

**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

**PLAINTIFFS’ MOTION TO DISMISS
DEFENDANT AETNA’S AMENDED COUNTERCLAIMS**

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 Motion to Dismiss Aetna’s Amended Counterclaims (Doc. 291) (“Motion”) and would respectfully show the Court as follows:

INTRODUCTION

To characterize Aetna’s Amended Counterclaims (“Counterclaims”) as grasping at straws would be an understatement. In an attempt to create fraud without facts, Aetna challenges the Independent Dispute Resolution (“IDR”) program itself. Don’t like the way the Departments explicitly permit (and previously required) line-item payment disputes? Claim state law somehow prohibits it. Don’t like that eligibility for the federal IDR program is a complex determination in which the Departments require Aetna to participate? Say state law makes Plaintiffs pay for it. Don’t like the fact that an attestation says it is “to the best of my knowledge” within a narrow subject matter? Pretend it says something else. Don’t like the fact the witness explained that

different in-network percentages apply to different calculations? Quote the deposition transcript selectively.

In reality, Aetna's trumped up Counterclaim is part of its No Surprises Act ("NSA") litigation playbook. As another provider group recently explained to another federal court:

Aetna's ambitious goal is to avoid paying many thousands of independent NSA arbitration awards and deny [providers] from future access to the NSA remedies. The why of Aetna's strategy is revealed when the Court learns the context. Aetna repeatedly fails as a party before the NSA's Independent Dispute Resolution Entities ("IDREs"), which adjudicate out-of-network disputes: Aetna lost 98% of the time. This lawsuit is part of Aetna's long game to beat the system, while still booking record profits, cheating self-funded plans by making unduly low payments to out-of-network providers, then pushing all its NSA losses to those same self-funded customers after pocketing the phantom shared savings, all while denying patients and hospitals with access to [medical] services.

See Aetna Health Inc. et al. v. Radiology Partners, Inc., Case No. 3:24-cv-01343 (M.D. Fl.) at Doc. 27 at p. 2.

To begin, Aetna's counterclaims for violation of CUTPA, fraudulent misrepresentation, and money had and received must all be dismissed because they are preempted by the NSA and the Airline Deregulation Act ("ADA"). The NSA provides the only path to challenge the award *or* the process that resulted in it—means not employed by Aetna here. Separately, CUTPA does not even apply to Plaintiffs because, among other reasons, unlike Aetna, Plaintiffs are not Connecticut citizens. Last—even if the Court were to consider the factual allegations, they fall short of federal court pleading requirements.

This lawsuit concerns Aetna's continued failure to timely pay IDR awards in violation of state and federal law. As much as Aetna would like to distract from that fact, its second attempt at a counterclaim fares no better than its first.

LEGAL STANDARD

To survive dismissal under FED. R. CIV. P. 12(b)(6), a plaintiff must plead sufficient factual allegations "to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550

U.S. 544, 570 (2007). A claim is facially plausible “when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). The Court must “accept all well-pleaded factual allegations in the complaint as true,” *Lynch v. City of New York*, 952 F.3d 67, 74–75 (2d Cir. 2020) (internal quotations omitted), but may “disregard legal conclusions.” *Red Fort Capital, Inc v. Guardhouse Productions LLC*, 397 F. Supp. 3d 456, 465 (S.D.N.Y. 2019). Under this standard, a pleading that “offers ‘labels and conclusions’ or ‘a formulaic recitation of the elements of a cause of action will not do.’” *Ashcroft v. Iqbal*, 556 U.S. at 678 (2009) (quoting *Twombly*, 550 U.S. at 555). “Nor does a complaint suffice if it tenders ‘naked assertion[s]’ devoid of ‘further factual enhancement.’” *Id.* While a court “must ‘accept all allegations in the complaint as true and draw all inferences in the non-moving party’s favor,’” *U.S. ex rel. Siegel v. Roche Diagnostics Corp.*, 988 F. Supp. 2d 341, 343 (E.D.N.Y. 2013), “threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice,” and must be dismissed. *Chavis v. Chappius*, 618 F.3d 162, 170 (2d Cir. 2010).

ARGUMENTS & AUTHORITIES

I. Federal law preempts Aetna’s claims.

The NSA created a dispute resolution process for payment disputes between insurers and out-of-network providers of emergency services like Plaintiffs. The NSA required the Departments of Health and Human Services, Labor, and Treasury (collectively the “Departments”) to “establish by regulation one independent dispute resolution process” that would resolve payment disputes between insurers and out-of-network providers of emergency services. 42 U.S.C. § 300gg-112(b)(2)(A).

The Departments have issued numerous rules and regulations on the IDR process, including how payment disputes are submitted. *See, e.g.*, “Requirements Related to Surprise

Billing, Part II,” 45 CFR Parts 147 and 149 (86 Fed. Reg. 55,980)¹; “Requirements Related to Surprise Billing: Final Rules,” 45 CFR Part 149 (87 Fed. Reg. 52,618); “Federal Independent Dispute Resolution Process Administrative Fee and Certified IDR Entity Fee Ranges,” 45 CFR Part 149 (88 Fed. Reg. 88,494).²

Aetna asserts three state law causes of action in its counterclaim: violation of CUTPA, fraudulent inducement, and money had and received. All three causes of action are based on the same factual allegations that Plaintiffs have:

- Continued to file line-item payment disputes in IDR after it was no longer required by the Departments but instead was a permissible practice;
- Signed attestations that, to “the best of [their] knowledge,” emergency air ambulance services were “within the scope of the Federal IDR process”;
- Filed some disputes on claims that were later determined ineligible for the federal IDR process;
- Told IDR entities that its pilots averaged over 5,000 hours even though it would hire new pilots with less experience;
- Told IDR entities that its fleet was state of the art; and
- Told IDR entities that it was in-network with 70% of commercial payors, a number that included all business billed under commercial health as opposed to counting only IDR-eligible transports.

Both the NSA and the ADA preempt Aetna’s Counterclaims, which concern conduct during the IDR process. “A fundamental principle of the Constitution is that Congress has the power to preempt state law.” *Crosby v. National Foreign Trade Council*, 530 U.S. 363, 372

¹ Identical regulations were issued by each of the three Departments. For purposes of this brief, only citations to the regulations issued by Health and Human Services are cited.

² These various rules and regulations are available in the No Surprises Act section of the Centers for Medicare and Medicaid Services website, available at <https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets>.

(2000). Pursuant to the Supremacy Clause, state law that conflicts with federal law has no effect. *Marentette v. Abbott Labs., Inc.*, 886 F.3d 112, 117 (2d Cir. 2018) (affirming district court's grant of motion to dismiss based on conflict preemption). Aetna's Counterclaims attempt to wield state law in a manner that conflicts with the express purpose of the NSA and the ADA, including that the Departments would create and decide the rules for IDR proceedings and police the process. Because of this, Aetna's counterclaims should be dismissed.

A. The NSA preempts state law challenges to IDR awards or the process that resulted in them.

The NSA preempts Aetna's Counterclaims premised on the validity of awards or conduct during the IDR process itself because the NSA provides the exclusive grounds for judicial review of IDR awards and the process that leads to them.

1. The NSA governs judicial review of IDR awards and proceedings.

Aetna's state-law claims for fraudulent misrepresentation, violation of CUTPA, money had and received, and declaratory and injunctive relief should be dismissed because the NSA solely governs any challenge to IDR awards or the process that led to them. The NSA provides that IDR awards are "binding" and further provides that they "*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" of the Federal Arbitration Act ("FAA"). 42 U.S.C. § 300gg-11(c)(5)(E)(i)(II) (emphasis added). Aetna does not mention the NSA's standards anywhere in its Counterclaims.

Just as the FAA preempts state-law claims seeking to challenge arbitration awards or the process that led to them, the NSA preempts state law claims seeking to challenge or vacate IDR awards or the process that led to them. As the Second Circuit has explained:

[The] district court correctly concluded that the plaintiff's claims are barred by the Federal Arbitration Act...which ordinarily provides the *exclusive remedy* for parties seeking to challenge an arbitral award *or the process that led to that award.*"

Ibarzabal v. Morgan Stanley DW, Inc., 333 F. App'x 605, 606 (2d Cir. 2009) (emphasis added). In other words, a party cannot challenge an arbitration award or the process that led to it through state law claims because the FAA provides the exclusive path to challenge it. So too here, the NSA provides the exclusive grounds for challenging an IDR award or the heavily-regulated processes that led to it. *See also Key Investment Services, LLC v. Oliver*, 691 F. Supp. 3d 496, 502 (D. Conn. 2023) (“The Federal Arbitration Act...provides the exclusive, and limited, authority for federal court review of an arbitral award.”) (internal quotations omitted); *C.T. Shipping, Ltd. v. DMI (U.S.A.) Ltd.*, 774 F. Supp. 146, 148–149 (S.D.N.Y. 1991) (“It is therefore clear that the federal statute, when it is applicable, preempts state statutes purporting to create alternative grounds for confirming or vacating arbitration awards.”). This Court already noted in its prior order that “Courts cannot vacate *or entertain collateral attacks on [IDR] awards.*” Doc. 264 at p. 15 (emphasis added). Aetna’s Counterclaims are preempted and should be dismissed.

