISA plans as it applies equally to a broad spectrum of health plan types. As a court in this district previously ruled, CUTPA claims based on surprise billing laws that are generally applicable to many types of health plans are not preempted by ERISA. *See Nems PLLC v. Harvard Pilgrim Health Care of Connecticut Inc.*, 615 F. Supp. 3d 125, 142 (D. Conn. 2022) (finding no ERISA preemption of CUTPA claim premised on violation of Connecticut surprise billing law). Accordingly, Plaintiffs may assert CUTPA claims against Defendants for all health plan types insured or administered.

VII. Plaintiffs State a Claim Under CUTPA and CUIPA

Plaintiffs allege two different types of CUTPA violations. The first is that Defendants violated CUTPA through a scheme of “making low initial payments that force providers to file IDR proceedings to obtain a fair payment, not paying IDR awards within thirty days as required by federal law, not including interest on late payments when made, and not investing in the compliance programs, systems and personnel needed to assure timely payment of IDR awards.” SAC ¶ 42. The second CUTPA claim is for not timely paying IDR awards in violation of Conn. Gen. Stat. § 38a-816(6)(F) (the Connecticut Unfair Insurance Practices Act or “CUIPA”). Plaintiffs adequately state both claims and Defendants’ motions should be denied.

A. Plaintiffs’ Plead A CUTPA Claim Premised on Violation of the NSA

Defendants argue that “Plaintiffs rely on the same conduct to allege that Aetna engaged in unfair settlement practices (CUIPA) and unfair trade practices (CUTPA)” and that “[t]his,

Plaintiffs cannot do.” Doc. 127 at 28. To the extent Defendants are arguing that the same conduct cannot violate two statutory duties, they are clearly wrong. For example, the Connecticut Supreme Court has held that CUTPA claims may be premised on violations of federal statutes, even those without a private right of action. *See Centatiempo* 333 Conn. 769 at 792 .

If Defendants are arguing that Plaintiffs cannot sustain a CUTPA claim premised on anything other than the conduct covered by CUIPA, that is a matter currently pending before the Connecticut Supreme Court. *See NEMS, PLLC v. Harvard Pilgrim Healthcare of Connecticut, Inc.* (SC 20914). Accordingly, this Court should defer ruling on the merits of that argument as it did previously in *Murphy Medical Associates, LLC v. United Medical Resources, Inc.*, 2024 WL 1072731 (D. Conn. Mar. 12, 2024). Alternatively, it should rule that a CUTPA claim may be based on violations of the NSA for the same reasons the court in *NEMS* concluded that a CUTPA claim may be based on a violation of the state’s surprise billing law (before certifying the question to the Connecticut Supreme Court). *NEMS*, 615 F. Supp. 3d at 138 (holding that plaintiff may “maintain a CUTPA action, independent of CUIPA, where there is an alleged violation of a ‘statute regulating a specific type of insurance related conduct’”).

B. Plaintiffs State a Claim for Unfair Claim Settlement Practices Under CUIPA

Plaintiffs also state a proper claim for unfair claim settlement practices under CUIPA. As a threshold matter, Defendants’ argument that Plaintiffs’ allegations are “entirely conclusory” and “[m]erely recit[e] the statutory elements...” lacks merit. Doc. 127 at 30.

CUIPA prohibits insurers from not making good faith attempts to effectuate equitable settlements once liability is reasonably clear. *See* Conn. Genn. Stat. § 38a-816(6)(F); SAC ¶ 20-21 . Plaintiffs allege that Defendants violated this statute in three ways: 1) by making unreasonably low initial payments; 2) by not making good faith settlement attempts during the open negotiation period; and 3) by not paying the OON rate determined in IDR awards within 30 days as required

by federal law. *See* SAC ¶44. Plaintiffs further explain that Defendants’ initial payments continue to be “well below the amount ultimately awarded in IDR” and that “IDR entities on average have determined that the appropriate price for transports is **nearly 150% more** than what [Defendants] initially pay[s].” SAC ¶ 20-21 (emphasis in original). Plaintiffs’ also allege that this was purposeful in hopes that “providers will be too busy to file IDR proceedings or will miss one of the NSA’s strict deadlines.” SAC ¶ 21. Drawing all reasonable inferences in Plaintiffs favor, based on the number of unpaid IDR awards won by Plaintiffs at issue, *see* SAC at Exs. A and B, it is not difficult to surmise that Defendants’ low-balling tactics in the initial payment stage continued to the open negotiation period. This is more than a mere recitation of the elements.

