

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT**

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

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-680
(MPS)(SDV)

CIGNA’S REPLY IN FURTHER SUPPORT OF ITS MOTION TO DISMISS

Defendant CIGNA Health and Life Insurance Company (“Cigna”) through undersigned counsel, files this Reply in Further Support of its Motion to Dismiss Plaintiffs’ Second Amended Complaint and Memorandum in Support (Dkt. No’s. 123 and 124), and further state as follows:

As an initial matter, Cigna notes that Plaintiffs’ Joint Opposition to Defendants’ Motions to Dismiss Plaintiffs’ Second Amended Complaint (Doc. 131, hereinafter, “Plaintiffs’ Response”) devotes considerable space to matters well outside the four corners of the Second Amended Complaint (“2AC”), including: a recitation of facts contained nowhere in the Complaint about the identities, demographic characteristics, injuries, and other circumstances surrounding certain of the transports that the Complaint sets forth as nothing more than dispute numbers. Dkt. No. 131, p. 2. For example, Plaintiff’s Response opens with a description of a handful of transported patients as “a young boy”, “a woman pregnant with twins,” and “a newborn baby”. *Id.*, at p. 2. Plaintiffs go on to state that “Defendants seek to demonize Plaintiffs” while it is “literally raining profits at big

insurers like [Defendants].”¹ To paraphrase a mantra repeated often by Plaintiffs themselves, As Plaintiffs themselves have argued, this Court should disregard Plaintiffs’ many (unpleaded) “factual allegations masquerading as legal argument.” *Id.*, p. 5.

After further extraneous factual assertions not directed to this Defendant, Plaintiffs Response presents Plaintiffs’ own spin on the history of the No Surprises Act beginning on page 7. They start by positing that the NSA created a “coverage mandate” requiring health plan providers such as Defendants to cover emergency services provided by out-of-network (“OON”) healthcare providers where in-network services are covered. *Id.*, p. 7. However, all health plans are and have long been required to cover emergency services that a patient receives out-of-network and to apply in-network cost-sharing to those services. See 42 U.S.C. § 18022 (defining “Essential health benefits” which must be provided by any Qualified Health Plan as “emergency services”).

Plaintiffs also seek to cast the NSA in terms of a measure Congress took primarily for the benefit of the air ambulance companies and other OON providers of emergency services. However, the NSA’s primary thrust was to make illegal the formerly common practice of out-of-network hospitals, doctors, and *air ambulance providers* like the Plaintiffs, of billing the patient **far** more than the in-network cost sharing amount for out-of-network emergency services. Congress intended it to protect patients from these providers’ “surprise bills.” 42 U.S.C. § 300gg-135; see H. Rpt. 116-615, at 47 (2020). It did this by providing a direct mechanism for health plans to pay providers directly for OON services and prohibiting the OON providers’ well-documented practice of pursuing the patients for the difference between their billed charges and the plans’

¹ Plaintiffs attempt to support this assertion with two hyperlinked articles: <https://www.beckerspayer.com/payer/big-payers-ranked-by-2023-profit-beckers.html> and <https://www.fiercehealthcare.com/payers/unitedhealth-ceo-andrew-witty-was-2023s-highestpaid-payer-ceo-heres-what-his-peers-earned>. However, these links did not access articles when selected by the undersigned.

reimbursement rates. *Id.* This removed the patients from the middle of amount-of-payment disputes, where the intense financial pressures these surprise bills exerted on the patients created leverage on the plans as well to increase their reimbursement payments to spare their members from collection efforts by the providers. The impetus for the NSA was *not*, as Plaintiffs argue, to create new rights and remedies for the surprise-billing providers themselves. *Id.* Plaintiffs contend however, that such is precisely the NSA's focus².

