

**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

AETNA’S MOTION FOR SUMMARY JUDGMENT

Pursuant to Federal Rule of Civil Procedure 56, Defendants Aetna Health Inc., Aetna Life Insurance Co., and Aetna Health and Life Insurance Co. (collectively, “Aetna”) respectfully move the Court for summary judgment in their favor on all claims asserted by Plaintiffs in their Consolidated First Amended Complaint (ECF No. 109). As set forth in the accompanying Memorandum in Support of Motion for Summary Judgment, there is no genuine dispute as to any material fact on any of Plaintiffs’ claims, and Aetna is entitled to judgment as a matter of law.

First, the Court should reconsider and reverse its May 2025 interlocutory ruling that there is an implied private right of action under the NSA to enforce an IDR award. As the Court already noted, the analysis underpinning the prior ruling was incomplete, as the parties did not cite the NSA’s provision setting forth administrative remedies, including 42 U.S.C. § 300gg-22. Moreover, every other court to consider the issue, including the U.S. Court of Appeals for the Fifth Circuit in a June 2025 opinion, has held that there is no private right of action under the NSA to enforce an IDR award.

**ORAL ARGUMENT
REQUESTED**

Second, for similar reasons, the Court should reconsider and reverse its interlocutory ruling that Plaintiffs have an ERISA claim. As the Fifth Circuit also held in the same June 2025 opinion, providers lack standing to bring derivative ERISA claims to enforce IDR awards. ERISA's general enforcement provision, 29 U.S.C. § 1132(a)(1)(B), does not provide Plaintiffs with a cause of action to recover IDR payments, and Plaintiffs cannot use that provision to circumvent the NSA's regulatory enforcement regime.

Third, Plaintiffs' state-law CUTPA claim for alleged violations of the Connecticut Unfair Insurance Practices Act fails as well. State law cannot be used to circumvent the NSA's lack of a private right of action to enforce an IDR award. Moreover, CUIPA's unfair claim settlement practices provisions do not apply to the payment of IDR awards, and as third-party claimants, Plaintiffs are not proper CUTPA/CUIPA plaintiffs under Connecticut law. When the NSA's provisions setting forth administrative remedies are considered, Plaintiffs' CUTPA claim is preempted by federal law. Even if Plaintiffs could bring a CUTPA claim, there is no evidence that Aetna has violated CUIPA, and in particular, there is no evidence that Aetna acted in bad faith.

Fourth, in no event are Plaintiffs entitled to punitive damages. Plaintiffs' claim for punitive damages is premised on their having a viable CUTPA claim, and as the CUTPA claim fails, Plaintiffs' claim for punitive damages likewise fails. Alternatively, a punitive damages award requires evidence the defendant acted with "reckless indifference" to the plaintiff's rights, or in "intentional and wanton violation of those rights," and Plaintiffs have no such evidence against Aetna.

For these reasons, summary judgment should be granted in Aetna's favor on all of Plaintiffs' causes of action. This motion is supported by the accompanying Memorandum in

Support of Motion for Summary Judgment, the Statement of Undisputed Material Facts and exhibits thereto.

WHEREFORE, Aetna respectfully requests that the Court grant its Motion for Summary Judgment and dismiss with prejudice all of Plaintiffs' claims against Aetna.

Respectfully submitted, this the 19th of March, 2026.

Respectfully Submitted,

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AETNA HEALTH AND LIFE
INSURANCE CO.**

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was filed electronically on March 19, 2026. Notice of this filing will be sent by operation of the Court's electronic filing system to all parties indicated on the electronic filing receipt.

/s/ M. Katherine Strahan

M. Katherine Strahan

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

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AETNA’S MEMORANDUM IN SUPPORT OF ITS
MOTION FOR SUMMARY JUDGMENT

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Pursuant to Rule 56 of the Federal Rules of Civil Procedure, Defendants Aetna Health Inc., Aetna Life Insurance Co., and Aetna Health and Life Insurance Co. (collectively, “Aetna”) move for summary judgment on all claims that Plaintiffs assert in their “Consolidated First Amended Complaint” (“Compl.”) (ECF No. 109). Aetna respectfully shows as follows:

I. INTRODUCTION AND SUMMARY OF ARGUMENT

Plaintiffs are air ambulance companies owned by Global Medical Response (“GMR”), a for-profit, private-equity-owned air ambulance provider. Compl. (ECF No. 109), ¶¶ 3–8. This case is a dispute over the payment of Independent Dispute Resolution (“IDR”) awards issued under the No Surprises Act (“NSA”) for transports provided to members of health plans administered or insured by Aetna. *Id.* ¶ 1. Plaintiffs assert causes of action under the NSA, ERISA § 502(a)(1)(B), and the Connecticut Unfair Trade Practices Act (“CUTPA”) for Aetna’s alleged failure to timely pay IDR awards, seeking damages (including punitive damages) as well as “[e]quitable relief requiring [Aetna] to comply with ERISA and the NSA by paying all future IDR awards within thirty (30) days.” *Id.* at 8–15; Ruling on Mot. to Dismiss (“MTD Ruling”) (ECF No. 264) at 5–7, 10.¹ Plaintiffs’ claims fail as a matter of law.

More specifically, Plaintiffs allege that Aetna has “not invested in the compliance systems and personnel needed” to meet its statutory obligation “to pay IDR awards within thirty days of each IDR determination.” MTD Ruling (ECF No. 264) at 6. The evidence conclusively establishes otherwise. Aetna’s policies are designed so that Aetna complies with the NSA’s timing for awards. And Aetna has invested heavily in employees whose only job is to deal with NSA-related claims and in developing technology to assist the employees’ work. The problem does not lie with Aetna; it lies with the tsunami of IDR disputes that Plaintiffs and other providers have initiated against

¹ Plaintiffs also brought a claim under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), but the Court correctly dismissed this claim. *See* MTD Ruling (ECF No. 264) at 10.

Aetna, Cigna, and other payors. Plaintiffs know full well that the sheer volume of disputes is the source of their complaints—because overwhelming the IDR system is part of their design. Plaintiffs and their contemporaries are trying to create [REDACTED] so that they pay providers' inflated claims without question or dispute. For example, Plaintiffs could help alleviate the backlog of IDR volume by bundling their air ambulance mileage and transport claims together.

[REDACTED]

[REDACTED]

Plaintiffs' allegations are not only factually groundless, they are legally baseless as well:

- (1) The Court should reconsider and reverse its May 2025 interlocutory ruling that there is an implied private right of action under the NSA to enforce an IDR award.
 - As the Court already noted, the analysis underpinning the prior ruling was incomplete, as the parties did not cite the NSA's provision setting forth administrative remedies, including 42 U.S.C. § 300gg-22.
 - Every other court to consider the issue, including the U.S. Court of Appeals for the Fifth Circuit in a June 2025 opinion, has held that there is *no* private right of action under the NSA to enforce an IDR award.
- (2) The Court should also reconsider and reverse its interlocutory ruling that Plaintiffs have an ERISA claim.
 - As the Fifth Circuit also held in the same June 2025 opinion, providers lack standing to bring derivative ERISA claims to enforce IDR awards.
 - ERISA's general enforcement provision, 29 U.S.C. § 1132(a)(1)(B), does not provide Plaintiffs with a cause of action to recover IDR payments.
 - Plaintiffs cannot use 29 U.S.C. § 1132(a)(1)(B) to circumvent the NSA's regulatory enforcement regime.
- (3) Plaintiffs' CUTPA claim for alleged violations of the Connecticut Unfair Insurance Practices Act ("CUIPA") fails as well.
 - State law cannot be used to circumvent the NSA's lack of a private right of action to enforce an IDR award.
 - When the NSA's provisions setting forth administrative remedies are considered, federal law preempts Plaintiffs' CUTPA claim.
 - CUIPA's unfair settlement practices provisions do not apply to the payment of IDR awards under the terms of the statute.

- As third-party claimants, Plaintiffs are not proper CUTPA/CUIPA plaintiffs under Connecticut law.
 - Even if Plaintiffs could bring a CUTPA claim, there is no evidence that Aetna has violated CUIPA. In particular, there is no evidence that Aetna acted in bad faith.
- (4) In no event are Plaintiffs entitled to punitive damages.
- Plaintiffs' claim for punitive damages is premised on their having a viable CUTPA claim. As the CUTPA claim fails, Plaintiffs' claim for punitive damages likewise fails.
 - Alternatively, a punitive damages award requires evidence the defendant acted with "reckless indifference" to the plaintiff's rights, or in "intentional and wanton violation of those rights." Plaintiffs have no such evidence against Aetna.

Thus, summary judgment should be granted in Aetna's favor on all of Plaintiffs' causes of action.²

II. BACKGROUND

A. The NSA's Regulatory Scheme

1. The IDR process and limited judicial review

"The No Surprises Act is intended to protect patients from 'surprise' medical bills by limiting the amount an insured patient will pay for emergency services furnished by an out-of-network provider." *Tex. Med. Ass'n v. U.S. Dep't of Health & Human Servs.*, 110 F.4th 762, 767 (5th Cir. 2024) (citation modified). "The Act also limits the amount an insured patient will pay for certain non-emergency services furnished by an out-of-network provider at an in-network facility." *Id.* at 767-68 (citation modified). "Out-of-network providers are those who have not entered contracts for payment" with payers like Aetna; in-network providers are those who agree to contracts with rates for services provided to members of the payers' network. *Id.* at 768. Certain out-of-network air ambulance services are covered under the NSA. *See* 42 U.S.C. § 300gg-112.