2. The NSA preempts state-law challenges to IDR proceedings.

The NSA, as administered by the Departments, solely governs the method and manner of submitting and deciding IDR disputes. Aetna’s Counterclaims seek to upend the NSA by challenging what occurred during the IDR process (IDR attestations, eligibility procedures and results, representations made in IDR submissions, and how many payment disputes were submitted per IDR proceeding) without asserting a basis for judicial review under the NSA itself.

“The key to the preemption inquiry is the intent of Congress. Congress may manifest its intent to preempt state or local law explicitly, through the express language of a federal statute, or implicitly, through the scope, structure, and purpose of the federal law.” Doc. 264 at p. 28 (quoting *New York SMSA Ltd. P’ship v. Town of Clarkstown*, 612 F.3d. 97, 104 (2d Cir. 2010)). “Conflict preemption, one form of implied preemption, refers to situations where compliance with both state and federal law is a physical impossibility, or...where the state law at issue ‘stands as an obstacle

to the accomplishment and execution of the full purposes and objectives of Congress.’” *Id.* at 28-29 (quoting *Marentette*, 886 F.3d at 117 (internal citation omitted)).

Here, Aetna’s Courtnerclaims are inconsistent with Congress’s express decision to delegate to the Departments the authority to determine the rules, regulations, and guidance on the IDR process under the NSA. Recently, in June 2025, the Departments created a “process for reopening disputes to correct errors identified after dispute closure” that they determined were needed “to ensure program integrity.”³ That process includes correcting three categories of errors: clerical, jurisdictional, and procedural. Jurisdictional errors include “when the certified IDR entity incorrectly determines that an item or service either is or is not a qualified IDR item or service eligible for the Federal IDR process under the requirements of the NSA.”⁴ Here, Aetna seeks to create its own rules through state-law claims on issues such as who bears the cost of participating in claim eligibility determinations, how many payment disputes Plaintiffs can file, and the type of advocacy and arguments that can be included in IDR submissions. These claims clearly conflict with the NSA and the exclusive authority it gave the Departments to make these determinations.

Aetna’s preempted claims are starkly different from the CUTPA claim this Court has ruled Plaintiffs may bring. Plaintiffs use state law to assist in enforcing the NSA’s payment obligations and statutory payment deadlines. As this Court noted, “[i]mposing state law penalties for Defendants’ failure to timely pay IDR awards would not create any obstacles to the NSA’s purposes and objectives, as untimely payments are already proscribed by the NSA.” Doc. 264 at p. 30. Aetna, on the other hand, seeks to use state law to challenge the Departments’ rules

³ Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties, June 2025, available at <https://www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf>.

⁴ *Id.* at p. 3.

(allowing single HCPC code IDR payment determinations, *see infra* at IV.B.), the IDR proceedings that led to the awards (alleging misrepresentations), the Departments’ requirement that insurers bear their own costs and participate in the eligibility determination process (claiming Plaintiffs have filed too many ineligible claims and thus should pay Aetna’s costs), and the IDR attestation used to initiate disputes.

This Court already provided one example of when the NSA would preempt state law. It stated that a claim “would be preempted” if it sought to “[i]mpos[e] liability on health plans and insurers for their *conduct during the open negotiation period*” because it “could frustrate the NSA’s statutory scheme by allowing courts to weigh in on *what constitutes a fair payment*.” Doc. 264 at p. 30 n. 10 (emphasis added). This is exactly what Aetna’s Counterclaims seek—to have the Court weigh in on the fairness of IDR policies, procedures, and the process that led to the awards issued against Aetna. But per the NSA, Aetna’s remedies are limited to those contained in the statute. Beyond that, it is the Departments who make the rules and police the process.

B. The Airline Deregulation Act preempts Aetna’s claims.

The Airline Deregulation Act also preempts Aetna’s claims because those claims relate to Plaintiffs’ prices and services. In 1978, Congress deregulated the airline industry by enacting the ADA. The statute contains a broad, express preemption provision that states:

Except as provided in this subsection, a State ... may not enact or enforce a law, regulation, or other provision having the force and effect of law *related to a price, route, or service of an air carrier* that may provide air transportation under this subpart.

49 U.S.C. § 41713(b)(1) (emphasis added). A primary purpose of this provision was to “ensure that the States would not undo federal deregulation with regulation of their own.” *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 378 (1992). “In place of stifling federal and state price, route, and service regulation, Congress granted the Department of Transportation (DOT) authority

to police ‘unfair or deceptive practice[s] or ... unfair method[s] of competition,’ 49 U.S.C. § 41712(a), terms that have a long federal history in statutes such as Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45.” *Ferrell v. Air Evac EMS, Inc.*, 900 F.3d 602, 604 (8th Cir. 2018). As the United States Supreme Court has ruled, consumer fraud and deceptive practices statutes fall within the class of preempted state laws. *See Am. Airlines, Inc. v. Wolens*, 513 U.S. 219, 227 (1995) (ADA preempted plaintiffs’ claim under the Illinois consumer fraud statute). Similarly, state common law claims that embody “binding standards of conduct” are preempted. *See Nw., Inc. v. Ginsberg*, 572 U.S. 273, 282 (2014) (dismissing as preempted class action claim that Northwest Airlines violated duty of good faith and fair dealing when it revoked membership in its frequent flyer program).

The ADA likewise applies to air ambulance transports.⁵ In *Ferrell*, one of the Plaintiffs in this lawsuit (Air-Evac) was sued by a patient asserting damages under the Arkansas Deceptive Trade Practices Act “for concealing or omitting disclosure of its price until it completes air-ambulance transport.” 900 F.3d at 604. The Eighth Circuit had no trouble concluding that the claim, which sought to impose a “statutory price disclosure,” “obviously relate[d] to Air Evac’s price and service.” *Id.* at 606. It likewise rejected plaintiff Ferrell’s argument that ADA decisions should not apply to air ambulance companies, noting that air-ambulance operators are air carriers

⁵ The ADA defines “air carrier” as “a citizen of the United States undertaking by any means, directly or indirectly, to provide air transportation.” 49 U.S.C. § 40102(a)(2). This includes air ambulance companies. *See, e.g., Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 763 (4th Cir. 2018) (noting that “many courts have considered this question and uniformly held that the ADA preemption clause applies to the air ambulance market” and agreeing that air ambulance providers are “air carriers” under the ADA); *Schneberger v. Air Evac EMS, Inc.*, 2017 WL 1026012 at *2 (W.D. Okla. 2017) (noting that courts have all but uniformly held that air ambulance providers are “air carriers” under the ADA).

subject to DOT oversight. *Id.*; *see also Morales*, 504 U.S. at 387–88, 390–91 (noting DOT’s oversight authority is sufficient to protect consumers).

“[W]hen the statute’s language is plain,” the court’s “inquiry into preemption both begins and ends with the language of the statute itself.” *Ferrell*, 900 F.3d at 606–07 (quoting *EagleMed LLC v. Cox*, 868 F.3d 893, 903 (10th Cir. 2017)). Courts “may not refuse to apply ADA preemption merely because [they] do not believe it would be sound public policy to enforce the statute Congress enacted.” *Ferrell*, 900 F.3d at 607. The *Ferrell* court likewise dismissed the claim that the air ambulance company “attempts to gouge patients with its exorbitant charges” and thus should be denied any restitutionary remedy for the transport at issue. *Id.* at 607. In doing so, it noted:

Determining whether Air-Evac lacks the “clean hands” necessary to obtain equitable relief such as restitution under Arkansas law because it “attempts to gouge patients with its exorbitant charges” would require determining whether Air Evac’s pricing practices are “unconscientious or unjust.” It is hard to imagine a state-law claim more at odds with the congressional intent “[t]o ensure that the States would not undo federal deregulation with regulation of their own.”

Id. (internal citations omitted).