I. The NSA Gives Plaintiffs No Private Right of Action

Plaintiffs argue that their newfound right to a direct payment specified in the NSA carried with it the implied remedy of enforcement actions in Federal court despite the absence of any such remedy in the NSA itself. In response, Defendants have pointed to the ever-growing body of US District Court decisions declining to find even an implied right of action that the OON providers can assert under the NSA. *See Guardian Flight, LLC v. Health Care Serv. Corp.*, 3:23-CV-01861-B, 2024 WL 2786913 (N.D. Tex. May 30, 2024); *FHMC LLC v. Blue Cross & Blue Shield of Ariz. Inc.*, No. CV-23-00876-PHX-GMS, 2024 U.S. Dist. LEXIS 62018, at *8-9 (D. Ariz. Apr. 3, 2024); and *Los Robles Emergency Physicians Med. Grp. v. Stanford-Franz*, No. 2:23-cv-9487-DSF-MARx, 2024 U.S. Dist. LEXIS 23971, at *4-5 (C.D. Cal. Feb. 8, 2024). Plaintiffs' response amounts to: *FHMC* and *Los Robles* are distinguishable, and *Guardian Flight* is plain wrong. For the reasons that follow, Plaintiffs' arguments miss the mark.

² While Plaintiffs downplay the issues payors face in navigating the glut of IDR appeals (which providers have filed in an amount estimated to be fourteen times the volume projected by Congress, *see* 88 Fed. Reg. 75,744, 75,753 (Nov. 3, 2023)), Plaintiffs also take no ownership over their role and that of air ambulance companies in general in creating these problems. In 2023, Plaintiffs' parent corporation Global Medical Response was responsible for initiating roughly half the air ambulance IDR proceedings filed that year. *See* Ctrs. for Medicare & Medicaid Servs., Federal IDR Supplemental Tables for 2023 Q1 through Q4, tbls. 10 (Feb. 15 and June 13, 2024), <https://tinyurl.com/49x3j7p9> ("2023 Tables").

First, Plaintiffs claim this Court should disregard *Guardian Flight* and instead follow *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). However, no court since then has followed *GPS of New Jersey*. It does not apply to the instant dispute because unlike here, both plaintiff and defendant there assumed that portions of the Federal Arbitration Act not mentioned - let alone expressly incorporated - in the NSA applied to the dispute. The provider who sought to vacate an award in favor of the payor invoked Section 10 of the Federal Arbitration Act (“FAA”) to vacate the award. The payor who had prevailed in the IDR process invoked FAA Section 9 to confirm the award. Neither side argued what every court to take up this issue since then has held: that the only portion of the Federal Arbitration Act incorporated into the NSA was Section 10, which only provides the narrow standards and exceptional circumstances under which an IDR determination may be vacated. *See Med-Trans Corp. v. Capital Health Plan, Inc.*, No. 3:22-cv-1153-TJC-JBT, 2023 U.S. Dist. LEXIS 195736, at *14-15 (M.D. Fla. Nov. 1, 2023). The reasoned opinion of the court in *Med-Trans* specifically addressed why *GPS of New Jersey* did not apply:

In *GPS of New Jersey M.D.*, the parties assumed that 9 U.S.C. § 9 applied to IDR awards, and the court’s analysis focused on § 10(a)(3) and (4)—two of the four explicitly incorporated paragraphs. That court simply had no need to grapple with the broader applicability of the FAA to the NSA.

...

Interpretation of statutes is guided by the text. Neither the NSA nor the FAA says that the FAA bears on the NSA outside the four explicitly incorporated paragraphs. The Court will not assume otherwise.

Med-Trans Corp. v. Cap. Health Plan, Inc., 2023 U.S. Dist. LEXIS 195736, 14 (internal citations omitted). Plaintiffs next attempt to distinguish two cases, also subsequent to *GPS of New Jersey*, which hold similarly. Plaintiffs argue that *FHMC LLC V. Blue Cross and Blue Shield of Az.* Case No. 2:23-cv-876 (D.C. Az. April 4, 2024) is distinguishable from the instant case. Plaintiffs claim that because the provider in that case conceded that it had the IDR process available to it, and also,