² Aetna is asserting counterclaims arising out of the same IDR awards that Plaintiffs have put into issue based on the Court's prior rulings in this case. Aetna does not move on its counterclaims. Nor does Aetna move on all of its defenses, including that Air Med Response LLC is not a proper party.

The NSA sets forth a detailed process for providers such as Plaintiffs and payers such as Aetna to resolve payment disputes arising from surprise medical bills covered by the NSA. *See* 42 U.S.C. §§ 300gg-111, 300gg-112. Beyond eliminating the ability to “balance bill” patients, the process’s primary goal is to “tether payment rates for surprise out-of-network bills directly to market-based prices, curbing cost growth relative to the status quo.” House Committee on Education and Labor, Ban Surprise Billing Act, H.R. Rep. No. 116-615, at 57 (2020).

Under the NSA’s framework, payers must first issue an initial payment or notice of denial of payment to a provider within 30 days after the provider submits a bill for an out-of-network service. 42 U.S.C. § 300gg-111(a)(1)(C)(iv), (b)(1)(C). If the provider disagrees with the payer’s payment determination, the provider may initiate a 30-day open-negotiation period with the payer over the claim. *Id.* § 300gg-111(c)(1)(A). If the parties cannot resolve the payment dispute through negotiation, the parties may then proceed under the NSA’s IDR process. *Id.* § 300gg-111(c)(1)(B). Either party may invoke the IDR process. *Id.* § 300gg-111(c)(2)(B).

The parties must agree upon an IDR entity not later than the last day of the 30 business day period “following the date of the initiation of the [IDR] process.” *Id.* § 300gg-111(c)(4)(F). If the parties cannot agree on an IDR entity, the Departments³ must select an IDR entity. *Id.* § 300gg-111(c)(4)(F)(ii). IDR arbitration is “baseball style,” meaning the “provider and insurer [or payer] each submits a proposed payment amount and explanation to the arbitrator,” and the arbitrator “must select one of the two proposed payment amounts.” *Tex. Med. Ass’n v. U.S. Dep’t of Health & Human Servs.*, 587 F. Supp. 3d 528, 534 (E.D. Tex. 2022). “Not later than 30 days after the date of selection of the certified IDR entity” the entity must notify the parties of its determination. 42 U.S.C. § 300gg-111(c)(5)(A)(ii). Payment of an IDR award shall be made “not later than 30 days

³ “Departments” refers to the Departments of Health and Human Services (“HHS”), Labor, and Treasury.

after the date on which such determination is made.” *Id.* § 300gg-111(c)(6).⁴

With limited exceptions, IDR awards “shall be binding” and “shall not be subject to judicial review.” *Id.* §300gg-111(c)(5)(E)(i) (“A determination of a certified IDR entity under subparagraph (A)— (I) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and (ii) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of [the Federal Arbitration Act (“FAA”)].”).

Section 10(a)(1)-(4) of the FAA allows review where: (1) the award was procured by corruption, fraud, or undue means; (2) there was evident partiality or corruption in the arbitrators, or either of them; (3) the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy, or of any other misbehavior by which the rights of any party have been prejudiced; or (4) the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made. 9 U.S.C. § 10(a)(1)–(4).

2. The regulatory enforcement regime

While the NSA strictly limits judicial review, it is not a toothless statute. Congress granted broad enforcement powers to HHS. *See* 42 U.S.C. § 300gg-22. The Secretary of HHS has enforcement authority “with respect to individual health insurance coverage or group health plans that are non-Federal governmental plans.” 42 U.S.C. § 300gg-22(b)(1)(B); *see* 29 U.S.C. § 1185e(c)(2) (delegating authority over the IDR process to the Secretary). This authority includes

⁴ Plaintiffs demand interest on IDR awards paid outside the 30-day window. *See, e.g.*, Compl. (ECF No. 109) at ¶¶ 1, 22, 25 & p.14. However, section 300gg-112(b)(6) does not contain any reference to “interest,” nor does it provide any method for calculating interest for a failure to meet the 30-day payment requirement. Additionally, an administrative penalty prescribed by 42 U.S.C. § 300gg-22(b)(2)(C)(i) which may be assessed by CMS is a flat dollar amount. This strongly suggests that Congress did not intend to allow for interest (necessarily predicated on the amount of the underlying IDR award liability) to remedy any failure to pay an IDR award within 30 days. In any event, questions of interest on late-paid IDR awards are for CMS to resolve, not the courts. *See* § IV.A, *infra*.

“empower[ing] HHS to assess penalties against insurers for failure to comply with the NSA.” *Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 277 (5th Cir. 2025) (“*HCSC*”) (citing 42 U.S.C. § 300gg-22(b)(2)(A); 45 C.F.R. § 150.301 *et seq.*).⁵

Importantly, ‘CMS, a federal agency within HHS, assumed authority over the IDR enforcement process and has entered into collaborative enforcement agreements with state agencies.’ *E. Coast Adv. Plastic Surgery, LLC v. Cigna Health & Life Ins. Co.*, No. 25 CIV. 1686 (PAE), 2025 WL 2371537, at *17 n.11 (S.D.N.Y. Aug. 14, 2025). In advance of the NSA’s effective date, for example, CMS sent a letter to the Governor of Connecticut and Commissioners from the Connecticut Insurance Department and the Department of Public Health, informing them that “*CMS will directly enforce” the NSA “in Connecticut with respect to health insurance issuers, health care providers, facilities, and providers of air ambulance services.*” Aetna’s Local Rule 56(a)1 Statement of Undisputed Material Facts (“SOF”) ¶ 1 (emphasis added). In particular, the letter advised that “CMS will enforce the outcome of the federal independent dispute resolution process for such cases in Connecticut under section 2799A-2(b) of the PHS Act.” SOF ¶ 2.

Also of significance, CMS has acted on its delegated IDR enforcement authority “by soliciting provider complaints and compelling payors to pay IDR awards where appropriate.” In fact, “CMS maintains an online portal through which providers may submit complaints regarding the IDR process.” *HCSC*, 140 F.4th at 277 (footnote omitted).⁶

B. Aetna has devoted significant resources to complying with the NSA process, which has been marked by an unanticipated and overwhelming volume of IDR disputes

Aetna has instituted internal policies and procedures to ensure its compliance with the

⁵ Congress is plainly monitoring the administrative enforcement mechanism, as bipartisan legislation was introduced on July 23, 2025, to increase the administrative penalties for violations of the NSA. *See No Surprises Act Enforcement Act*, S.2420, 119th Cong. (2025), *available at* <https://www.congress.gov/>.

⁶ *See* Providers: submit a billing complaint, CMS.gov, <https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint> (last visited Feb. 24, 2026).

NSA, including regarding the timing of payment of IDR awards. SOF ¶ 3. When the NSA took effect, Aetna’s Federal NSA team had approximately 40 colleagues supporting open negotiations, 11 supporting IDR, and 3 project managers. SOF ¶ 8. That said, “[n]o one person at Aetna is responsible for th[e] entire process. Rather, the workflow is coordinated across multiple teams and departments, involving hundreds of different employees at Aetna.” SOF ¶ 7.

As Aetna’s corporate representative, Katherine O’Brien, testified in her June 27, 2025, deposition,⁷ Aetna “strive[s] for 100 percent accuracy 100 percent of the time.” SOF ¶ 6. Aetna tries to do its “absolute best to be compliant with everything, all the timelines and procedures, 100 percent of the time.” *Id.* Achieving that goal, however, has required Aetna to rapidly and substantially expand its operations to meet the demands of the IDR process.

The NSA’s implementation had “a chaotic rollout” at the federal level that “created instability” in the IDR process. SOF ¶ 9. The federal IDR system was quickly overwhelmed with disputes—in the first eight months alone, “nearly 164,000 cases were filed,” compared with a preliminary projection of only 17,500 for all of 2022. *See* Rosso, Ryan J. & Wen W. Shen (Nov. 26, 2025), *No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process Data Analysis for 2024* (CRS Report No. R48738), *available at* <https://www.congress.gov/crs-product/R48738> (“Rosso, CRS Report No. R48738”) at 1 (“In 2022 and 2023, the IDR process was marked by delays or disruptions, including periods of IDR portal suspension in response to several court decisions arising from legal challenges against agency rules implementing the process.”)

As a result, IDR entities (or “IDREs”) fell “far behind in processing decisions.” SOF ¶ 10. Additionally, there have been “multiple disruptions in the process since implementation.” *Id.* These disruptions included the federal IDR portal shutting down for months in 2023, during which

⁷ Plaintiffs deposed Ms. O’Brien on November 11, 2024, June 27, 2025, and March 12, 2026. She was designated as Aetna’s corporate representative for the June 27, 2025 and March 12, 2026 depositions.

initiating parties accumulated volume. SOF ¶ 11. “The unanticipated volume of disputes” and the “temporary shutdown of the IDR portal early on in the process created a snowball effect introducing instability in the IDR process and resulting in substantial backlogs and uncertainty for providers and insurers.” SOF ¶ 12.