Here, Aetna’s state-law claims attempt to place “binding standards of conduct” on Plaintiffs’ prices and services—standards preempted under *Ginsberg*. *See Ginsburg*, 572 U.S. at 282. Put differently, Aetna wants to use state law to control the way Plaintiffs file their IDR disputes and recover payments in the IDR process; how many disputes they can file; and how Plaintiffs describe their services in IDR submissions. Aetna’s entire premise is that Plaintiffs’ decisions—whether their IDR eligibility determinations, their statements about the value of their air ambulance services, or their decision to continue filing IDR proceedings for each billed charge (as they were required to do for over a year)—are “driven by *strategic profiteering*,” Doc. 291 at ¶ 32 (emphasis added), and that these allegedly fraudulent representations “lead to artificially

inflated IDR valuations.” *Id.* at ¶ 34. Aetna also alleges that Plaintiffs “charge exorbitant prices.” *Id.* at ¶¶ 14, 16, 20, 35, 42. In other words, Aetna wants this Court to decide whether Plaintiffs’ services are actually worth the amounts the IDR entities are awarding them and, if not, to provide it a refund in the form of damages.

Aetna’s state-law claims plainly “relate” to Plaintiffs’ prices and services and are thus preempted by the ADA. Just as the plaintiff in *Ferrell* sought to impose a price disclosure obligation, Aetna seeks here to limit the way Plaintiffs participate in IDR proceedings. Plaintiffs’ IDR submissions are the “price” it seeks in IDR, and Aetna is attempting a backdoor challenge to those decisions to obtain refunds under the guise of damages. That is a direct attack on Plaintiffs’ rates and services. Moreover, whether Plaintiffs’ IDR offers, which are the “price,” are submitted in one proceeding or two is Plaintiffs’ decision to make and not for a State, or Aetna, to regulate. *See Stout v. Med-Trans Corporation*, 313 F. Supp. 3d 1289, 1296 (N.D. Fla. 2018) (holding that “Plaintiffs’ claims for unjust enrichment, breach of the implied covenant of good faith and fair dealing, and breach of implied-in-fact contract [based on Defendants’ billing practices] directly relate to the price of Defendants’ air carrier services.”).

II. Choice of law principles bar Aetna’s Connecticut law claims.

Even if Aetna could overcome its preemption problems, choice of law principles bar Aetna’s CUTPA and Connecticut common law claims. Connecticut courts apply the “most significant relationship test” to determine which forum’s law applies.⁶ *Victor G. Reiling Associates and Design Innovation, Inc. v. Fisher-Price, Inc.*, 406 F. Supp. 2d 175, 200 (D. Conn. 2005). Under that test, courts consider “(1) the place where the injury occurred; (2) the place where the conduct

⁶ “A federal court sitting in diversity applies the choice-of-law rules of the forum state.” *Maryland Cas. Co. v. Continental Cas. Co.*, 332 F.3d 145, 151 (2d Cir. 2003).

causing the injury occurred; (3) the domicile, residence, nationality, place of incorporation and place of business of the parties; and (4) the place where the relationship, if any, between the parties is centered.” *Id.*

Here, all of the factors weigh against applying Connecticut law. First, Aetna did not suffer injury in Connecticut; it claims its “injury” is that Plaintiffs are “manipulating” the IDR process to “continue inflating payments and driving profits.” Doc. 291 at ¶ 19. But if the scheme is to “inflate payments” for air ambulance transports, then the injury is typically not Aetna’s at all and occurs across the country in every state. That is because Aetna mostly administers self-funded employer group health plans, and it does so for companies across the country. *See* “Self-insurance plans,” available at <https://www.aetna.com/employers-organizations/self-insurance-plans.html>. This means that the companies themselves, not Aetna, pay the additional amounts owed from the alleged “inflated” IDR awards. Hence, the place of “injury” would be the location of every employer group across the country (likely all 50 states). Fully insured groups are a much smaller part of Aetna’s business, and a part of it the company wants to further shrink.⁷ While Aetna also complains of increased administrative fees and IDR charges, Doc. 291 at ¶ 33, nowhere does it allege that it, as opposed to its self-funded customers, pay these amounts.

As to the second factor—that the conduct causing the alleged injury did not occur in Connecticut—none of the Plaintiffs are located there. *See, e.g., Reiling*, 406 F. Supp. 2d at 200 (“the allegedly unfair practices...all took place in or from New York, where Fisher-Price is located.”); *Sec. Systems, Inc. v. Alder Holdings, LLC*, 421 F. Supp. 3d 1186, 1191 (D. Utah 2019)

⁷ At the end of 2024, Aetna reported 14.2 million self-funded employer plans, an increase over the prior year. *See* “CVS plans to let Aetna fully insured group enrollment shrink,” available at <https://www.benefitspro.com/2024/11/07/cvs-plans-to-let-aetna-fully-insured-group-enrollment-shrink/>.

(“Plaintiff has not, however, alleged that any unfair activity or misconduct occurred within the State of Connecticut or to its Connecticut customers.”). As to the third factor, only Aetna is incorporated and maintains a principal place of business in Connecticut, meaning that factor weighs against it. Doc. 291 at ¶¶ 8–10; *see Reiling*, 406 F. Supp. 175 at 200 (finding the third factor did not weigh in favor of applying Connecticut law where only the plaintiffs were Connecticut entities). As to the fourth factor, there is no state where the Parties’ relationship is centered. Plaintiffs transport Aetna patients across the country and submit payment disputes to IDR entities scattered across the country.

Western Dermatology proves instructive. There, the court affirmed the lower court’s findings that CUTPA did not apply—despite the defendant being headquartered in Connecticut and the relevant contract being drafted in Connecticut—because the services rendered to the plaintiff were outside of Connecticut. *W. Dermatology v. Vital Works, Inc.*, 146 Conn. App. 169, 200, 208 (Conn. App. 2013). Here, Aetna’s attempts to tie Plaintiffs to Connecticut do not approach the facts in *Western Dermatology*. The only Connecticut connection Aetna claims is that it resides here and allegedly feels some harm here. That is not enough to establish Connecticut’s reach over Plaintiffs.

Notably, if Aetna suffering harm in Connecticut were enough to establish a CUTPA claim, then the statute’s plain language that it only applies to trade or commerce “in this state” would be rendered meaningless. *See* Conn. Gen. Stat. § 42-110a. And if CUTPA applies to Plaintiffs based on these threadbare facts, then every insurance company in the nation could make the same argument, leading to inconsistent standards of conduct in a federally regulated program.

For all these reasons, Connecticut law does not apply and Aetna’s Counterclaims should be dismissed.

III. **CUTPA does not apply to Plaintiffs.**

Aetna's CUTPA claim also fails because it does not tie Plaintiffs' conduct to trade or commerce intimately associated with Connecticut. Also, Plaintiffs' separate submission of base and mileage disputes are exempt from CUTPA under Conn. Gen. Stat. Ann. § 42-110c because the Departments expressly allow those disputes to be submitted separately.

A. Plaintiffs' alleged conduct is not tied to trade or commerce intimately associated with Connecticut.

Plaintiffs' alleged conduct did not occur within Connecticut and falls outside CUTPA's reach. CUTPA's plain language is "directed at unfair competition taking place 'in this state.'" *Reiling*, 406 F. Supp. At 200. Despite this, courts have held that "CUTPA does not require that a violation actually occur in Connecticut, *if* the violation 'is tied to a form of trade or commerce intimately associated with Connecticut....'" *Id.* (citing *Uniroyal Chem. Co. v. Drexel Che. Co.*, 931 F. Supp. 132, 140 (D. Conn. 1996) (emphasis added)). Aetna's allegations do not meet this test.

Aetna attempts to tie Plaintiffs to Connecticut by alleging that Plaintiffs engage in trade or commerce associated with Connecticut. Specifically, it alleges:

[Plaintiffs] provided air ambulance and related healthcare transportation services in the State of Connecticut; conduct Connecticut-based transports that form the basis of IDR disputes at issue; actively participate in IDR proceedings involving services rendered in Connecticut; engage in negotiations with Aetna, a Connecticut-based corporation; market and advertise their services to Connecticut residents and insurers; enter into contracts affecting the delivery and pricing of services in Connecticut; and receive reimbursement for such services through transactions occurring in Connecticut's stream of commerce.

Doc. 291 ¶ 52. That is not enough. To begin, Plaintiffs are not Connecticut companies and do not maintain their principal places of business in Connecticut. *See id.* at ¶¶ 2–7 (alleging the incorporation state and principal place of business for each Plaintiff). Indeed, there is no allegation that Plaintiffs maintain any place of business in Connecticut. Focusing on Plaintiffs' alleged misconduct, the CUTPA allegations are limited to "(1) submitting knowingly false attestations of

IDR eligibility; (2) falsely representing to Aetna that the disputes were eligible for IDR prior to initiating the IDR process; and (3) overwhelming the IDR process by submitting separate IDR submissions....” *Id.* at ¶ 53. Aetna contends that Plaintiffs have “engaged in the practices...with Connecticut patients, Connecticut health plans, and Connecticut-based IDR proceedings.” *Id.* at ¶ 54. But notably, Aetna does not actually allege that any of these acts took place in Connecticut (because they did not). Similarly absent from Aetna’s pleading is any explanation of how the alleged IDR submission process involves “Connecticut patients.” As this Court noted, the NSA has removed patients from the equation with respect to air ambulance billing and payment disputes. *See* Doc. 264 at p. 2.