to paraphrase the Plaintiffs' Response, "conceded that it did not avail itself of that process", the Court held that *under those circumstances*, the provider had no private right of action. Dkt. 31, p. 21. However, the opinion does not rely for its holding on a concession by the provider that it had not made use of the IDR process³. The "circumstances" the Court referred to were: (1) the option to "initiate IDR for all their unpaid or underpaid claims, 42 U.S.C. § 300gg-111(c)(1)(B)", (2) the option to "notify the Centers for Medicare & Medicaid Services ("CMS") about its issues with the IDR process", and (3) to "report [the health plan in that case] to CMS for their violations of the NSA," including [health plan's] alleged failure to comply with the adjudicatory time limits specified in the statute. (Doc. 29 at 8). Those three circumstances are also present in this case: 1) Plaintiffs had the option to initiate IDR; 2) Plaintiffs had the option to notify CMS of alleged violations; and 3) Plaintiffs had the option to report Defendants for alleged violations. The relevant circumstances are the same as those in *FHMC*. No private right of action under the NSA existed there, and none exists here.

Plaintiffs also argue the Court should disregard *Los Robles Emergency Physicians* because that case involved a *pro se* Plaintiff who sued a healthcare provider alleging it had violated the NSA's balance billing protections. Plaintiffs argue in conclusory fashion that the case has no application because it does not involve a provider suing to enforce an IDR determination. But a distinction between patient and provider was not dispositive in *Los Robles Emergency Physicians*. Instead, the court there examined the *Cort* factors for determining whether a statute evidences Congressional intent to imply a private right of action. *Cort v. Ash*, 422 U.S. 66, 95 S. Ct. 2080 (1975). The court in *Los Robles Emergency Physicians* noted the presence of an extensive dispute

³ It appears from the pleadings that the provider in *FHMC* alleged it was somehow excused from initiating an unspecified number of IDR arbitrations. See Case. No. 2:23-cv-876, Dkt. No. 1.

resolution process between insurers and medical providers and the extremely limited judicial review available to them. When it concluded that “[t]hese provisions indicate the intent of Congress not to provide *any* private right of action under § 9816 *using typical litigation in federal courts*,” it gave no indication that it would have reached a different result had the Plaintiff been a provider looking to enforce an IDR award. *Id.* at *5. Any persuasive effect that *GPS of New Jersey*, decided in September 2023, might have had is drowned out by a growing chorus of subsequent decisions that the NSA offers no private right of action to anyone, save for the narrow grounds for vacatur not at issue in this case.

Plaintiffs further argue that *Cheminova A/S v. Griffin LLC* (182 F. Supp. 2d 68 (D.D.C. 2002)) compels the result they seek. It does not. These same Plaintiffs, through this same counsel, made this same argument in *Guardian Flight v. Health Care Serv. Corp.*, and the court there was unpersuaded. Importantly, the Federal Insecticide, Fungicide, and Rodenticide Act (“FIFRA”) at issue in *Cheminova* involves a statutory wrinkle not found in the NSA. Arbitrations to determine fees for using a prior insecticide registration under FIFRA proceed under the rules of the Federal Mediation and Conciliation Service (“FMCS”) established in 7 U.S.C. § 136a(c)(1)(F)(iii). Those rules expressly provide that the parties “‘shall be deemed to have consented that judgment upon the arbitration award may be entered’ in federal or state court.” *Cheminova*, 182 F. Supp. 2d 68, 72-73 (citations omitted). Plaintiffs have cited no analogous provision in the NSA or in any of the regulations implementing it, and indeed there is none.

Moreover, unlike *Cheminova* and *GPS of New Jersey*, Plaintiffs are very specifically *not* asking this Court to confirm arbitration awards; rather, they purport to bring a private cause of action under the NSA’s “Timing of Payment” provision and seek damages, attorney’s fees, pre-

and post-judgment interest, and costs. Thus, *Cheminova* and *GPS*, both of which employ the device of *confirming* an arbitration award, are inapposite.