Critically, the surge was driven entirely by providers. Rosso, CRS Report No. R48851 (“Providers have initiated nearly all disputes. . . .”). Before the IDR portal reopened in December 2023, Aetna received IDR determinations for [REDACTED] SOF ¶¶ 13–14. After the portal reopened, Aetna received determinations for [REDACTED], an [REDACTED]. *Id.* Because providers unilaterally control the initiation of IDR disputes, there was no practical way for Aetna to anticipate the volume of disputes that would be filed after the federal IDR portal re-opened, and the staffing levels needed to process them. SOF ¶ 15. Moreover, Aetna’s incoming volume of IDR disputes “grew exponentially” after the federal IDR portal reopened; Aetna received 17,788 applications between October 2 and November 3, 2023. SOF ¶ 16. IDR disputes quadrupled within months after the federal portal reopened. SOF ¶ 17.

Being proactive, Aetna requested reports from CMS to ensure it had records of all determined cases, sent CMS detailed breakdowns of its inventory when volume surged, reported that its team was “working overtime and on weekends” to meet turnaround deadlines, and submitted a formal proposal to regulate the volume of disputes received by non-initiating parties. SOF ¶ 19. As the spike in volume continued, [REDACTED] Aetna “engaged in having the conversation with [REDACTED], knowing that if [REDACTED] [REDACTED] and engaged in [REDACTED] [REDACTED]. SOF ¶¶ 20–21. Aetna then [REDACTED] [REDACTED] to address the surge, and retains the ability to scale up and add additional personnel if needed. SOF ¶ 22. Additionally, Aetna’s [REDACTED]

—a number that does not include employees working for other departments that . SOF ¶ 23. In total, Aetna’s Federal NSA team currently has . SOF ¶ 24.

Aetna’s Federal NSA team does not itself “issue payment on any claim”; rather it processes IDR disputes in Aetna’s tracking system, and if additional payment is due to the provider, the claim “is routed to a rework claim processor to have that claim reworked to pay out that additional amount.” SOF ¶¶ 25–26. Aetna’s claims rework team has , with . SOF ¶ 27. Additional team members can be trained as needed . SOF ¶ 28. Aetna treats IDR claims as “priority claims for handling,” with the rework team “always trying to do their best to get it done as quickly as possible.” SOF ¶ 29.

Aetna is also “using wherever [it] can to ensure” that NSA claims “are processed as quickly as possible.” SOF ¶ 30. For example, Aetna has invested in developing a to “gain efficiencies” in processing IDR claims. SOF ¶ 31. Further, consistent with CMS directives, Aetna set up and maintains a dedicated email address to receive IDR awards, and it raised concerns with CMS when IDREs used incorrect addresses for Aetna. SOF ¶ 32; *see* Requirements Related to Surprise Billing, 87 Fed. Reg. 52,618, 52,619 (Aug. 26, 2022) (“The plan or issuer must provide contact information, including a telephone number and email address, for the appropriate office or person for the provider, facility, or provider of air ambulance services to contact to initiate open negotiation for purposes of determining an amount of payment (with the amount including cost sharing) for the item or service.”).

In addition to “ ” for IDR processing, Aetna tightened its internal turnaround goal for processing IDR awards through its claim system from . SOF ¶¶ 33–34. Aetna proactively tightened this goal because it “wanted to ensure we got the claim out as quickly as possible because we wanted to tighten up that

turnaround time.” SOF ¶ 34. As of December 2, 2025, the oldest IDR claim with Aetna’s rework team was from November 18, 2025—well within the 30-day statutory deadline. SOF ¶ 35.

C. The IDR process itself, including how Plaintiffs choose to submit disputes, cause the problems for which Plaintiffs blame Aetna

While all NSA stakeholders have been impacted by the instability in IDR volume and the IDR process itself—thereby, causing delays by providers, IDREs and payers in virtually every aspect of the IDR process—Plaintiffs complain about that impact on the payments of their IDR awards within 30 days. Aetna does not control the amount of IDR initiations it receives. *See* SOF ¶ 15. Only providers have agency in that respect. *Id.* In particular, providers can choose to reduce the burden on the IDR system by bundling (or “batching”) their mileage charges and transport charges into a single IDR claim (i.e., “trip level”) rather than two separate IDR claims. SOF ¶ 36.

[REDACTED] SOF ¶¶ 38–39. [REDACTED]
[REDACTED]. *See* SOF ¶ 42. An analysis of data for 2023 and 2024 shows that Plaintiffs [REDACTED]
[REDACTED], while all other providers [REDACTED]
[REDACTED]. *Id.* [REDACTED]
[REDACTED]. *See* SOF ¶ 41. In a December 2023 internal email, GMR’s Vice President of Managed Care, [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Id. (emphasis added).

Aetna also does not control how IDR entities (“IDREs”) administer disputes. “Since the

IDR process became operational in April 2022 and through 2024, its utilization has exceeded initial expectations, with over 2 million initiated disputes.” Rosso, Ryan J. (Feb. 10, 2026), *An Analysis of No Surprises Act (NSA) Independent Dispute Resolution (IDR) Emergency Service Outcomes Relative to In-Network Rates* (CRS Report No. R48851), available at <https://www.congress.gov/crs-product/R48851> (“Rosso, CRS Report No. R48851”). “[T]he volume of disputes filed through the IDR process has been well beyond” the expectations of the federal government and everyone else, “and has continued to increase.” SOF ¶ 45. “When it first opened in 2022, the Federal IDR portal received an influx of disputes nearly 14 times greater than what was initially projected—and the annual volume is now more than 100 times the initial projection.”⁸

“During the initial years of IDR implementation, the program struggled to keep pace with the unexpectedly high number of dispute initiations.” *Id.* at 2. “In the first year of implementation, certified IDR entities reached a payment determination in only 8% of all disputes submitted. While this percentage improved over time, at the start of 2025, more than 600,000 disputes still awaited determinations. Additionally, providers and payers faced significant delays in dispute resolution, with 69% of open disputes being more than 30 business days old at the start of 2025.” *Id.*

At times, IDREs hold cases for months or even years, “and then start making decisions on them all at one time.” SOF ¶ 45. In one instance, a single IDRE submitted over 3,500 requests within a 2-day time period and more than 2,700 fee invoices to Aetna on a single day in June 2024. SOF ¶ 46. IDREs have also issued IDR awards without the claim number—which Aetna needs to coordinate potential payment of the awards. SOF ¶ 47. IDREs have even sent awards to the wrong Aetna email address, rather than the NSA-required, dedicated email address that Aetna has set up

⁸ Fact Sheet: Clearing the Independent Dispute Resolution Backlog (Sept. 19, 2025) at 2, available at <https://www.cms.gov/files/document/fact-sheet-clearing-independent-dispute-resolution-backlog.pdf> (“2025 Fact Sheet”).

to receive IDR awards from IDREs. SOF ¶ 48.

CMS’s own systems have repeatedly contributed to the dysfunction at issue. The CMS portal has, at times, malfunctioned and prevented submission of dispute responses. SOF ¶ 49. It has also generated email volumes so high that Microsoft rejected more than 1,700 messages, placing Aetna at risk of missing critical communications. SOF ¶ 50. In addition, the portal has blocked uploads for final offers and application responses, resulting in complete work stoppages. SOF ¶ 51. Importantly, however, when the IDR system does not function as Congress intended, Plaintiffs’ remedy is exclusively to seek recourse through CMS, not the courts. *See* 42 U.S.C. §§ 300gg-22(b)(1)(B), 300gg-111(c)(5)(E)(i).

III. SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate where “the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” Fed. R. Civ. P. 56(a). The movant “bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of [the record] which it believes demonstrate the absence of a genuine issue of material fact.” *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). Once the moving party has met its burden, the non-moving party must then “come forward with specific facts showing that there is a genuine issue for trial.” *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586–87 (1986) (citation modified).

“A party cannot overcome summary judgment by relying on mere speculation or conjecture as to the true nature of the facts because conclusory allegations or denials are insufficient to create a genuine dispute of material fact.” *Jones v. Int’l Union of Operating Eng’rs*, 671 F. App’x 10, 11 (2d Cir. 2016) (citation modified). Further, when an issue presented for summary judgment is purely a matter of law, no burden of proof is placed upon the movant. *Sequa Corp. & Affiliates v. United States*, 350 F. Supp. 2d 447, 449 (S.D.N.Y. 2004) (“[N]o burden of proof is applicable, as

statutory interpretation is purely a legal question for the Court.”), *aff’d*, 437 F.3d 236 (2d Cir. 2006) (per curiam). By contrast, a plaintiff suing under an implied right of action bears the burden to show the existence of such a right. *Olmsted v. Pruco Life Ins. Co. of N.J.*, 283 F.3d 429, 433 (2d Cir. 2002) (“A strong presumption that Congress did not intend a private right of action places a heavy burden on the plaintiffs to demonstrate otherwise.”). Plaintiffs cannot meet their burden.

IV. ARGUMENT AND AUTHORITIES

A. **Aetna is entitled to summary judgment on Plaintiffs’ NSA claim because there is no private right of action to enforce an IDR award**

In deciding Aetna’s motion to dismiss, the Court ruled on May 14, 2025, that the NSA does not “expressly create a private right of action to enforce [IDR] payment requirements,”⁹ but that the NSA does create an implied “private cause of action to enforce IDR awards.” MTD Ruling (ECF No. 264) at 13–18. Aetna submits that the Court should reconsider the latter interlocutory ruling, and then hold—like the Fifth Circuit and every other court to consider the issue since—that the NSA does not create an implied right of action to enforce an IDR award.