Aetna likewise provides no explanation of what a “Connecticut-based IDR proceeding” is. Notably, there is no allegation that any of the thirteen IDR entities currently accepting claims and making payment decisions are located in Connecticut.⁸ And IDR proceedings are completely electronic, with submissions going through a CMS online portal.⁹ There is simply no meaningful connection between Plaintiffs and Connecticut other than the fact that Aetna resides there (and is subject to its law). At best, Aetna’s allegations only result in harm being felt in Connecticut. As the courts in *Security Systems v. Alder Holdings, LLC*, 421 F. Supp. 3d 1186 (D. Utah 2019) and *Reiling* explain, that is insufficient.

In *Reiling*, the court found CUTPA did not apply because the allegedly unfair practices all took place outside Connecticut. 406 F. Supp. 2d at 200 (emphasis added). The *Reiling* court also reasoned that the products that “allegedly misappropriated plaintiffs’ concepts were marketed and

⁸ *See* “List of certified independent dispute resolution entities,” available at <https://www.cms.gov/nosurprises/help-resolve-payment-disputes/certified-idre-list>.

⁹ *See* “Notice of Initiation,” available at <https://nsa-idr.cms.gov/paymentdisputes/s/>.

sold in stores nationwide and on the Internet, not just in Connecticut.” *Id.* Likewise, in *Security Systems*, the court granted a motion to dismiss the plaintiff’s CUTPA claim because the alleged misconduct did not occur within the State of Connecticut or to Connecticut customers. *Sec. Systems v. Alder Holdings, LLC*, 421 F. Supp. 3d 1186, 1191 (D. Utah 2019). The court explained, relying on *Reiling*, that to establish CUTPA applied, “much more Connecticut connection was required” and that a plaintiff “merely being headquartered, incorporated or feeling harm [in Connecticut]” is not enough. *Id.*

Aetna’s allegations here mirror those in *Security Systems* and *Reiling*. Taken as true, Plaintiffs’ alleged “scheme”—to submit knowingly false attestations of IDR eligibility, falsely represent to Aetna that the disputes were eligible, submit base rate and mileage payment disputes in separate IDR proceedings, and charge exorbitant prices—happened, if at all, where Plaintiffs are located and make billing and IDR decisions. There is no allegation that any of this happened in Connecticut (because it did not). Similarly, just like the products at issue in *Reiling* were sold nationwide, the IDR awards at issue in this proceeding against Aetna concern air ambulance transports that occurred nationwide.

As an example, Plaintiff Med-Trans is alleged to be a North-Dakota corporation with its principal place of business in Texas. Doc. 291 at ¶ 5. Even if an IDR proceeding includes a Connecticut patient and a Connecticut health plan (which would be rare), the alleged misconduct still occurs in Texas. It is only the effects of the alleged misconduct that are potentially felt in Connecticut. That is not sufficient under *Security Systems* and *Reiling*. Because Plaintiffs’ alleged conduct is not tied to trade or commerce that is intimately associated with Connecticut, CUTPA does not apply and Aetna’s claim should be dismissed.

B. CUTPA does not apply here because the Departments expressly allow and prefer base and mileage disputes to be submitted as separate line-item disputes.

CUTPA broadly exempts “[t]ransactions or *actions otherwise permitted under law as administered by any regulatory board or officer* acting under statutory authority of the state or *of the United States.*” Conn. Gen. Stat. Ann. § 42-110c (emphasis added). When assessing whether CUTPA’s exemption applies, courts apply a two-part analysis. First, a court must identify the “transactions or actions” at issue by determining “the broader pattern of activity by the defendant, not the specific allegations of misconduct.” *Garcia v. Fry*, 186 F. Supp. 3d 228, 234 (D. Conn. 2016). Second, a court must determine whether the transactions or actions are authorized or permitted under law. *See id.* Notably, the CUTPA exemption does not require that the activity at issue be directed or required “but only that the actions *be permitted and be subject to regulation* by a regulatory board or officer.” *Id.* (internal quotations omitted) (emphasis added); *see also Connelly v. Housing Auth. of City of New Haven*, 213 Conn. 354, 361 (Conn. 1990) (holding that “the continued leasing or renting of subsidized apartments to low income tenants” which is regulated by the Department of Housing and Urban Development was excepted from CUTPA’s applicability). This exemption extends to batching base and mileage payment disputes into one IDR proceeding and filing ineligible claims.¹⁰

¹⁰ Aetna confusingly uses the term “unbundling” when referencing the submission of the base rate and mileage charge in separate IDR proceedings. A bundled payment is one where a provider “bills for multiple items or services *under a single service code*[.]” *See* Technical Assistance for Certified IDR Entities (August 2022), page 9 (emphasis added), available at <https://www.cms.gov/files/document/TA-certified-independent-dispute-resolution-entities-August-2022.pdf>. NSA bundling rules are irrelevant to Aetna’s Counterclaim, which concerns Plaintiffs not batching two different service codes in a single IDR proceeding once that process became available.

Batching concerns the submission of “multiple qualified IDR dispute items and services” in one IDR proceeding. *See* 42 U.S.C. § 300gg111(c)(3)(A). The Departments originally issued rules stating that providers could only batch claims billed under the same service code, meaning that payment disputes over base rates and mileage rates required two IDR proceedings. *See Texas Med. Ass’n v. U.S. Dept. of Health and Human Servs.*, 2023 WL 5489028, at *14 (E.D. Tex. August 24, 2023). In August 2023, the Departments’ batching rule was set aside. *See id.* at *15. In response, the Departments issued the following guidance in December 2023¹¹:

As a result of the *TMA III* order, air ambulance services for a single air ambulance transport, including an ***air ambulance mileage code and base rate code, may be submitted as a batched dispute***, so long as all provisions of the batching regulations are satisfied, in accordance with guidance. ***Nothing*** in the FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 63 or the *TMA III* opinion and order ***precludes an air ambulance mileage code or base rate code from being submitted separately as a single dispute***.

In other words, the Departments’ current official policy is that base and mileage rates may be batched together or they may be submitted separately.

It is against this backdrop that Aetna now claims that CUTPA *compels* Plaintiffs to submit mileage and base rate payment disputes as batched disputes and *precludes* them from submitting them in separate proceedings. This claim makes no sense given the fact the Departments required Plaintiffs for over a year to submit base rate and mileage disputes in separate IDR proceedings. It took federal litigation to compel the Departments to allow the option of filing the two line items as a batched dispute. Three federal agencies (HHS, Treasury and Labor) have created the rules for the federal IDR program and plainly allow an IDR proceeding for each line-item payment dispute.

¹¹ *See* “Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties” (available at <https://www.cms.gov/files/document/federal-idr-guidance-disputing-parties-march-2023.pdf> (“December Guidance”) at p. 22 (emphasis added)).

Indeed, they have tried to mandate it.¹² Similarly, the Departments allow the initiation of disputes that might later be determined ineligible.

In sum, Aetna has alleged that Plaintiffs are engaged in a scheme to “submit disputes for the base rate and mileage rate in two separate submissions, even though they can be submitted together.” Doc. 291 at ¶ 29. The submission of a payment dispute for each service code (base and mileage) is the “transaction or actions” at issue. And as explained above, that action is allowed (and even encouraged) by the Departments. Aetna does not make a single allegation that submitting separate payment disputes for base rates and mileage rates is prohibited by the NSA. Similarly, the Departments have gone to great effort to create an eligibility program that continues to evolve. Aetna’s CUTPA claim is an improper attempt at rulemaking through tort liability and should be dismissed.

IV. Aetna has failed to state a claim.

A. Aetna fails to state a claim for fraudulent misrepresentation.

Aetna’s fraudulent misrepresentation claims rest on two premises; first, that Plaintiffs knowingly submitted false attestations regarding IDR eligibility, Doc 291 at ¶ 39, and second, that Plaintiffs made knowingly false representations and omissions of fact in their IDR submissions regarding the value of the transports provided. *Id.* at ¶ 43. Both of these allegations are insufficient as a matter of law. To state a claim for fraudulent misrepresentation under Connecticut law, a plaintiff must allege:

(1) that the defendant made a fraudulent misrepresentation of or concealed a material fact; (2) that the statement (or omission) was false and was known by the defendant to be false or was made with a reckless indifference to its truth; (3) that the statement (or omission) was made in order to induce the plaintiff to act in reliance on it; (4) that the plaintiff did so act, with justifiable or reasonable reliance on the representation[;] and (5) that the plaintiff was...injured as a result of the reliance.