Plaintiffs further urge that the Court should apply the principles of the Administrative Dispute Resolution Act (“ADRA”), which “allows regulatory agencies to use a dispute resolution proceeding for the resolution of an issue in controversy so long as the parties agree to it.” They argue that the IDR process fits the definition of “dispute resolution proceeding” under ADRA, and that such a final award in a dispute resolution proceeding “may be enforced pursuant to sections 9 through 13 of title 9.” Dkt. 131, at p. 13 (citing 5 U.S.C. § 580(c)). Accordingly, Plaintiffs argue, the ADRA’s provisions allowing District Courts to apply FAA confirmation and enforcement procedures should extend to IDR determinations, which it contends without support are “administrative programs”. This again rejects the clear prevailing opinion in interpreting the NSA; if Congress had intended to make IDR determinations enforceable like FAA arbitration awards, it would have said so in the NSA itself. The fact that the ADRA specifically adopts FAA sections other than Section 10 (including section 9, which expressly provides for the judicial enforcement of arbitration awards) when the NSA does not, actually supports Defendants’ argument, not that of Plaintiffs.

Next, Plaintiffs lean hard on two specific phrases in the NSA as proof of congressional intent to supply a private right of action: language that a health plan “shall pay” an IDR award within 30 days and that an IDR determination “shall be binding on the parties.” Dkt. No. 131, at p. 13. However, neither phrase constitutes such magic words as Plaintiffs insist.

Language directing that a health plan “shall pay” a provider under Federal law has been repeatedly held not to “support the existence of an implied cause of action. Indeed, the “Timing of Payment” provision in the NSA that Plaintiffs claim grants them a private right of action is similar

to a payment provision in the Coronavirus Aid, Relief, and Economic Security (“CARES”) Act, 116 P.L. 136. District courts have almost universally found did not create a private cause of action for health care providers. Specifically, the CARES Act provided that during the COVID-19 public health emergency, health plans that do not have a negotiated rate with a diagnostic testing provider “shall reimburse the provider in an amount that equals the cash price for such services as listed by the provider on a public internet website . . .” CARES Act, § 3202(a)(2); compare with 42 U.S.C. § 300gg-112(b)(6) (health plan payments for IDR awards “shall be made directly to the non-participating provider not later than 30 days after the date on which such determination is made”). Nearly all courts that examined the CARES Act payment provision have found that it did not create a private cause of action for health care providers. *See, e.g., Genesis Lab. Mgmt. LLC v. United Health Grp., Inc.*, No. 21-cv-12057, 2023 U.S. Dist. LEXIS 38156, at *9 (D.N.J. Mar. 6, 2023) (“[E]ven if Congress intended to create a personal right of reimbursement for providers, like [p]laintiff, through the FFCRA and the CARES Act, there is nothing in the text or structure of those acts suggesting that Congress intended to afford a privately enforceable remedy to Plaintiff.”); *Saloojas Inc. v. Blue Shield of Cal. Life & Health Ins. Co.*, No. 22-cv-03267-MMC, 2022 U.S. Dist. LEXIS 180717, at *2 (N.D. Cal. Oct. 3, 2022) (“the overwhelming majority of district courts to have addressed the issue found that § 3202 of the CARES Act does not create a private right of action”) (collecting cases); *GS Labs, Inc. v. Medica Ins. Co.*, No. 21-cv-2400, 2022 U.S. Dist. LEXIS 169307, at *27-28 (D. Minn. Sept. 20, 2022) (noting that “[t]he Court is mindful of the Supreme Court’s disfavor of implied rights of action” in finding no implied cause of action under § 3202); *Murphy Med. Assocs., LLC v. Cigna Health & Life Ins. Co.*, No. 3:20-cv-1675 (JBA), 2022 U.S. Dist. LEXIS 43351, at *13-14 (D. Conn. Mar. 11, 2022) (acknowledging the plaintiff’s argument that it will be “left remediless without a private right of action” “may provide

a good policy reason to create a private right of action, [but] it does not provide an indication that Congress intended to create such a right.”)

Additionally, District Courts have refused to find that the “final and binding” language standing alone, without conduct from which an agreement could be inferred, is sufficient to create an implied right to judicially enforce arbitration awards. *See e.g., Higgins v. U.S. Postal Service*, 655 F. Supp. 739, 744 (D. Maine 1987). These two phrases are not magic words which unlock the courthouse doors to Plaintiffs.