“The doctrine of law of the case is discretionary and does not limit a court’s power to reconsider its own decisions prior to final judgment.” *Maraschiello v. City of Buffalo Police Dep’t*, 709 F.3d 87, 97 (2d Cir. 2013) (citation modified). Indeed, a court need not adhere to a prior ruling in the case when “cogent and compelling reasons militate otherwise.” *United States v. Quintieri*, 306 F.3d 1217, 1225 (2d Cir. 2002) (citation modified). “Compelling reasons to revisit a decision include an intervening change in law, availability of new evidence, or the need to correct a clear error or prevent manifest injustice.” *Doe v. E. Lyme Bd. of Educ.*, 962 F.3d 649, 662–63 (2d Cir.

⁹ Courts continue to uniformly agree that the NSA “contains no express right of action to *enforce or confirm* an IDR award.” *Jeffrey Farkas, M.D., LLC v. Horizon Blue Cross Blue Shield of N.J.*, 790 F. Supp. 3d 129, 137 (E.D.N.Y. 2025) (quotation omitted); *see T.V. Seshan M.D., P.C. v. Blue Cross Blue Shield Ass’n*, No. 25-CV-1255 (CS), 2025 WL 3496382, at *7 (S.D.N.Y. Dec. 5, 2025) (same).

2020) (citation modified). Two such cogent and compelling reasons exist here to revisit the implied private right of action decision.

First, in regard to its May 2025 ruling, the Court has already noted that “[t]he parties did not address 42 U.S.C. § 300gg-22 in their briefs.” *See* MTD Ruling (ECF No. 264) at 16 n.6 (“Because the parties do not address [42 U.S.C. § 300gg-22], I decline to consider whether this provision . . . bears on the availability of a private right of action to enforce this provision.”). In this motion for summary judgment, however, Aetna *is* squarely addressing 42 U.S.C. § 300gg-22 and the robust system of administrative enforcement that Congress devised under the NSA.

Second, each court to subsequently address the issue, including the Fifth Circuit in a June 2025 opinion that expressly addressed this Court’s May 2025 ruling, has rejected attempts to judicially enforce IDR awards rather than through the administrative agency process that Congress provided. The Fifth Circuit relied on 42 U.S.C. § 300gg-22 in finding statutory evidence that Congress opted to provide an administrative remedy rather than a private cause of action, and as this Court noted in September 2025, “[i]t is possible [the Court] would have reached a different conclusion had that issue [of § 300gg-22] been briefed.” *See* Order, *Guardian Flight LLC v. Aetna Life Ins. Co.*, No. 24-cv-680 (MPS) (D. Conn. Sept. 30, 2025), Dkt. No. 295. **This** is the opportunity for the Court to reach that different conclusion.¹⁰ And the corollary to such a conclusion, as Aetna explains below, is that Plaintiffs’ ERISA and CUTPA claims fail as well.

¹⁰ Courts have “the authority and obligation to change course regarding [their] opinions if the law so requires.” *Diagnostic Affiliates of Ne. Hou, LLC v. Aetna, Inc.*, 654 F. Supp. 3d 595, 608 (S.D. Tex. 2023). In *Diagnostic Affiliates*, for example, the district court entered an interlocutory ruling, “as a matter of first impression, that the FFCRA and CARES Act did create a private right of action for Covid-19 test providers.” *Id.* at 608. Subsequently, however, three sister courts addressed the same question and came to the opposite conclusion. *Id.* The *Diagnostic Affiliates* court then considered the issue “anew, with the benefit of the reasoning of the intervening opinions,” disavowed its prior ruling, held “that the FFCRA/CARES Act does not carry with it an implied private cause of action to enforce its terms,” and granted a motion to dismiss the FFCRA/CARES Act claim. *Id.* at 611.

1. The NSA’s administrative remedies are exclusive

The Supreme Court has long held that congressional intent is the primary determinant of whether a private right of action exists. *See, e.g., Touche Ross & Co. v. Redington*, 442 U.S. 560, 568, 575–76 (1979). “Like substantive federal law itself, private rights of action to enforce federal law must be created by Congress.” *Alexander v. Sandoval*, 532 U.S. 275, 286–87 (2001). “The judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy. Statutory intent on this latter point is determinative.” *Id.* (internal citation omitted). “Without it, a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute.” *Id.* Here, there is simply no direct expression by Congress of any intent to provide a private right of action or private remedy under the NSA to out-of-network providers, such as Plaintiffs, to enforce an IDR award.

When Congress enacted the NSA, it permitted providers to recover payment directly from payors, which is a “new public right” as opposed to a “private right.” *Haller v. U.S. Dep’t of Health & Human Servs.*, 621 F. Supp. 3d 343, 354–55 (E.D.N.Y. 2022), *aff’d in part, vacated on other grounds and remanded*, No. 22-3054, 2024 WL 290440 (2d Cir. Jan. 23, 2024). As such, “[o]ut-of-network providers’ claims against insurers do not arise under state common law, but instead depend upon the will of Congress, and flow from a federal statutory scheme. Indeed, a provider’s right to recover payment directly from [a payor] is completely dependent upon the adjudication of a claim created by the [NSA].” *Id.* (citation modified). The NSA does not compel providers to use the IDR process to resolve their claims for recovery against payors. Instead, the NSA creates the provider’s right to recover payments directly from the payor. *Id.* at 353–54.

In doing so, Congress created extensive administrative enforcement remedies, including federal agency oversight over the IDR process, federal agency authority to compel payment and

penalize non-compliant companies, and state oversight of payors. *See* 42 U.S.C. § 300gg-22; *see also HCSC*, 140 F.4th at 277 (explaining administrative remedies under NSA); *E. Coast Adv. Plastic Surgery, LLC*, 2025 WL 2371537, at *17 & n.11; (same); *Mod. Orthopaedics of N.J. v. Premera Blue Cross*, No 2:25-cv-01087 (BRM) (JSA), 2025 WL 3063648, at *9–12 (D.N.J. Nov. 3, 2025) (“Congress . . . create[d] a robust system of administrative enforcement and therefore this Court has no jurisdiction to confirm [the provider’s] award.”).

“[T]he mere presence of ‘agency enforcement creates a strong presumption against implied private rights of action’” *Mod. Orthopaedics of N.J.*, 2025 WL 3063648, at *9 (quoting *Wisniewski v. Rodale, Inc.*, 510 F.3d 294, 305 (3d Cir. 2007)). “This presumption cannot be overcome, because the plain language of the statute limited ‘judicial review’ other than to vacate awards gained through misconduct.” *Id.* (quoting 42 U.S.C. § 300gg-111(c)(5)(E)). “[A]n implied right of action is unavailable where Congress has provided an alternative method of enforcing that provision and where the ‘nature of the relevant provision’s text’ is ‘judicially unadministrable.’” *E. Coast Adv. Plastic Surgery, LLC*, 2025 WL 2371537, at *17 (citation modified); *see FHMC LLC v. Blue Cross & Blue Shield of Az. Inc.*, No. 23 Civ. 876, 2024 WL 1461989, at *3 (D. Ariz. Apr. 4, 2024) (holding that because providers have the option to notify CMS “about issues with the IDR process,” and report a payor “to CMS for their violations of the NSA,” including a payor’s “alleged failure to comply with the adjudicatory time limits” specified in the NSA, [t]here is no implied private right of action in such circumstances” (citation modified)).

Because the NSA provides an administrative remedy, Congress did not intend to imply a judicial remedy as well. *See Murphy Med. Assocs., LLC v. Yale Univ.*, 120 F.4th 1107, 1112 (2d Cir. 2024) (per curiam) (holding that a statute does not create a private right of action when its text and structure show that “Congress intended for agency enforcement to be the exclusive remedy”).

2. The Fifth Circuit and every other court to address the issue has held that there is no private right of action to enforce an IDR award

On June 12, 2025, the Fifth Circuit observed in *HCSC* that the NSA expressly bars judicial review except for cases described in section 10(a) of the FAA, and that this “bar on judicial review strongly suggests Congress did not insert a private right of action into the statute.” 140 F.4th at 275. The *HCSC* plaintiffs argued that they merely wanted judicial enforcement, not judicial review, but the Fifth Circuit found “[t]hat is a distinction without a difference.” *Id.* Congress knew how to create a private right of action if it had so desired, “but took a different tack: it empowered HHS to assess penalties against [payors] for failure to comply with the NSA.” *Id.* at 277 (citing 42 U.S.C. § 300gg-22(b)(2)(A); 45 C.F.R. § 150.301 *et seq.*).

Thus, the Fifth Circuit held that the “inference from the NSA’s broader structure” is “plain.” 140 F.4th at 275. “Congress’s policy choice [was] to enforce the statute through administrative penalties, not a private right of action.” *Id.*; *see id.* at 276 n.5 (“We follow the NSA’s plain text and structure in concluding Congress created no general private right of action in the NSA.”). The Fifth Circuit’s decision is especially salient given that the *HCSC* providers petitioned the U.S. Supreme Court to review the Fifth Circuit’s holding that IDR determinations lack judicial enforcement. On January 12, 2026, the Supreme Court denied certiorari. *See Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, No. 25-441, 2026 WL 79855 (U.S. Jan. 12, 2026).