¹² Notably, Aetna seeks to hold Plaintiffs liable for their alleged “unbundling scheme” only from October 2023 onwards, after the original batching rule was vacated. *See* Doc. 278 at p. 13 ¶ 51.

Flemming v. Goodwill Mortg. Servs., LLC, 648 F. Supp. 2d 292, 296 (D. Conn. 2009) (quoting *Vertrue Inc. v. Meshkin*, 429 F. Supp. 2d 479, 497–98 (D. Conn. 2006)).

Moreover, to properly plead fraud with particularity under FED. R. CIV. P. 9(b), a complaint must: “(1) specify the statements that the plaintiff contends were fraudulent, (2) identify the speaker, (3) state where and when the statements were made, and (4) explain why the statements were fraudulent.” *Parola v. Citibank (S. Dakota) N.A.*, 894 F. Supp. 2d 188, 200 (D. Conn. 2012) (citing *Rombach v. Chang*, 355 F.3d 164, 170 (2d Cir. 2004)). Here, Aetna has not plausibly alleged that Plaintiffs’ attestations of IDR eligibility and representations of the value of the transports provided are false, nor has it met the heightened pleading requirement under Rule 9(b).

1. Aetna does not plausibly allege that Plaintiffs knowingly made false attestations.

Aetna contends that because Plaintiffs submitted some disputes through the IDR process that were ultimately ineligible, Plaintiffs must have known those disputes were ineligible at the time they were filed. Doc. 291 at ¶¶ 40-41. That is not enough to meet the knowing falsity element of a fraudulent misrepresentation claim.

Aetna fails to include a single allegation explaining how Plaintiffs knew such disputes were ineligible. Instead, Aetna makes conclusory allegations that Plaintiffs knew the disputes were ineligible because they submitted attestations which state that the disputes qualify. *Id.* at ¶ 41. But the language in the attestation itself is fatal to Aetna’s fraud claim.

I, the undersigned initiating party (or representative of the initiating party), attests that ***to the best of my knowledge...the item(s) and/or service(s) at issue are*** qualified item(s) and/or service(s) ***within the scope*** of the Federal IDR process.

Id. (emphasis added).

Aetna does not allege that Plaintiffs submitted “services” that were not “within the scope” of the federal IDR process. The federal IDR process concerns emergency services furnished by

out-of-network providers. All of the transports at issue were emergency air ambulance transports provided to Aetna health plan participants and thus were “within the scope” of services covered by the federal IDR process. What Aetna attempts here (and has attempted against other providers) is to expand the attestation of in-scope services into an attestation on *all aspects of eligibility*. But eligibility turns on numerous factors, many solely within the health plan’s knowledge. That is why if the non-initiating health plan or insurer thinks the claim is ineligible, “the non-initiating party must notify the Departments by submitting the relevant information through the Federal IDR portal as a part of the certified IDR entity selection process.”¹³ Then the Departments “will supply this information to the selected certified IDR entity, *who may ask for additional information* pursuant to this notification.”¹⁴ Then, “[t]he certified *IDR entity must determine* whether the Federal IDR Process is applicable.”¹⁵ Eligibility disputes can be subject to legal and factual disputes just like disputes over federal court jurisdiction.

There are many reasons an emergency service might be ineligible for the federal IDR process that would be solely within Aetna’s knowledge. First, enacting regulations concluded that the federal IDR program does not apply to retiree-only plans, health reimbursement arrangements or other account-based plans, excepted benefits plans, or short-term limited-duration plans.¹⁶ Second, self-insured plans in twenty-one states may opt in to a state IDR process rather than use

¹³ See “Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities” § 4.4, available at <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/federal-independent-dispute-resolution-process-guidance-for-certified-idr-entities.pdf>.

¹⁴ *Id.* (emphasis added).

¹⁵ *Id.* (emphasis added).

¹⁶ 86 Fed. Reg. 36903-36904 (“Applicability”) (July 13, 2021).

the federal IDR process.¹⁷ Similarly, Federal Employee Health Benefit carriers can decide by agreement whether a state or federal IDR process applies.¹⁸ And if emergency service are received in a state other than the one in which the individual enrolled in their health plan, plan language regarding the geographic scope of coverage may be relevant to determining whether a state or federal process applies.¹⁹ On top of this, with respect to air ambulance payment disputes, the effect of preemption under the ADA must be considered (there being an exception for intra-state flights in Alaska)²⁰. These detailed, plan-specific facts and elections are known to Aetna, not Plaintiffs. It is no wonder that the “complexity of making *eligibility* determinations” has resulted in long delays in payment determinations.²¹

Aetna contends that “until recently, at least 16% of the claims” Plaintiffs submitted to IDR (not just with Aetna) were found ineligible. Doc. 291 at ¶ 25. A recent CMS report reveals that this number is lower than the industry average. Between April 15, 2022 when the IDR portal

¹⁷ See “Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process,” available at <https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf>.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ The Departments noted in their eligibility guidance “the state of Alaska’s **assertion** that the Alaska Division of Insurance applies 3 AAC 26.110(a) to all out of network health care claims paid by insurance companies **including** to air ambulance providers as summarized in their enforcement letter.” *Id.* (emphasis added). However, the ADA only has an exception for intrastate air travel, not interstate air travel. See 49 U.S.C. § 41713(b)(2) (noting that preemption of state regulation does not apply “to air transportation provided entirely in Alaska”). Accordingly, Plaintiffs contend that interstate flights remained subject to the Federal IDR process up until the State of Alaska terminated its state pricing program, which was effective January 1, 2024.

²¹ See “Independent Dispute Resolution (IDR) Timeline for Claims,” available at <https://www.cms.gov/files/document/independent-dispute-resolution-idr-timeline-claims.pdf> (emphasis added).

opened, and July 31, 2025, over 24% of all IDR initiations, more than 600,000 claims, were determined to be ineligible.²² Recognizing the current difficulty in determining eligibility, CMS last week issued a report explaining the steps it has taken and plans to take in the future to “enhance and modernize the IDR portal” and “enhance the data used to determine dispute eligibility,” with the goal of “eliminat[ing] ineligible disputes and transform[ing] the IDR experience for both payers and providers.”²³ A quarter of healthcare providers are not committing fraud. They are all desperately trying to navigate a complex regulatory system that is the only way they receive fair payments after insurers like Aetna unilaterally low-pay them.

Further, as a matter of law, an attestation made “to the best of my knowledge” is insufficient to state a fraud claim. Such a statement “does not purport to be made on such person’s actual personal knowledge and does not purport to ‘verify’ the truth of the statement.” *See U.S. v. Bernstein*, 533 F.2d 775, 803 (2d Cir. 1976) (Graafeiland, J. dissenting) (citing *First National Bank v. Gregg*, 79 Pa. 384, 387 (1875)); *Newman v. Silver*, 553 F. Supp. 485, 498 (S.D.N.Y. 1982), *aff’d* in part, *vacated* in part, 713 F.2d 14 (2d Cir. 1983) (finding “no cause of action for fraud has been proven” where fraud claim was premised on statement made “to the best of [defendant’s] knowledge” and “there was no indication that [defendant] did not believe the truth of statements when they were made.”). Declarations with these limitations are not “knowingly false simply because potentially conflicting information was received months later,” such as when the IDR entity finally makes its eligibility determination. *See Diabetes Centers of Am., Inc. v. Healthpia*

²² *See* “Federal Bi-Monthly Reports” as of July 31, 2025, available at <https://www.cms.gov/nosurprises/policies-and-resources/reports>.

²³ *See* “Fact Sheet: Clearing the Independent Dispute Resolution Backlog (September 19, 2025)” at p. 3, available at <https://www.cms.gov/nosurprises/policies-and-resources/reports>.

Am., Inc., 2007 WL 1655923, at *2 (S.D. Tex. Jun. 7, 2007) (dismissing fraud claim based on representations made to the best of defendants’ knowledge).

Aetna’s allegation, even accepted as true, cannot support a fraudulent misrepresentation claim as a matter of law. Plaintiffs attested their services were “to the best of [their] knowledge” “within the scope” of the federal IDR process. Aetna does not claim the services submitted were of a type that fell “outside the scope” of the IDR process—only that they were ineligible, which as explained above, could be due to a multitude of reasons. That is not fraud, and Aetna’s fraud claim based on Plaintiffs’ IDR attestations should be dismissed.