II. Plaintiffs Can Plead No ERISA Violation

Plaintiffs’ allegations that the conduct alleged violates ERISA fail because Plaintiffs lack the Article III standing necessary for such a claim. Plaintiffs, who have a direct right of payment under the IDR process, cannot derive standing from assignments of benefits. *Guardian Flight, LLC v. Health Care Serv. Corp.*, 3:23-CV-01861-B, 2024 WL 2786913. This is because the beneficiaries from whom they have obtained those assignments have no stake in an IDR determination, and therefore no concrete injury from an alleged violation of same. Plaintiffs attempt to escape this conclusion in a couple of ways, but neither succeed.

First, Plaintiffs claim that because the NSA amended ERISA (and multiple other statutes), “the civil enforcement provisions of ERISA now apply to the NSA”. But the reason the NSA was incorporated into an amendment to ERISA (and to the Internal Revenue Code, and to the Public Health Service Act) was to ensure members of all group health plans, whether issued by private employers, by non-federal government plans, or to federal employees, were all equally protected from surprise billing, not to create a cause of action for providers under ERISA. Again, Plaintiffs seek to stretch the framework designed to protect patients from surprise medical bills in order to try and fashion themselves a remedy where Congress has set forth none, aside from the agency

enforcement actions they are free to seek from CMS and the other Departments responsible for NSA oversight.

Plaintiffs appear to fundamentally misunderstand the available remedies under ERISA, 29 U.S.C. § 1132(a) *et seq.* Plaintiffs cite two subsections of section 1132(a) and appear to use them interchangeably. Section 1132(a)(1)(B) belongs to a beneficiary to sue “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan”. An 1132(a)(1)(B) claim, however, is to establish that a beneficiary is entitled to a benefit. It is a coverage question. Even if the Plaintiffs possessed valid assignments of benefits from beneficiaries, and even if those assignments of benefits conferred standing on Plaintiffs (which they do not, because the beneficiaries themselves have no injury, and therefore no standing, from an alleged failure to promptly pay an IDR award), the claim a provider could bring under Section 1132(a)(1)(B) claim would not be necessary or appropriate to enforce an IDR award. In a case involving an allegedly late paid or underpaid IDR award, the health plan has already provided the beneficiary its benefit (after all, IDR awards only arise when there has already been a determination that coverage exists). A Section 1132(a)(1)(B) claim, even if it were allowed, would be moot, as there is already a benefit provided, albeit in a lesser amount than Plaintiffs contend it should have been provided. As Plaintiffs are quick to point out in other contexts, fundamental differences exist between “right to payment” cases - whether there *is* coverage - and “amount-of-pay” cases – in what *amount* is the indemnity payment - when it comes to determining whether ERISA applies. See *Montefiore Med. Ctr. v. Teamsters Local* 272, 642 F.3d 321, 331 (2d Cir. 2011).

To this end, Montefiore emphasizes a common distinction in the case law between claims involving the "right to payment" and claims involving the "amount of payment"—that is, on the one hand, claims that implicate coverage and benefits established by the terms of the ERISA benefit plan, and, on the other hand, claims regarding the computation of contract payments or the correct execution of such payments. The former are said to

constitute claims for benefits that can be brought pursuant to § 502(a)(1)(B), while the latter are typically construed as independent contractual obligations between the provider and the PPO or the benefit plan.

Id. Thus, to the extent ERISA would apply to NSA claims at all, a right to sue for benefits under 502(a)(1)(B) would only exist if there had been a denial of coverage (a “right to payment” claim), not an initial payment that was later determined to be an insufficient amount (an “amount of payment” claim). *Id.* See also *Whole Life Recovery LLC v. Aetna Life Ins. Co.*, 2017 U.S. Dist. LEXIS 13917 (E.D.N.Y. Jan 28 , 2017).