Every court to have addressed the issue since *HCSC*, including in the Eastern District and Southern District of New York, has agreed with the Fifth Circuit and held that there is no private right of action to enforce IDR awards. *See Conn. Gen. Life Ins. Co. v. E. Coast Adv. Plastic Surgery, LLC*, No. 25 CIV. 1686 (PAE), 2026 WL 518442, at *7 (S.D.N.Y. Feb. 24, 2026) (observing that “[t]he Court has already found, joining the substantial majority of courts to consider the issue, that the NSA does not contain an express or implied right of action,” and dismissing NSA counterclaim); *T.V. Seshan M.D., P.C.*, 2025 WL 3496382, at *9 (same); *Jeffrey Farkas, M.D.*,

LLC, 790 F. Supp. 3d at 137 (same).¹¹

“[I]t is not absurd for Congress to shield the IDR processes from judicial review while leaving the courts an oversight role to prevent gross misconduct [under Section 10 of the FAA].” *Mod. Orthopaedics of N.J.*, 2025 WL 3063648, at *13; *see Riccio v. Sentry Credit, Inc.*, 954 F.3d 582, 588 (3d Cir. 2020) (“As long as Congress could have any conceivable justification for a result—even if the result carries negative consequences—that result cannot be absurd.”). Because Congress chose not to create a private right of action when it passed the NSA, this Court should dismiss Plaintiffs’ NSA claim with prejudice. And Plaintiffs’ ERISA § 502(a)(1)(B) and CUTPA claims fall apart at the seams for similar reasons.

B. Plaintiffs cannot use ERISA to end-run the NSA’s exclusive administrative remedies

1. As the Fifth Circuit held in *HCSC*, Plaintiffs lack Article III standing

“There is no ERISA exception to Article III.” *Thole v. U.S. Bank N.A.*, 590 U.S. 538, 547 (2020). To demonstrate standing for their derivative ERISA § 502(a)(1)(B) claim, Plaintiffs must show that the “beneficiaries for whom they are assignees suffered a concrete injury, had those beneficiaries brought the claim themselves.” *HCSC*, 140 F.4th at 278. In its ruling on Aetna’s motion to dismiss, this Court found that “Plaintiffs’ ERISA claim is based on Defendants’ [alleged] improper denial of payment and benefits for out-of-network air ambulance services,” and Plaintiffs

¹¹ See also *Zahariev v. Gower Fam. Dentistry, LLC*, No. 9:25-2801-RMG, 2026 WL 457751, at *2 (D.S.C. Feb. 18, 2026); *SpecialtyCare, Inc. v. MedCost, LLC*, No. 2025-0011-DH, 2026 WL 432302, at *1 (Del. Ch. Feb. 16, 2026); *SpecialtyCare Inc. v. Meritain Health, Inc.*, No. CV 25-198-MN, 2026 WL 353259, at *3 (D. Del. Feb. 9, 2026), *report and recommendation adopted*, 2026 WL 745341 (D. Del. Mar. 17, 2026); *Worldwide Aircraft Servs., Inc. v. Aetna Life Ins. Co.*, No. 8:25-CV-2231-KKM-TGW, 2026 WL 291011, at *3 (M.D. Fla. Feb. 4, 2026); *GuardION Med., LLC v. MedCost Benefit Servs., LLC*, No. 5:25-CV-223 (MTT), 2026 WL 205961, at *1 (M.D. Ga. Jan. 27, 2026); *SpecialtyCare Inc. v. Aetna, Inc.*, No. 1:25-CV-224, 2025 WL 3719227, at *2 (M.D. Pa. Dec. 23, 2025); *Worldwide Aircraft Servs. Inc. v. Freedom Life Ins. Co. of Am.*, No. 8:25-CV-01158-WFJ-AEP, 2025 WL 3551397, at *3 (M.D. Fla. Dec. 11, 2025); *Mitchell F. Reiter MD PC v. Horizon Blue Cross Blue Shield of N.J.*, No. 2:25-CV-12526 (WJM), 2025 WL 3514300, at *5 (D.N.J. Dec. 8, 2025); *Interventional Pain Mgmt. v. Horizon Blue Cross Blue Shield of N.J.*, No. CV 25-12032 (SRC), 2025 WL 3470569, at *8 (D.N.J. Dec. 3, 2025); *Worldwide Aircraft Servs., Inc. v. United Healthcare*, No. 8:24-CV-2527-TPB-LSG, 2025 WL 3312169, at *2 (M.D. Fla. Nov. 28, 2025); *Mod. Orthopaedics of N.J.*, 2025 WL 3063648, at *9–14.

have derivative standing because their “patient-assignors are still owed these benefits under the plans for which they contracted, and their denial remains a concrete injury,” notwithstanding that the NSA shields the patients from any meaningful harm associated with IDR award payments. MTD Ruling (ECF No. 264) at 20–23 (cleaned up). However, the Fifth Circuit subsequently held in *HCSC* that providers like Plaintiffs **lack** derivative ERISA standing in these very circumstances. *HCSC* provides good reason for the Court to reconsider and reverse its standing decision.¹²

Like Plaintiffs, the providers in *HCSC* claimed that they had derivative standing because “the beneficiaries suffered concrete injuries when HCSC refused to provide them with out-of-network coverage benefits under the parties’ contracts.” 140 F.4th at 278. The Fifth Circuit disagreed, because “[t]he NSA shields the beneficiaries from liability for any out-of-network coverage costs, so the beneficiaries have not suffered—and could not suffer—any concrete injury from HCSC’s failure to cover medical bills that fall within the scope of the NSA.” *Id.* “Further, the beneficiaries had nothing to gain or lose in the IDR proceedings between Appellants and HCSC. That process exists entirely outside and independent of ERISA.” *Id.*; see 42 U.S.C. § 300gg-135 (out-of-network air ambulance providers “shall not bill, and shall not hold liable, [the] participant, beneficiary, or enrollee for a payment amount for such service furnished by such provider” above the patient’s cost-sharing amount). The *HCSC* providers argued “the injury to beneficiaries is nonetheless cognizable because the beneficiaries have suffered a breach of contract and so have been denied a benefit of their bargain with HCSC.” 140 F.4th at 278. The Fifth Circuit disagreed, because “[t]his technical violation, if it amounts to one, does no actual harm to the beneficiaries and is consequently an abstract theory insufficient for Article III injury.” *Id.*; see *Soule v. Conn.*

¹² This Court’s “[d]enial of the motion[s] to dismiss on standing grounds does not preclude later consideration on summary judgment or indeed at trial as standing is an aspect of subject matter jurisdiction.” *Breeden v. Kirkpatrick & Lockhart LLP (In re Bennett Funding Grp., Inc.)*, 336 F.3d 94, 102 (2d Cir. 2003).

Ass'n of Schs., Inc., 90 F.4th 34, 45–46 (2d Cir. 2023) (en banc) (recognizing that an alleged Article III injury cannot be “abstract or speculative”).

“In short,” the Fifth Circuit held in *HCSC* that “because the beneficiaries would lack Article III standing if they brought an ERISA claim on their own, Providers lack standing to bring a derivative ERISA claim as their assignees.” 140 F.4th at 278; *see SpecialtyCare, Inc. v. Cigna Healthcare, Inc.*, No. 24-1378-RGA, 2026 WL 483259, at *6–7 (D. Del. Feb. 20, 2026) (recommending dismissal of an ERISA claim based on the defendants’ alleged failure to pay IDR awards because, in light of the NSA, “[t]he plan participants have no real interest in the outcome of this case.”); *SpecialtyCare, Inc. v. UMR, Inc., Inc.*, No. 24-1396-RGA 2026 WL 483259, at *5–7 (D. Del. Feb. 20, 2026) (same). The Court should likewise hold that Plaintiffs lack ERISA standing and dismiss their ERISA claim.

2. ERISA § 502(a)(1)(B) does not provide Plaintiffs with a cause of action to recover IDR payments

Not only do Plaintiffs lack Article III standing, they also lack statutory standing. A plaintiff has statutory standing to assert an ERISA § 502(a)(1)(B) claim only where it has “a cause of action under ERISA.” *Am. Psychiatric Ass’n v. Anthem Health Plans*, 821 F.3d 352, 359–60 (2d Cir. 2016). And a plaintiff only has a cause of action where its “interests in the litigation fall within the zone of interests protected by the law invoked.” *Fed. Defs. of N.Y., Inc. v. Fed. Bureau of Prisons*, 954 F.3d 118, 129 (2d Cir. 2020) (citation modified). Whether a plaintiff comes within the zone of interests is an issue that requires determining, “using traditional tools of statutory interpretation, whether a legislatively conferred cause of action encompasses” the plaintiff’s claim. *Lexmark Int’l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118, 127 (2014) (citation modified).

As the Court framed it in the ruling on the motions to dismiss, Plaintiffs allege an ERISA claim under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), to enforce allegedly assigned rights and obligations under 29 U.S.C. § 1185f:

[T]he NSA amended ERISA, along with two other statutes, and created coverage and reimbursement obligations that apply to ERISA health plans, *see* 29 U.S.C. § 1185f. Plan participants and beneficiaries can bring an action under ERISA to enforce these rights. *See id.* § 1132(a)(1)(B).

MTD Ruling (ECF No. 264) at 24–25 (internal citations omitted). However, while plan participants and beneficiaries (and their assignees) can use ERISA § 502(a)(1)(B) to enforce some obligations under the NSA, the obligations at issue in this case are *not* among them.