2. Aetna has not plausibly alleged that Plaintiffs knowingly misrepresented the value of their transport services.

Aetna’s claim that Plaintiffs knowingly misrepresented the value of their transport services is similarly flawed. Aetna alleges that Plaintiffs (1) misrepresented that they operate state-of-the-art aircraft (and withhold information concerning their aircraft safety record); (2) overstate the minimum pilot qualifications and flight hours; and (3) inflate the claimed percentage of air ambulances under commercial contract. Doc. 291 at ¶ 33. But Aetna fails to meet the high bar for fraud in explaining how these statements are false, and in fact incorporates documents into its Counterclaim that suggest they are true.

Expressions of opinion cannot form the basis for a fraud claim. *See, e.g., McCullough v. World Wrestling Ent., Inc.*, 172 F. Supp. 3d 528, 563 (D. Conn. 2016) (“Fraudulent statements must be statements of fact and therefore *an expression of opinion* or skepticism as to the truth of a matter asserted by another cannot usually support a fraud claim.”) (emphasis added). Aetna claims Plaintiffs referred to their aircraft as being “state-of-the-art” in their IDR offers, which are pieces of advocacy, when they are actually “standard within the air ambulance industry.” Doc. 291 at ¶ 47. First, those two concepts are not mutually exclusive. “State of the art” means “the

level of development (as of a device, procedure, process, technique, or science) reached at any particular time usually as a result of modern methods.”²⁴ It can become “standard” in an industry to use aircraft that has reached the modern level of development available in today’s world. Second, whether something is state-of-the-art is an opinion. And here, Aetna conveniently ignores that it is the opinion that was provided to them under oath by one of Plaintiffs’ executives in charge of operations:

Q: But with respect to the aircrafts that you do have for the businesses that you supervise for GMR, *do you consider them to be state-of-the-art?*

A: *Absolutely.* I think they are highly maintained. We upgrade the avionics. All of our aircraft have crash-resistant fuel cells. All of them have auto-pilot. They are designed—they also are in the process of transitioning them all to these polycarbonate ballistic-resistant windshields that are designed to help reduce the risks associated with bird strikes. They don’t eliminate it, but they do reduce it.

So there is a lot that have been invested in these aircraft to take them even beyond where they were when they were initially acquired, and we continue to maintain that kind of approach to having that aircraft where they are truly mission capable and able to perform in the environments that we are deploying them in.

Dralle Dep. (June 25, 2025) at 65:10–66:5. Aetna has not plausibly alleged that Plaintiffs’ representation that they operate “state-of-the-art” aircraft in a piece of advocacy is a knowingly false, objective fact. This is fatal, and Aetna’s fraud claim premised on Plaintiffs’ representation that their aircraft are “state-of-the -art” is groundless.

Aetna also fails to include a single allegation on Plaintiffs’ representation regarding the safety record of the air ambulances, pilots, and crew members. In fact, it is only mentioned once throughout Aetna’s entire complaint. *See* Doc 291 at ¶ 33(d). Aetna has not alleged that Plaintiffs made knowingly false statements regarding safety or why those unidentified statements are allegedly fraudulent as required by FED. R. CIV. P. 9(b). Aetna’s claim that it was fraud to “omit”

²⁴ <https://www.merriam-webster.com/dictionary/state-of-the-art>.

information about safety incidents (such as crashes) is meritless. The NSA allows the parties the ability to provide any information they want in support of their payment offer so long as it is not a prohibited factor. *See* 42 U.S.C. § 300gg-111(b)(5)(A)-(D). The idea that a provider must include a tragedy like an air ambulance crash in its offer statements is, frankly, ludicrous.²⁵ That this omission constitutes fraud, even more so.

Next, Aetna alleges that the statement that Plaintiffs’ pilots “have an average of 5,000 hours experience” is fraudulent because “some pilots have as few as 1,800 hours.” Doc. 291 at ¶ 47. This is meritless on its face. An “average,” by definition, means there are some pilots with less experience and some with more. Aetna has wholly failed to allege how Plaintiffs’ representation of an average pilot flight time of 5,000 hours is false, much less knowingly false, or fraudulent as required by FED. R. CIV. P. 9(b).

Last, Aetna alleges that Plaintiffs are committing fraud in statements on the amount of their commercial book that is in-network. This claim, too, fails in light of Aetna’s selective quotes from the deposition testimony.²⁶ *See United States ex rel. Integra Med Analytics, L.L.C. v. Baylor Scott & White Health*, 816 F. App’x 892, 897 (5th Cir. 2020) (per curiam) (“A claim is merely conceivable and not plausible if the facts pleaded are consistent with both the claimed misconduct and a legal and obvious alternative explanation.”). Aetna cites the following testimony from the deposition of Barbara Berkowitz:

²⁵ These are contested submissions, and Aetna was free to include any information it wanted in its submission, including such information.

²⁶ Since Aetna cited and relied on the deposition in its Counterclaim, the Court may consider other portions of the same document. *Rodriguez v. City of New York*, 623 F. Supp. 3d 225, 237 (S.D.N.Y. 2022) (“The court may consider the full text of documents that are cited in, incorporated by reference in, or ‘integral’ to the complaint.”); *In re Vicuron Pharms., Inc. Sec. Litig.*, No. CIV.A. 04-2627, 2005 WL 2989674, at *3 (E.D. Pa. July 1, 2005) (A “court may consider any document in its entirety when a portion is explicitly relied upon in the complaint.”).

Q: Yes, ma'am, I'm asking about commercial.

A: Out of the commercial health, about 50 percent of our volume is contracted. So between all of those, it's about 50 percent.

Q: And meaning "all of those," you mean both -- (Simultaneous speaking.)

A: All of my contracted payors.

Q: Including both national and regional?

A: Correct.

Berkowitz Dep. (June 25, 2025) at 36:13–22. But Aetna does not include the entire line of questioning, presumably because that would torpedo its fraud claim.

Q: Is that the highest percentage of volume of claims, 50 percent, as it stands right now that GMR has ever had?

A: So you will see at times *people use the number 70 percent*, which is -- includes government contracts that include Indian -- which includes what I will call predictable pricing that's *billed under our commercial insurance*, which is different—commercial insurance category, which is different than commercial health eligible for IDR. Not all commercial health is IDR eligible.

Q: With respect to commercial health that is *eligible or available for IDR*, what is the highest percentage of volume of claims that GMR has had?

A: It's probably ranged *between 50 to 60 percent*.

Q: When was it 60 percent?

A. *It could be 60 percent today.*

Id. at 36: 23–37:15 (emphasis added).

Aetna claims the fraudulent statement is that Plaintiffs are in-network with more than 70% of commercially insured transports "*or words to that effect.*" Doc. 291 at ¶ 44(a)–(x) (emphasis added). But Aetna makes no allegation as to what was said—it simply repeats a third party's summary of what was supposedly said. *Id.* To the extent there was an error in the percentage cited at IDR, Aetna alleges nothing to show that any error was an intentional scheme to mislead as opposed to an inadvertent error. Indeed, Ms. Berkowitz explained as much at her deposition when

she said the amount of business in-network varies between 50 and 70% depending on the timeframe and whether it includes all business billed under commercial insurance or just IDR-eligible claims. Here, not only is there an obvious alternative explanation to fraud, but Aetna fails to allege that Plaintiffs knew that its statements about its network status are false, or how those statements are fraudulent as required by FED. R. CIV. P. 9(b). For all these reasons, Aetna's claim for fraudulent misrepresentation must be dismissed.

3. Aetna has not pled specific intent or specific reliance as required under the elements of its claim or under Fed. R. Civ. P. 9(b).

Aetna's fraud claims also fail because it does not plead fraudulent intent by Plaintiffs or Aetna's own specific reliance on any allegedly fraudulent statements.

The statements Aetna claims were fraudulent are statements allegedly made *to the IDR entities* in payment offers submitted by Plaintiffs. This occurs in a blind process, meaning neither Plaintiffs nor Aetna see the offer statements each side submits to the IDR entities. Aetna bases its fraud claim on some of the reasons listed in a handful of IDR awards about Plaintiffs' evidence and arguments. Not having seen the offer statements when they were submitted means Aetna could not have relied on anything contained within them as a matter of law. This is why Aetna makes the conclusory statement that it "relied on these statements," *id.* at ¶¶ 42, 48, but fails to allege any facts supporting reliance. Indeed, the alleged statement was not even made to Aetna.