Defendants have not *denied* benefits or coverage to any patient in any of these claims; the existence of an IDR award is only possible once there has been an initial payment by the health plan. The patient’s concrete interest in the benefit of receiving covered services from OON providers is satisfied. So even a valid assignment of benefits under ERISA can do no more than outfit these providers with a claim that coverage exists in the first place, which was already conceded when the health plan paid the initial amount for the air transport. It is not with any denial of coverage that Plaintiffs take issue, it is simply the reimbursement rate. Thus, Plaintiffs have no 1132(a)(1)(B) claim.

Plaintiffs also contend they have an ERISA remedy under Section 29 U.S.C. 1132(a)(3), but that subsection also does not support Plaintiffs’ position. Plaintiffs claim that the same assignments of benefits they offer to support their claims for benefits under § 1132(a)(1)(B) also give them the right to enforce ERISA’s requirements generally, as opposed to a right to obtain a specific benefit. Plaintiffs contend the NSA’s timely payment provisions have been grafted onto ERISA and they are suing to enforce those under § 1132(a)(3). However, § 1132(a)(3) allows a participant, beneficiary, or fiduciary to bring a civil action for appropriate relief “under this subchapter.” The types of relief typically available under this provision are equitable in nature, such as injunctions, restitution, or other forms of relief designed to address or rectify the breach or

violation. What § 1132(a)(3) does *not* allow is a suit for money, whether consisting of compensatory or punitive damages. As the Second Circuit has held, “[c]lassic compensatory and punitive damages are never included within ‘other appropriate equitable relief.’” *Gerosa v. Savasta & Co.*, 329 F.3d 317, 321 (2d Cir. 2003). Yet that is exactly what Plaintiffs here seek, through interest, penalties, attorneys’ fees, and costs, among other things. To the extent the 2AC includes a throwaway reference to “equitable remedies,” such as asking this Court to require Defendants to “file quarterly reports with the Court certifying compliance” (Dkt. 131, p. 12), the 2AC remains at bottom a classic underpayment claim and cannot be dressed in equitable clothing in an attempt to seek relief under § 502(a)(3). *LI Neuroscience Specialists v. Blue Cross Blue Shield of Fla.*, 361 F. Supp. 3d 348, 357 (E.D.N.Y. 2019). *See also MBody Minimally Invasive Surgery, P.C. v. Empire HealthChoice HMO, Inc.*, No. 13-CV-6551 TPG, 2014 U.S. Dist. LEXIS 114012, 2014 WL 4058321, at *5 (S.D.N.Y. Aug. 15, 2014) (dismissing § 502(a)(3) claim because “[a]t base, plaintiffs seek damages for alleged underpayment or denial of payment”).

III. Plaintiffs’ CUTPA Theories Fail

Turning to Plaintiffs’ claims under the Connecticut Unfair Trade Practices Act (“CUTPA”), Plaintiffs cannot state a cause of action. This is because: 1) an alleged violation of a surprise billing law cannot serve as the basis for a CUTPA claim; 2) Plaintiffs’ attempt to fashion a CUTPA claim by incorporating the “unfair settlement practices” prohibition in CUIPA would lead to an absurd result when applied to the facts of this or any case related to the NSA, and 3) to the extent ERISA could ever apply to this case, obstacle preemption precludes a claim based upon CUTPA.

Plaintiffs argue that a CUTPA claim can be premised on the alleged violations of the NSA it asserts. In the Motions to Dismiss, Defendants contended that only the enumerated conduct set forth in CUIPA could sustain a CUTPA claim. Plaintiffs countered with authority that other

statutes relating to the regulation of insurance could form the basis of a CUTPA claim and that this precise argument was at the time a certified question pending before the Connecticut Supreme Court. The Connecticut Supreme Court has now resoundingly answered that a surprise billing law (Connecticut's state statute that is similar to the NSA) cannot form the basis for a CUTPA claim. *Nems, PLLC v. Harvard Pilgrim Health Care of Conn., Inc.*, No. 20914, 2024 Conn. LEXIS 193, at *19 (Aug. 21, 2024).