Determining whether ERISA § 502(a)(1)(B) encompasses Plaintiffs’ interests in the litigation begins and ends with the statutory text. *See Bartenwerfer v. Buckley*, 598 U.S. 69, 74 (2023) (“We start where we always do: with the text of the statute.” (citation modified)); *Oklahoma v. Castro-Huerta*, 597 U.S. 629, 642 (2022) (“Congress expresses its intentions through statutory text.”). ERISA § 502(a)(1)(B) permits a participant or beneficiary “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B) (emphasis added). Thus, Congress intended ERISA § 502(a)(1)(B) to protect the right to benefits under the terms of an ERISA-governed plan, which is why a cause of action only falls within the scope of ERISA § 502(a)(1)(B) if “the *actual claim* that the plaintiff asserts can be construed as a colorable claim for benefits pursuant to § 502(a)(1)(B).” *Wurtz v. Rawlings Co., LLC*, 761 F.3d 232, 241–42 (2d Cir. 2014) (quotation omitted). Plaintiffs’ claim cannot be so construed.

Plaintiffs’ ERISA claim is a far cry from a colorable claim for benefits under the terms of an ERISA-governed plan. Plaintiffs’ claim is premised on their theory that (1) the NSA amended ERISA to include IDR payment requirements, so (2) so those requirements are now de facto part of every ERISA plan, which means (3) that Aetna improperly denied benefits under an ERISA-plan by failing to comply with the NSA’s payment provisions. *See* Compl. (ECF No. 109) at 11–12 (¶¶ 37–39). By their own admission, “Plaintiffs’ claims do not derive from their plans or require investigation into the terms of their plans; rather, they derive from” two statutory provisions:

29 U.S.C. §§ 1185e and 1185f. *See Wurtz*, 761 F.3d at 243. If Plaintiffs were somehow to prevail on their NSA claim to recover payment of IDR awards then their ERISA § 502(a)(1)(B) claim would be moot—highlighting that the latter claim does not look to the terms of any plan to evaluate whether Plaintiffs are entitled to benefits, and so is outside the interests that ERISA § 502(a)(1)(B) is intended to protect. *See Richards v. Gen. Motors Corp.*, 850 F. Supp. 1325, 1332 (E.D. Mich. 1994) (“Plaintiffs’ . . . claims under § 1140—each of which allege a violation of ERISA and not the plan itself—cannot be brought under § 1132(a)(1)(B)”).

Moreover, it is well-established “canon of construction that a specific provision controls over one of more general application.” *Natofsky v. City of New York*, 921 F.3d 337, 345 (2d Cir. 2019) (citation modified). This canon applies “regardless of the priority of enactment,” *Morton v. Mancari*, 417 U.S. 535, 550–51 (1974), and is especially applicable where “Congress has enacted a comprehensive scheme” like ERISA “and has deliberately targeted specific problems with specific solutions.” *RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645 (2012) (quotation omitted). Further, where two statutory provisions are interrelated—*e.g.*, two modes of enforcement—the canon is “particularly” salient. *HCSC-Laundry v. United States*, 450 U.S. 1, 6 (1981) (per curiam); *see Lollar v. Baker*, 196 F.3d 603, 609–10 (5th Cir. 1999) (recognizing that Congress “intended to foreclose resort to . . . general enforcement provisions” because it passed “a specific comprehensive internal enforcement mechanism”).

The coverage and reimbursement obligations created in 29 U.S.C. § 1185f are expressly subject to the provisions of 29 U.S.C. § 1185e(c)(5)(E), under which an IDR determination “shall not be subject to judicial review except in a case described” under section 10(a) of the FAA. Consequently, section 1185f—via section 1185e(c)(5)(E)—precludes participants, beneficiaries, and their assignees from judicial review of an IDR determination under ERISA § 502(a)(1)(B). Specifically, 29 U.S.C. § 1185f establishes an IDR process for covered services that an out-of-

network air ambulance provider provides to “a participant or beneficiary who is in a group health plan or group health insurance coverage offered by a health insurance issuer.” 29 U.S.C. §§ 1185f(a)–(c). Under 29 U.S.C. § 1185f(b)(5)(D), the provisions of 29 U.S.C. § 1185e(c)(5)(E) apply to an IDRE’s § 1185f determination:

Effects of determination

The provisions of section 1185e(c)(5)(E) of this title ***shall apply with respect to a determination of a certified IDR entity*** under subparagraph (A), the notification submitted with respect to such determination, the services with respect to such notification, and the parties to such notification in the same manner as such provisions apply with respect to a determination of a certified IDR entity under section 1185e(c)(5)(E) of this title, the notification submitted with respect to such determination, the items and services with respect to such notification, and the parties to such notification.

29 U.S.C. § 1185f(b)(5)(D) (emphasis added). In turn, section 1185e(c)(5)(E) mirrors word-for-word 42 U.S.C. § 300gg-111(c)(5)(E)(i), the NSA provision that circumscribes judicial review.

Congress’s intent is clear; its choice to specifically prohibit judicial review of IDR awards in 29 U.S.C. § 1185e(c)(5)(E) trumps Plaintiffs’ attempt to use the general enforcement mechanism in ERISA § 502(a)(1)(B) to enforce IDR award payments. Indeed, the NSA amended ERISA to expressly cut the patient out of the reimbursement/balance-billing equation. So, there was absolutely no need, and Congress clearly had no intent, in amending ERISA to incorporate the NSA to provide a plan participant or beneficiary with an opportunity to file an ERISA § 502(a)(1)(B) action about an IDR award payment.

This is further reinforced by the 29 U.S.C. § 1152,¹³ which sets forth a set of specific NSA statutory violations about which “participants and beneficiaries of” ERISA-covered plans may formally complain. All of the listed statutory violations concern illegal balance billing by a

¹³ “[T]he words of a statute must be read in their context and with a view to their place in the overall statutory scheme.” *Roberts v. Sea-Land Servs., Inc.*, 566 U.S. 93, 101 (2012) (quotation omitted).

provider—not enforcement of IDR award payments. *See* 29 U.S.C. § 1152(a) (providing for investigations of “violations of sections 300gg–131, 300gg–132, or 300gg–135 of title 42”). Complaints about balance billing, in turn, may lead to enforcement actions by “States or the Secretary of [HHS] (as determined appropriate by the Secretary).” 29 U.S.C. § 1152(b). Congress’s choice to cross-reference the NSA’s balance-billing provisions in 29 U.S.C. § 1152 but not to any other NSA provisions “strongly suggests it acted intentionally and purposefully in the disparate decisions.” *Azar v. Allina Health Servs.*, 587 U.S. 566, 577 (2019) (citation modified).

In light of the foregoing, ERISA § 502(a)(1)(B) is plainly not a vehicle to bring an NSA-related claim regarding payment of an IDR award. ERISA § 502(a)(1)(B) is intended to protect a participant or beneficiary’s right to benefits under the terms of a plan. Plaintiffs’ action does not fit the mold, as they merely allege statutory violations that have no tangible connection to the particular terms of a specific ERISA plan. And without a proper cause of action, Plaintiffs’ ERISA § 502(a)(1)(B) claim must fail.

3. Plaintiffs cannot use ERISA § 502(a)(1)(B) as a means to circumvent the NSA’s exclusive regulatory enforcement regime

Even assuming Plaintiffs could establish both Article III standing and statutory standing to bring an ERISA § 502(a)(1)(B) claim, Aetna is still entitled to summary judgment because Plaintiffs cannot use ERISA § 502(a)(1)(B) to circumvent the NSA’s regulatory enforcement regime established in 29 U.S.C. §§ 1185f(b)(5)(D) and 1185e(c)(5)(E).

In *Bushell v. UnitedHealth Group Inc.*, 17-CV-2021 (JPO), 2018 WL 1578167, at *1 (S.D.N.Y. Mar. 27, 2018), the plaintiff filed suit against her insurer under ERISA, 29 U.S.C. § 1132(a), alleging that the insurer discriminated against those suffering from mental illness in violation of, *inter alia*, a New York statute (“Timothy’s Law”). The district court found that Timothy’s Law lacked a private right of action. *Id.* at *3. The plaintiff argued, however, “that because Timothy’s Law is incorporated into her plan, she can sue under ERISA for violation of

Timothy’s Law just as she could sue for violation of any other contractual provision.” *Id.* (citing 29 U.S.C. § 1132(a)(1)(B)). In other words, the plaintiff argued “that since the statutory obligation is incorporated into her insurance contract, she can sue for violation of her plan terms, which is distinct from merely suing for violation of the law itself.” *Id.* The district court rejected the argument, finding *Astra USA, Inc. v. Santa Clara County, California*, 563 U.S. 110 (2011), “instructive.” *Id.*

Astra dealt with a contract (the “PPA”) between the government and drug companies (“Astra”), in which Astra agreed to abide by price caps under Section 340B of the Public Health Services Act. 563 U.S. at 113. The operator of several medical facilities (“County”) sued the drug companies for violating the Section 340B price caps, but the district court ruled that Section 340B lacked a private right of action. *Id.* at 116–17. The County then argued that it was a third-party beneficiary of the PPA and could therefore challenge Astra’s breach of that agreement. *Id.* The Supreme Court unanimously rejected the attempt to use contract law to assert a claim that was “in substance one and the same” as a suit to enforce Section 340B directly. *Id.* at 113–14. Recognizing that “any private right of action for violating a federal statute . . . must ultimately rest on congressional intent to provide a private remedy,” the Supreme Court explained that a suit to enforce the contract “is in essence a suit to enforce the statute itself.” *Id.* at 117–18 (citation modified). The Supreme Court further explained that the “absence of a private right of action to enforce [the statute] would be rendered meaningless” if a plaintiff could simply sue to enforce the contract instead. *Id.*

Applying this rationale, the *Bushell* court held that the plaintiff could not use ERISA to circumvent the lack of a private right of action in Timothy’s Law and dismissed the claim. 2018 WL 1578167, at *4 (“And since there is no private right of action to enforce the regulation directly, [plaintiff] cannot enforce it under the guise of an ERISA claim. A conclusion to the contrary would

mean that this one provision allows suit for violation of any state or federal law.”). A related principle also applies here: Plaintiffs cannot enforce 29 U.S.C. § 1185f under the guise of 29 U.S.C. § 1132(a)(1)(B), as a conclusion to the contrary would render meaningless the express prohibition on judicial review in 29 U.S.C. § 1185e(c)(5)(E). *See New Process Steel, L.P. v. N.L.R.B.*, 560 U.S. 674, 680 (2010) (explaining that courts must “harmonize and give meaningful effect to all of the [statutory] provisions”); *Corley v. United States*, 556 U.S. 303, 314 (2009) (noting that a “statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant” (citation modified)). Aetna is therefore entitled to summary judgment on Plaintiffs’ ERISA claim.