Aside from arguing that Plaintiffs’ allegations are conclusory, Defendants posit that liability is not “reasonably clear” during the initial payment or open negotiation periods. In support they quotes a portion of a footnote from *Tucker v. American Intern. Group, Inc.*, 2015 WL 403195 (D. Conn. Jan. 28, 2015). There, the *Tucker* court noted that liability must be “substantially certain” to be “reasonably clear.” 2015 WL 403195, at *27 n.48. The court went on to state that “[l]ogically speaking, liability cannot be substantially certain where it plainly does not exist on the explicit...terms of the contract.” *Id.* The court also cited a *Bohn v. Vermont Mut. Ins.*, 922 F. Supp. 2d 138, (D. Mass. 2013) and noted that case interpreted a similar Massachusetts law. *Id.* The *Bohn* court held that “[l]iability is reasonably clear if a reasonable person with knowledge of the relevant facts and law, would probably have concluded that the insurer was liable to the plaintiff.” *Bohn* 922 F. Supp. 2d at 146-147.

Here, liability was reasonably clear from the day Plaintiffs sent Defendants their bills for each air ambulance transport. Defendants knew at that time that the transports were subject to the NSA, meaning the health plans covered in-network air ambulance transports and were therefore

required to cover OON transports too. There are no insurance coverage disputes that might make liability unclear, such as disputes in automobile accidents as to whose driver was at-fault and thus which insurance policy pays for repairs. Once liability is clear, insurers must then make good faith settlement efforts, such as making a reasonable settlement offer based on the value of the service provided. Accordingly, the only issue for trial on this claim will be whether each of Defendants' initial offers and open negotiation offers were good faith attempts to settle these liabilities.

Finally, Defendants do not contest that liability is reasonably clear for Plaintiff's "third category" of conduct (failure to timely pay IDR awards, *see* SAC ¶ 44). *See* Doc. 127 at 31-32. Rather, Defendants feign ignorance and rehash the various *factual excuses* as to why they did not timely pay awards that they listed previously. *Id.* at 31. Notably, Defendants appear to be able to participate in the IDR process (including submitting payment offers and position statements) without problem. It is only after they lose and payment becomes due that they claim to lose track of things. In other words, Defendants provide zero legal arguments that would support dismissal of a CUTPA claim for their continual (and as of the date of this brief, continuing) violations of federal law by not timely paying the OON rate that is unquestionably owed.¹⁴

CONCLUSION

For the reasons stated above, Plaintiffs respectfully request that Defendants' Motions be denied. If this Court grants them, Plaintiffs request the opportunity to amend to plead additional facts and/or theories of recovery.

¹⁴ Defendants argue in a footnote that Plaintiffs' as third-parties "cannot bring a direct claim for violations of CUIPA." Doc. 127 at 29 n. 24. This Court previously addressed this issue in *Murphy Medical* and found that the policy reasons underlying the Connecticut Appellate Court's ruling in *Carford v. Empire Fire & Marine Ins. Co.*, 94 Conn. App. 41, 891 A.2d 55 (2006) that a "private cause of action for CUIPA violations through CUTPA does not extend to third parties absent subrogation or judicial determination of the insured's liability" were not present. 2024 WL 1072731, at *5 (D. Conn. Mar. 12, 2024). This case is similar to *Murphy Medical* in that Plaintiffs have never filed claims against its patients, nor do they intend to do so, and Plaintiffs have valid assignments from them. *See* Ex. A. Plaintiffs agree with this Court's prior analysis, which is applicable here.

Dated: August 9, 2024

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Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I certify that on August 9, 2024, a true and correct copy of the foregoing was served electronically on all counsel of record.