To make out a claim of fraudulent or negligent misrepresentation a plaintiff must show...that there was a *false statement of fact* by the defendant and *justifiable reliance on the statement by the plaintiff to its detriment.*" *Silent Partner Marketing, LLC v. TKCT, LLC*, 2016 WL 4150263, at *2 (Conn Super. Ct. Jul 1, 2016) (quoting *Retrofit Partners I v. Lucas Industries*, 201 F.3d 155, 162 (2d Cir. 2000)) (emphasis added). Aetna cannot show that it justifiably relied on Plaintiffs' allegedly false statements to its detriment because those statements were made to a

third party in a submission Aetna never saw. Aetna likewise cannot satisfy Rule 9(b)’s required showing that Plaintiffs specifically intended to defraud Aetna because Plaintiffs’ statements—fraudulent or not—were directed at IDR entities, not Aetna. *See Allstate Ins. Co. v. Advanced Health Professionals, P.C.*, 256 F.R.D. 49, 63 (D. Conn. 2008) (quoting *Lerner v. Fleet Bank, N.A.*, 459 F.3d 273, 290—291 (2d Cir. 2006) (requiring factual allegations supporting fraud and reliance). Rather, Aetna’s fraud claims rest on conclusory assertions that Plaintiffs “knowingly and willfully” submitted false attestations and made false representations “with the intent to defraud,” Doc. 291 at ¶¶ 39–42, but it provides no factual allegations that Plaintiffs intentionally made untrue statements. *See Allstate Ins. Co.*, 256 F.R.D. at 63 (dismissing fraud claim due to insufficient factual allegations).

Moreover, Aetna’s list of alleged misrepresentations made by Plaintiffs (e.g., “state-of-the-art” aircraft, pilot hours, and in-network participation percentage) is not tied to any Aetna decision, person, or payment that those statements induced. *Id.* at ¶¶ 44–47. Aetna does not even allege that any given IDR entity relied on those statements or would have made a different decision had they not been made (which would require discovery from multiple IDR entities on every decision they made). In short, Aetna’s fraud theory is simply untenable. *See McCreary v. One Strawberry Hill Ass’n, Inc.*, 2011 WL 2150442, at *5 (Conn. Super. Ct. Apr. 29, 2011) (holding that “because the plaintiffs have not alleged that they relied on the purportedly false statement made by the defendants, they have failed to properly plead a cause of action in fraudulent misrepresentation”).

B. Aetna has not stated a claim under CUTPA.

The portion of Aetna’s CUTPA claim based on allegations of fraud, including misrepresentations in IDR and the text of IDR attestations, fails for the same reason the fraud allegations fail. *See E. Point Systems, Inc. v. Steven Maxim, S2k, Inc.*, 133 F. Supp. 3d 430, 439–440 (D. Conn. 2015) (holding that because party “failed to plead fraud with sufficient particularity,

the[] fraud allegations cannot support a CUTPA claim.”); *Aviamax Aviation Ltd. v. Bombardier Aerospace Corp.*, 3:08–cv–1958 (CFD), 2010 WL 1882316, at *9 (D. Conn. May 10, 2010) (“When a plaintiff in federal court bases a CUTPA claim on fraud allegations, the plaintiff must satisfy the particularity requirement of Federal Rule of Civil Procedure 9(b).”).

Aetna’s CUTPA claim based on filing two disputes per transport likewise fails. To state a claim under CUTPA, a plaintiff must show that “(1) the defendant engaged in unfair or deceptive acts or practices in the conduct of any trade or commerce;...and (2) [it] has suffered an ascertainable loss of money or property as a result of the defendant’s acts or practices.” *Artie’s Auto Body, Inc. v. Hartford Fire Ins. Co.*, 287 Conn. 208, 217 (Conn. 2008). The Connecticut Supreme Court has adopted the FTC’s cigarette rule to determine whether a practice violates CUTPA. *See American Car Rental, Inc. v. Commissioner of Consumer Prot.*, 273 Conn. 296, 305 (Conn. 2005). The criteria set out in that rule asks:

(1) [W]hether the practice, without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the common law, or otherwise—in other words, it is within at least the penumbra of some common law, statutory, or other established concept of unfairness; (2) whether it is immoral, unethical, oppressive, or unscrupulous; (3) whether it causes substantial injury to consumers, [competitors or other businesspersons]

Id. at 305–306. Aetna merely states in a conclusory fashion that Plaintiffs’ alleged practices offend “public policy... is immoral, unethical, oppressive, and unscrupulous, and has caused substantial injury to Aetna, consumers and business.” Doc. 291 at ¶ 55. That is not enough. *See Priority Sales Mgmt., Inc. v. Carla’s Pasta, Inc.*, 2011 WL 3819748, at *3 (D. Conn. Aug. 26, 2011) (“Courts have held that ‘merely stating that the defendant’s conduct violates public policy or is unfair and/or deceptive is not sufficient to sustain a CUTPA claim.’”) (citation omitted).

1. Filing separate IDR proceedings for base rate and mileage disputes does not offend public policy and is not immoral, unethical, oppressive, or unscrupulous.

First, Plaintiffs’ alleged “unbundling scheme” of filing a single IDR payment dispute for each charge being contested does not offend public policy and is not immoral, unethical, oppressive, or unscrupulous. As discussed above, commencing separate IDR proceedings for base rate and mileage disputes was *previously required* by the Departments and is certainly now permitted by them. *See* December Guidance at p. 22 (“air ambulance mileage code and base rate code, may be submitted as a batched dispute” and “[n]othing . . . precludes an air ambulance mileage code or base rate code from being submitted separately as a single dispute”).

Aetna is unable to point to any statute or common law “public policy” that single charge IDR submissions violate. And aside from its conclusory statement, it provides no basis supporting the notion that the federal government’s rules on how IDR proceedings can be submitted are immoral, unethical, oppressive, or unscrupulous. For this Court to allow Aetna’s CUTPA claim to proceed, it would have to conclude that the federal government’s original rule itself *violated public policy* and embodied an *unfair trade practice* under Connecticut law. This is nonsense.

Aetna cannot credibly argue that a permissible practice in a highly regulated federal program, particularly a practice that was previously mandatory for the entire industry, offends public policy or is somehow immoral or unethical. *See, e.g., Arch Ins. Co. v. Centerplan Constr. Co., LLC*, 2018 WL 6519063, at *18 (D. Conn. Dec. 11, 2018) (“the Court finds that Defendants have failed to alleged conduct...which could be reasonably interpreted as ‘immoral, unethical, oppressive, or unscrupulous.’ Defendants have not set forth how [Plaintiff’s] alleged activities were offensive to public policy, or even which public policy the alleged actions offend. This is fatal to Defendants’ CUTPA claim.”); *cf. Personal Fin. Services, Inc. v. General Motors Acceptance Corporation*, 169 F. Supp. 2d 49, 54 (D. Conn. 2001) (concluding a CUTPA claim

could not be based on a non-disclosure theory when the federal Consumer Leasing Act law did not require such disclosure).

The Departments spent over a year in litigation defending the merits of the policy requiring separate IDR proceedings for base rate and mileage rate disputes. Aetna’s allegations are little more than legal conclusions masquerading as facts. *See also Riverview E. Windsor, LLC v. CWC Capital LLC*, 2012 WL 90152, at *8 (D. Conn. Jan. 10, 2012) (“These are not allegations of fact but conclusory statements, which will not save a complaint from dismissal. In the absence of factual allegations showing that the conditions were illegal, the complaints fail to adequately plead a claim on which relief can be granted.”). For these reasons, Aetna has not stated a claim under CUTPA.

2. Filing separate IDR proceedings for base rate and mileage disputes does not cause substantial injury to Aetna.

Aetna’s allegations are insufficient to plausibly establish that filing separate IDR proceedings for base rate and mileage causes substantial injury. “To plead that an action caused ‘substantial injury,’ in satisfaction of the third prong, [a plaintiff] must show that the injury was substantial, that it was not outweighed by ‘any countervailing benefits to consumers or competition that it produces’; and that it is an injury...[that] ‘could not have [been] reasonably avoided.’” *Edwards v. North American Power and Gas, LLC*, 120 F. Supp. 3d 132, 144 (D. Conn. 2015) (quoting *A–G Foods, Inc. v. Pepperidge Farm, Inc.*, 216 Conn. 200, 216 (Conn. 1990)).

Here, Aetna’s alleged injury is payment of an additional “non-refundable administrative fee” to participate in the IDR process, expanding “significant time and resources” in IDR, and the IDR entity fee it must pay when it loses. Doc. 291 at pp. 7-9. This is hardly a substantial injury in a heavily regulated process. All of these alleged injuries could be reasonably avoided if Aetna were to simply start paying claims at a fair price rather than forcing Plaintiffs to turn to IDR time

and time again. *See* Doc. 109 at ¶ 42. In reality, Aetna’s “injury” is entirely manufactured and of its own doing. Aetna’s claim should be dismissed.