C. Aetna is also entitled to judgment on Plaintiffs’ CUTPA claim for violations of CUIPA

Next, Plaintiffs contend in their CUTPA claim “that Defendants have engaged in unfair settlement practices in violation of the Connecticut Unfair Insurance Practices Act (‘CUIPA’),” Conn. Gen. Stat. § 38a-816(6)(F). MTD Ruling (ECF No. 264) at 28. Plaintiffs’ Complaint identifies three ways in which Aetna allegedly engaged in unfair claims settlement practices in violation of CUIPA § 38a-816(6)(F): (1) Aetna makes “unreasonably low initial payments”; (2) Aetna does not attempt to negotiate “in good faith” during the Open Negotiation Period; and (3) Aetna fails to “promptly, fairly and equitably settle the claim by paying the amount in the award (less any initial payment already made).” Compl. (ECF No. 109) at 13 (¶ 44). However, the Court has found that Plaintiffs’ first two theories of CUTPA/CUIPA liability fail as a matter of law because “any claims based on Defendant’s initial payments would be preempted.” MTD Ruling (ECF No. 264) at 30 n.10 (“Imposing liability on health plans and insurers for their conduct during the open negotiation period could frustrate the NSA’s statutory scheme by allowing courts to weigh in on what constitutes a fair payment. This is plainly inconsistent with Congress’s decision to have such issues decided by a third-party IDR entity, without judicial review.”).

Plaintiffs’ remaining CUTPA/CUIPA liability theory—the “prompt payment” theory—fails as well, for five separate reasons: (1) Plaintiffs cannot use CUTPA to circumvent the NSA’s absence of a private right of action to enforce an IDR award; (2) the NSA (and, alternatively, ERISA) preempts Plaintiffs’ claim; (3) CUIPA’s unfair claim settlement practices provisions do not apply to the payment of IDR awards; (4) as third-party claimants, Plaintiffs are not proper CUTPA/CUIPA plaintiffs; and (5) there is no evidence Aetna has violated CUIPA.

1. Plaintiffs cannot use CUTPA to circumvent the NSA

First, a plaintiff cannot use state law “to recover for violations of a federal statute that creates no private cause of action and, in fact, expressly restricts its enforcement to the federal government.” *In re Orthopedic Bone Screw Prods. Liab. Litig.*, 193 F.3d 781, 790–91 (3d Cir. 1999) (affirming dismissal of state claim that “rest[ed] solely upon the violation of a federal statute for which there is no corresponding private right of action”). Otherwise, “state common law would govern whether and how a federal statute may be enforced, irrespective of Congressional intent.” *Bauer v. Elrich*, 8 F.4th 291, 299 (4th Cir. 2021).

In fact, in *SpecialtyCare Inc. v. Meritain Health, Inc.*, a Delaware district court recently held that the provider plaintiffs in that case “may not use state common law to circumvent the absence of a private right of action” ***under the NSA***. 2026 WL 353259, at *4 (recommending granting the defendant’s motion to dismiss) (citation modified); 2026 WL 745341, at *1 (D. Del. Mar. 17, 2026) (adopting recommendation, “in particular the determinations (1) to follow the majority in finding the No Surprises Act (“NSA”), 42 U.S.C. §§ 300gg-111, does not create a private right of action for the reasons articulated in the Fifth Circuit’s decision in *Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 277 (5th Cir. 2025), and (2) that Plaintiffs may not circumvent Congress’ omission of a private right of action in the NSA by seeking to enforce a federal right under a state law theory.”). Likewise, Plaintiffs cannot use CUTPA to

circumvent the NSA.

The *SpecialtyCare* court based its holding on two opinions: *Astra* and *Umland v. PLANCO Financial Services, Inc.*, 542 F.3d 59 (3d Cir. 2008). 2026 WL 353259, at *4–6. As detailed above, the Supreme Court held in *Astra* that the plaintiffs could not bring breach of contract claims complaining of violations of federal statutes that did not have private rights of action, because to do so would render the absence of a private right meaningless. 563 U.S. at 118–19. In *Umland*, plaintiff brought breach of contract claims under the Federal Insurance Contributions Act (FICA). 542 F.3d at 65. The Third Circuit determined that FICA does not create a private right of action. *Id.* at 67. It then reasoned that “[i]f we were to read FICA’s provisions into every employment contract, we would contradict Congress’s decision to include expressly a private right of action and our belief that Congress did not intend to imply a private right of action either.” *Id.* Because the plaintiff’s breach of contract claim “at root allege[d] FICA violations,” the Third Circuit affirmed dismissal of the claims. *Id.*

The *SpecialtyCare* court also observed that, “[i]n addition to *Umland* and *Astra*, other courts have dismissed state law claims on non-preemption grounds when those claims sought to enforce a federal statute with no private right of action.” 2026 WL 353259, at *6; *see, e.g., Bauer*, 8 F.4th at 300 (“The essence of the plaintiffs’ claim, and their sole theory of wrongdoing, is that the County defendants’ implementation of the EARP violated [8 U.S.C. §] 1621, which does not authorize private enforcement. The plaintiffs cannot use the procedural mechanism of Maryland taxpayer standing to bring a claim that is ‘one and the same’ as a purported enforcement action brought directly under Section 1621.”) (citation modified); *Mankodi v. Trump Marina Assocs., LLC*, 525 F. App’x 161, 166 (3d Cir. 2013) (affirming dismissal of breach of contract claim because it attempted “to assert a claim based on a violation of the [Casino Control Act], which does not provide a private right of action”).

The *SpecialtyCare* court concluded that the plaintiffs’ state law claims were foreclosed because they were “one and the same” as their claims under the FAA and Delaware Revised Uniform Arbitration Act to enforce the IDR awards.” 2026 WL 353259, at *5 (citation modified). Although the state law claims “require[d] proof of certain elements specific to those claims, ‘the ultimate goal of the plaintiffs’ claim [was] to enforce the federal statute.’” *Id.* (quoting *Bauer*, 8 F.4th at 300 & n.6). Thus, the court held that, “[u]nder [*HCSC*], *Umland*, and *Astra*,” the plaintiffs “may not circumvent Congress’s omission of a private right of action in the NSA by seeking to enforce a federal right under a state law theory.” *Id.* at *7.

Similarly, Plaintiffs’ CUTPA claim seeks to enforce the NSA under a state law theory notwithstanding the NSA’s omission of a private right of action. As with the state law claims in *SpecialtyCare*, therefore, Plaintiffs’ CUTPA claim should be dismissed as an improper attempt to circumvent Congress’s decision to not include a private right of action in the NSA. Indeed, allowing Plaintiffs’ NSA-based CUTPA claim to proceed “not only would run afoul of common sense, but also would violate basic constitutional principles.” *Bauer*, 8 F.4th at 299.

2. The NSA preempts Plaintiffs’ claim

Second, Aetna is entitled to summary judgment because the NSA preempts Plaintiffs’ CUTPA claim for alleged failure to timely pay IDR awards.¹⁴ Aetna acknowledges the Court previously found that the NSA does not preempt Plaintiffs’ claim because imposing state law penalties “would not create any obstacles to the NSA’s purposes and objectives, as untimely payments are already proscribed by the NSA. And state penalties could help to ensure that parties comply with the NSA’s payment obligations and refrain from engaging in unfair practices to

¹⁴ In the alternative, or additionally, if Plaintiffs’ ERISA § 502(a)(1)(B) claim survives (and it should not) then it preempts the CUTPA claim. *See* 29 U.S.C. § 1144(a). Plaintiffs cannot use CUTPA to impose state-law penalties on the administration of ERISA-governed plans, as doing so would affect central ERISA functions—such as the Secretary’s exclusive authority to decide civil money penalties.

circumvent these provisions.” MTD Ruling (ECF No. 264) at 29–30. However, the Court reached this conclusion without addressing the NSA’s provisions setting forth administrative remedies, including 42 U.S.C. § 300gg-22. *See id.* These statutory provisions are exclusive, leaving no place for courts to impose state penalties to “help ensure that parties comply with the NSA’s payment obligations and refrain from” circumvention. *See* § V.A, *supra*; *see also* *N.Y. State Telecomms. Ass’n, Inc. v. James*, 101 F.4th 135, 147–48 (2d Cir. 2024) (explaining how field preemption can apply under similar circumstances). The statutory provisions thus provide good reason for the Court to reconsider and reverse its preemption decision as well.