/s/ Adam T. Schramek

Adam T. Schramek

**UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT
NEW HAVEN DIVISION**

**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.

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

JURY TRIAL DEMANDED

DECLARATION OF ANGELA L. RICHMOND

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

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

2. GMR, through its operating subsidiaries, provides air ambulance services across the country. Plaintiffs in this proceeding are some of those operating subsidiaries. GMR utilizes a uniform set of forms for patient transports. These forms include an assignment by a patient being transported to the company conducting the transport. Attached as Exhibit “A” is a true and correct

copy of the assignment used for transporting the patient at issue in IDR proceeding DISP-04099. This form has been used since at least January 1, 2022 to present. It is standard practice across companies to obtain this assignment and the patient's or legal representative's signature on the form.

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

Dated: August 8, 2024

A handwritten signature in black ink that reads "Angela Richmond". The signature is written in a cursive, flowing style.

Angela L. Richmond

EXHIBIT A

EMS Agency Name: AE028-Effingham

Patient Name: H [REDACTED], Betty

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

Patient Last Name: [REDACTED]
 Supplier Means: AE028-Effingham

Header
 Patient First Name: Betty
 Transport Date: 02/20/2022 19:16:00

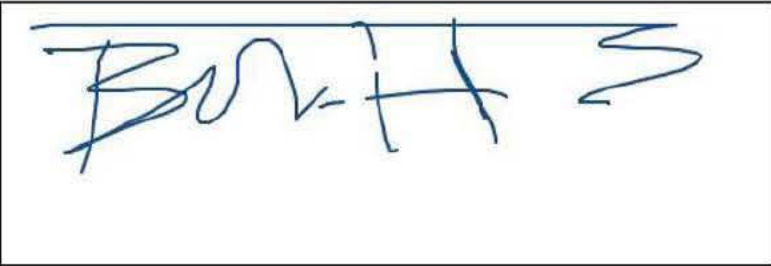
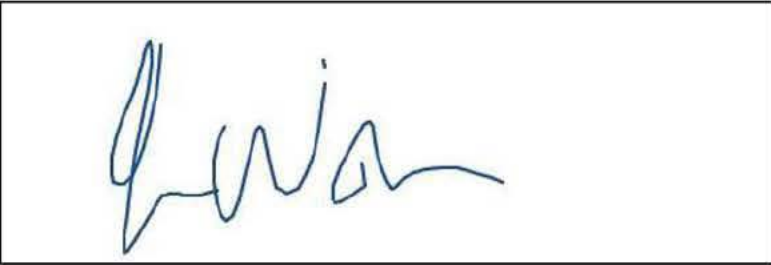
SECTION I

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

Authorization to Contact

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

SECTION I - PATIENT SIGNATURE

Question	Answer	Notes
PATIENT SIGNATURE	Patient must sign here unless physically or mentally incapable of signing. If patient signs with an "X" or other mark, it is recommended that someone sign below as a witness. 	
Witness Signature		
Witness Printed Name	Jess	
Witness Title	RN	

Unit Notified: 02/20/2022 18:33:49
 CAD #: 0122019817A

Patient Name: H [REDACTED], Betty

Date Printed: 02/20/2022 21:32
 Call #: 0122019817A

General Information

Case Name	Guardian Flight LLC et al v. AETNA Life Insurance Company Inc et al
Court	U.S. District Court for the District of Connecticut
Date Filed	Thu Apr 11 00:00:00 EDT 2024
Judge(s)	Michael P. Shea
Federal Nature of Suit	Statutes: Other Statutory Actions [890]
Docket Number	3:24-cv-00680
Parties	AETNA Life Insurance Company Inc; Global Medical Response, Inc.; REACH Air Medical Services, LLC; CVS Pharmacy, Inc.; Cigna Health and Life Insurance Co.; Reach Air Medical Services LLC; Aetna Health Inc; Aetna Health and Life Insurance Company; CVS Health Corporation; Calstar Air Medical Services, LLC; Med-Trans Corporation; Air Evac EMS, Inc.; Guardian Flight LLC; AirMed International, LLC