C. Aetna has not plausibly alleged a claim for money had and received.

“The action for money had and received is an equitable action *to recover back money paid by mistake*, where the payor is *free from any moral or legal obligation to make the payment* and the payee in good conscience has no right to retain it.” *Walker v. People’s United Bank*, 305 F. Supp. 3d 365, 380 (D. Conn. 2018) (quoting *Bridgeport Hydraulic Co. v. Bridgeport*, 103 Conn. 249, 261, 130 A. 164 (1925) (emphasis added)). “To prevail on a claim for money had and received, a plaintiff must prove both the *lack of authority to authorize the payment* and that it is inequitable for the recipient to retain it.” *Herron v. Daniels*, 208 Conn. App. 75, 112, 264 A.3d 184, 209 (2021) (quoting *Stratford v. Winterbottom*, 151 Conn. App. 60, 77–78, 95 A.3d 538, *cert. denied*, 314 Conn. 911, 100 A.3d 403 (2014)).

Aetna fails to meet either prong of the required elements. First, a money had and received claim requires that the payor be free from a legal obligation to make the payment. Here, Aetna has a legal obligation to pay IDR awards under the NSA. This obligation was contemplated and set forth by Congress, and Aetna cannot circumvent it by asserting a state law cause of action (which is also preempted by the NSA). An IDR award creates a direct payment obligation to a provider. For this reason alone, Aetna’s claim fails. *See Town of Stratford v. Winterbottom*, 151 Conn. App. 60, 77, 95 A.3d 538, 549 (2014) (money had and received claim fails if just one prong is not met).

Second, it is not inequitable for Plaintiffs to retain their IDR award payments since they actually provided the medical transport for which the payment was made. Here, there is a process for judicial review if Aetna believes any given award issued against it should be vacated. It has not followed that process, so there is no inequity in retaining payments made on valid,

unchallenged IDR awards. For these reasons, Aetna’s money had and received claim should be dismissed.

V. Aetna’s Declaratory Judgment Act and injunctive relief claims are improper.

In vague terms, Aetna has requested two declaratory judgments from this Court: one that Plaintiffs unlawfully submitted false attestations, initiated IDR for ineligible IDR items or services, and made material misrepresentations in their IDR submissions; and another that the IDR awards are not binding. Doc. 291 at ¶ 58. The claim must be dismissed.

A. Aetna’s requests for declaratory relief are untethered to any valid cause of action.

First, Aetna does not identify a cause of action supporting either declaration. “The [Declaratory Judgment Act (“DJA”)] is procedural only and does not create an independent cause of action.” *Chevron Corp. v. Naranjo*, 667 F.3d 232, 244 (2d Cir. 2012) (citations omitted). It is therefore improper for Aetna to ask this Court to declare certain conduct “unlawful” or the awards “nonbinding”—its requests for declaratory relief must be tethered to plausible legal claims, and they are not. *See, e.g., VW Credit Leasing LTD. v. Runway Towing Corp.*, 757 F. Supp. 3d 271, 290 (E.D.N.Y. 2024).

B. Aetna’s requested declaratory relief would serve no purpose.

Construed generously, Aetna’s requested declaration that Plaintiffs submitted false attestations, initiated IDR for ineligible IDR items or services, and made material misrepresentations in their IDR submissions seeks relief grounded in its fraudulent misrepresentation claim. But if so, a declaratory judgment would simply be duplicative, serve no purpose, and must be dismissed. Courts in this Circuit consider the following six factors when determining whether to entertain a request for a declaratory judgment:

- (1) whether the declaratory judgment sought will serve a useful purpose in clarifying or settling the legal issues involved;
- (2) whether such a judgment would

finalize the controversy and offer relief from uncertainty; (3) whether the proposed remedy is being used merely for procedural fencing or a race to res judicata; (4) whether the use of a declaratory judgment would increase friction between sovereign legal systems or improperly encroach on the domain of a state or foreign court; (5) whether there is a better or more effective remedy; and (6) whether concerns for judicial efficiency and judicial economy favor declining to exercise jurisdiction.

Admiral Ins. Co. v. Niagara Transformer Corp., 57 F.4th 85, 96, 99–100 (2d Cir. 2023).

This relief would serve no purpose and is duplicative of Aetna’s fraudulent misrepresentation counterclaim, which makes identical allegations: that plaintiffs submitted false attestations regarding IDR eligibility and made material misrepresentations in their IDR submissions. Doc. 291 ¶¶ 39–48. And a declaratory judgment does not “serve a useful purpose” under *Admiral Ins.* when it asks the Court to repeat work it has already done. *Grey Wall Software, LLC v. AeroSimple LLC*, 3:22-cv-203, 2023 WL 5802621, at *4 (D. Conn. Sept. 7, 2023) (“A counterclaim seeking a declaratory judgment may be dismissed if it...does not broaden the scope of the dispute[.]”); *Colt’s Manufacturing Co. v. American Int’l Specialty Lines Insurance Co.*, 3:23-cv-01156, 2025 WL 306582, at *2 (D. Conn. Jan. 27, 2025) (same); *Intell. Capital Partner v. Institutional Credit Partners*, No. 08 Civ. 10580, 2009 WL 1974392, at *6 (S.D.N.Y. July 8, 2009) (plaintiff’s request for “declaratory relief would serve no useful purpose as the legal issues will be resolved by litigation of the [plaintiff’s] breach of contract claim.”); *Core-Mark Intern. Corp. v. Commonwealth Ins. Co.*, No. 05 Civ. 0183, 2006 WL 2501884, at *9 (S.D.N.Y. Aug. 30, 2006) (“Because this Court has already analyzed the parties’ rights under the Policy in connection with the breach of contract claim, a declaratory judgment on the same issue would be superfluous.”).

Here, Aetna’s request for a declaration merely retreads the same ground as its fraudulent misrepresentation claim. As in *Intellectual Capital* and *Core-Mark*, the “legal issues will be resolved by litigation of” its other claims. Thus, it should be dismissed.

C. Aetna’s requested declaratory relief improperly encroaches on the IDR process.

Aetna’s second request for declaratory relief, a declaration that the IDR awards are not binding, is a *de facto* request to vacate those awards. But Aetna conspicuously does not even cite the NSA provisions that make the awards binding and govern judicial review. *See* 42 U.S.C. 300gg-11(c)(5)(E)(i). Those provisions—not state law, *see supra* Section I.A, and certainly not free-floating authority under the DJA—govern when and how IDR awards can be vacated. This backdoor attempt by Aetna to circumvent the plain language of the NSA should be rejected.

D. Aetna’s request for an impermissible follow-the-law injunction should be rejected as well.

Aetna seeks a permanent injunction prohibiting Plaintiffs from “continuing to submit false attestations and initiating IDR for items or services that are not qualified for IDR, or from seeking to enforce awards entered on items and services that are not qualified for IDR.” Doc. 291 at ¶ 58. But this relief is merely a request that the Court command Plaintiffs to “follow the law” and “not commit fraud.” This is improper and its injunction claim should be dismissed.

“[A]n injunction must be more specific than a simple command that the defendant obey the law.” *Peregrine Myanmar Ltd. v. Segal*, 89 F.3d 41, 51 (2d Cir. 1996); *Burns v. Rovella*, 3:19-cv-553, 2020 WL 12863774, at *12 (D. Conn. Feb. 21, 2020) (same). But so-called “obey-the-law” or “follow-the-law” injunctions—that is, injunctions purporting to force a party to do something that the law already proscribes—are widely “disfavored.” *Town of Newburgh v. Newburgh EOM LLC*, 24-cv-5059, 2025 WL 934381, at *6 (S.D.N.Y. March 27, 2025); *Gilmore v. Schenectady County Sheriffs*, 9:17-1349, 2018 WL 794579, at *8 (N.D.N.Y. Feb. 8, 2018). Here, Aetna’s request that Plaintiffs should be prohibited from “continuing to submit false attestations and initiating IDR for items or services that are not qualified for IDR, or from seeking to enforce awards entered on items and services that are not qualified for IDR,” Doc. 291 at ¶ 58,

simply asks Plaintiffs to comply with its existing obligations under federal and state law to “not commit fraud.” *See Newburgh*, 2025 WL 934381, at *6. This is improper, and Aetna’s requested injunction raises exactly the same concerns that courts routinely raise as problematic (and decline to enter) with such injunctions.

In addition, as noted above, Aetna’s request is based on a flawed reading of the attestation made to initiate an IDR proceeding. Eligibility is a complex determination that often requires information from health plans. An injunction against filing ineligible claims would in many cases be impossible to comply with because eligibility is not clear at the time a provider must initiate IDR or forever relinquish its right to additional payment for the emergency, life-saving service that was furnished. For all these reasons, Aetna’s request for injunctive relief is improper and should be dismissed.

CONCLUSION

Plaintiffs respectfully request that the Court grant the Motion and dismiss Aetna’s Amended Counterclaims with prejudice.

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CERTIFICATE OF SERVICE

I certify that on September 23, 2025, a true and correct copy of the foregoing was served electronically on all counsel of record.

/s/ Adam T. Schramek

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