Specifically, the Connecticut Supreme Court found that an alleged violation of Connecticut's own surprise billing law, while codified within Chapter 38a of the General Statutes but not contained within the enumerated practices designated as "unfair" and in violation of CUIPA within Section 38a-816, cannot form the basis of a CUTPA violation. *Id.* The Connecticut Supreme Court gave two reasons for this: first, the surprise billing law did not mention CUTPA, let alone state that a surprise billing violation would be actionable under CUTPA. *Id.* Other laws, passed before the surprise billing law, did specify CUTPA as a remedy for their violation. *Id.* The Connecticut Supreme Court therefore concluded that had the legislature intended CUIPA to address violations of surprise billing laws, it could have and would have drafted the statute to say so. *Id.*

Second, the *Nems* court reasoned, if there is a statute regulating a specific type of insurance related conduct outside the enumerated acts in CUIPA, such a statute would have to be "violations of the criminal law ... sufficiently egregious as to qualify as unfair trade practices[.]" *Id.* at *20. The Court went on, Connecticut's surprise billing law was not that sort of law. *Id.* Applying this reasoning here, it is inconceivable that the NSA's timing of payment provision (or any provision of the NSA) could be deemed to rise to this level. Like the NSA, Connecticut's Surprise Billing Law was enacted to "shield patients from being saddled with surprisingly high medical bills when

they receive emergency medical treatment.” *Id.*, at * 4. Like the NSA, the Connecticut law sets up a structure for resolving disputes over what amount should be paid for OON emergency services that seeks to fix a reasonable amount to be paid for the services. *Id.* It is self-evident that an alleged failure to comply with the NSA would not rise to the level of “violations of the criminal law,” such as outright fraud, which would be “sufficiently egregious as to qualify as unfair trade practices[.]” just as a violation of the Connecticut surprise billing statute would not exceed such a threshold. *Id.*, at *19-20. Thus, Plaintiffs’ Complaint does indeed fail to state a CUTPA claim premised on an NSA violation.

Plaintiffs also claim another path to a CUTPA claim exists, however. They claim that in allegedly failing to timely pay IDR determination awards, Defendants violate Section 38a-816(6)(F), prohibiting insurers from “not making good faith attempts to effectuate equitable settlements once liability is reasonably clear.” Concerning the IDR awards at issue, Plaintiffs claim that “liability was reasonably clear from the day Plaintiffs sent Defendants their bills for each ambulance transport.” Dkt. No. 131, at p. 39. They go on to state that “there are no insurance coverage disputes that might make liability unclear[.]” and that the obligation to make good faith attempts to settle such claims arises with the initial payment. *Id.*, p. 40. This cannot be the law, as it would lead to an absurd result – every claim which went into the IDR process after a health care plan received a bill from a provider would give rise to an alleged violation of this provision of CUIPA, because every IDR determination would only exist because of a failure to settle the claim at any of the earlier steps in the process. It is also worth noting that the IDR process itself is designed to incentivize good faith settlement offers, as the baseball-style structure rewards reasonableness in the offers submitted and the IDR entity’s greater likelihood to select an offer

made in good faith over an offer lacking in the same can be viewed as a self-executing safeguard against any such alleged bad faith.

Concerning ERISA preemption, Cigna has already adopted, as if set forth in its papers, the Aetna Defendants' arguments concerning the preemptive force of ERISA and other Federal statutes. Cigna incorporates by reference Aetna's reply brief concerning same, and notes in addition that courts routinely find that ERISA preempts CUTPA and CUIPA claims. *See MCI Healthcare, Inc. v. United Health Grp., Inc.*, No. 3:17-CV-01909 (KAD), 2019 U.S. Dist. LEXIS 117981, at *9 (D. Conn. July 16, 2019)(collecting cases).

WHEREFORE Defendant, CIGNA Health and Life Insurance Company, requests this Honorable Court dismiss Plaintiffs' Second Amended Complaint entirely and with prejudice.

Respectfully submitted,

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Dated: September 6, 2024

CERTIFICATE OF SERVICE

I, Ruel W. Smith, hereby certify that the documents filed through the ECF system will be sent electronically to all participants receiving electronic service.

/s/ Ruel W. Smith

Ruel W. Smith