Under the NSA, payors like Aetna are entirely beholden to a federal process that allows providers to submit complaints regarding the IDR process to CMS, and provides for CMS to impose federal civil money penalties for failure to meet a statutory requirement. *See* 42 U.S.C. § 300gg-22(b). Imposing alternative state penalties under CUTPA would be entirely inconsistent with, and an obstacle to the NSA’s purposes and objectives. For example, “[n]o civil monetary penalty shall be imposed” under the NSA “on any failure during any period for which it is established to the satisfaction of the Secretary [of HHS] that none of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.” *Id.* § 300gg-22(b)(2)(C)(iii)(I). Moreover, in determining the amount of any penalty to be assessed, “the Secretary shall take into account the previous record of compliance of the entity being assessed with the applicable provisions of [the NSA] and the gravity of the violation.” *Id.* § 300gg-22(b)(2)(C)(ii). Judicial imposition of a CUTPA penalty would usurp the Secretary’s exclusive authority.

“[I]t is well-established that ‘a precisely drawn, detailed statute pre-empts more general remedies.’” *Palmer v. Trump Model Mgmt., LLC*, 175 F. Supp. 3d 103, 108 (S.D.N.Y. 2016) (quoting *Hinck v. United States*, 550 U.S. 501, 506 (2007)). “Where Congress has devised a law,

such as the [NSA], with a ‘careful blend of administrative and judicial enforcement powers,’ this principle leads ‘unerringly to the conclusion that [the statute] provides the exclusive judicial remedy for claims’ falling within its scope.” *Id.* (quoting *Brown v. Gen. Servs. Admin.*, 425 U.S. 820, 833–35 (1976), and dismissing civil RICO claim because it fell within the scope of the Immigration and Nationality Act). A CUTPA action for failure to timely pay IDR awards would be inconsistent with the NSA’s legislative and administrative scheme to the same extent as would a cause of action directly under the NSA. As such, Aetna is entitled to summary judgment on Plaintiffs’ CUTPA claim.

3. CUIPA’s unfair claim settlement practices provisions do not apply to the payment of IDR awards

Third, Aetna is entitled to summary judgment because CUIPA’s unfair claim settlement practices provisions do not apply to Plaintiffs’ claims regarding the timing of IDR award payments. An IDR determination is not a “settlement” of a dispute between the parties; it is an arbitration award imposed by a neutral decisionmaker after the provider and the payor submit their positions. The text, structure, and purpose of CUIPA § 38a-816(6) demonstrate that the statute regulates insurer conduct during the investigation and negotiation of claims, rather than conduct occurring after an adjudicative determination has already resolved the dispute.

Section 38a-816(6) defines “unfair claim settlement practices” and enumerates specific categories of prohibited conduct in subsections (a) through (o). These provisions address conduct during the claim handling and settlement process. For example, they prohibit misrepresenting facts or policy provisions relating to coverage, failing to acknowledge or investigate claims, failing to affirm or deny coverage within a reasonable time, and failing to attempt in good faith to effectuate prompt, fair, and equitable settlements once liability becomes reasonably clear. Conn. Gen. Stat. § 38a-816(6)(a)–(f). Other provisions concern the negotiation and evaluation of claims prior to a final determination of liability and damages. None of the enumerated practices addresses the

timing of payment after issuance of an adjudicative arbitration award.

Moreover, the statute's text confirms that the legislature understood "settlements" and "arbitration awards" to be distinct concepts. Subsection (k) specifically addresses arbitration awards in the narrow circumstance of "making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration." Conn. Gen. Stat. § 38a-816(6)(k). The statute addresses arbitration awards only in the limited context of coercive appeals designed to pressure claimants into accepting lower settlements. Section 38a-816(6) contains no provision regulating the timing of payment of (or purportedly completely failing to pay) arbitration awards. Because the legislature distinguished arbitration from settlement and elected not to regulate post-award payment, conduct occurring after an arbitration award cannot constitute a "claim settlement practice" within the meaning of the statute.

NSA IDR awards are even further removed from being "claim settlement practices" than are arbitration awards under CUIPA. "[T]here is no contract between the parties let alone an agreement to arbitrate payment disputes through the IDR process." *Mod. Orthopaedics of NJ*, 2025 WL 3063648, at *6. "[A]lthough the IDR is often called arbitration and the IDR entities arbitrators, the NSA's IDR is statutorily compelled." *Id.* (citation modified). "[D]ifferences pervade the IDR and arbitration processes." *Id.* (identifying some of the differences). In particular, "the awards available are drastically different, as the IDR referee 'select[s] one of the offers submitted ... to be the amount of payment.'" *Id.* (quoting 42 U.S.C. § 300gg-111(c)(5)(A)(i); brackets and ellipses in original). "Arbitrators generally have no such limitation and instead have 'broad discretion to grant any remedy or relief,' including equitable relief." *Id.* (quoting *Govt Emps. Ins. Co. v. Mount Prospect Chiropractic Ctr., P.A.*, 98 F.4th 463, 469 (3d Cir. 2024)).

In short, because the payment of an IDR award does not involve the "settlement" of a claim,

it falls outside the scope of § 38a-816(6). Summary judgment should therefore be granted on this basis alone.

4. As third-party claimants, Plaintiffs are not proper CUTPA/CUIPA plaintiffs

The Connecticut legislature designed CUIPA to be enforceable by individuals who are insureds, not by third parties to the insurance policy. Plaintiffs are not insureds, and so are not proper plaintiffs under CUIPA. Thus, their CUTPA claim for alleged violations of CUIPA should be dismissed for lack of standing.

It is “wholly improper” to “expand or create insurance coverage where it does not exist.” *Minnesota Com. Ry. Co. v. Gen. Star Indem. Co.*, 408 F.3d 1061, 1063 (8th Cir. 2005) (quotation omitted); *26 Taconic Rd., LLC v. Welsh*, No. FSTCV126014382S, 2013 WL 1800338, at *5 (Conn. Super. Ct. Apr. 4, 2013) (“estoppel cannot be used to create or extend coverage”). “[T]he right to assert a private cause of action for CUIPA violations through CUTPA does not extend to third parties absent subrogation or a judicial determination of the insured’s liability.” *Carford v. Empire Fire & Marine Ins. Co.*, 891 A.2d 55, 62 (Conn. App. 2006). “To hold otherwise would create confusion, increased and multiple litigation both generally and within specific cases, the potential coercion of settlements when the insured’s liability has not been and may never be established, and an inherent conflict of interest.” *Id.* “The judicial creation of such a right would not further the policy underlying CUIPA and CUTPA. Rather, it is the province of the legislature to create new rights and remedies contained within the highly regulated industry of insurance.” *Id.*

Connecticut state courts have found in near unanimity that “*Carford* directly applies” to claims for unfair claim settlement practices brought under § 38a-816(6) (CUIPA). *See Grand Prix Motors, Inc. v. Greene*, No. DBDCV216038357S, 2021 WL 4287349, at *8 n.5 (Conn. Super. Ct. Sept. 1, 2021) (“Here, *Carford* directly applies as the plaintiff is bringing the claim under § 38a-816(6), for unfair claim settlement practices.”); *Clark v. Hanover Ins. Grp., Inc.*, No. 3:24-CV-348

(SVN), 2025 WL 2053366, at *12 n.5 (D. Conn. July 22, 2025) (“[A] majority of the Connecticut Superior Courts has held that § 38a-816(6) does not apply to third party claimants.”) (citation modified); *Asmus Elec., Inc. v. G.M.K. Contractors, LLC*, No. CV040489527, 2005 WL 758126, at *5 (Conn. Super. Ct. Feb. 25, 2005) (“The majority of [Connecticut] superior courts” have found that claims for unfair claim settlement practices “are actionable for insureds only, not for third-party claimants.” (second quotation omitted)).

Aetna acknowledges that the Court has found that CUIPA claims are actionable for third-party claimants. See *Murphy Med. Assocs., LLC v. United Med. Res., Inc.*, No. 3:22-CV-00083-MPS, 2024 WL 1072731, at *4–6 (D. Conn. Mar. 12, 2024) (“agree[ing]” with *NEMS PLLC v. Harvard Pilgrim Health Care of Conn. Inc.*, 615 F. Supp. 3d 125, 139–40 (D. Conn. 2022), in which Judge Nagala distinguished *Carford* on the basis its holding is “too narrow” and its facts “too dissimilar” to address medical providers’ claims against payors under §38a-816(6)(F)). However, Judge Nagala recently changed her view and found that *Carford* does indeed apply to bar a third-party claimant’s CUTPA claim. See *Clark*, 2025 WL 2053366, at *12 n.5.

Moreover, in a decision issued the same day in 2024 as *Murphy Medical*, a Connecticut Superior Court reiterated “that all constraints imposed on claims settlement practices by CUIPA in §38a-816(6) are aimed at the protection of insureds and do not impose on insurers direct obligations to third-party claimants.” *Levin v. Travelers Prop. Cas. Co.*, No. X03-CV-23-6164244-S, 2024 WL 1172214, at *8 (Conn. Super. Ct. Mar. 12, 2024) (granting motion to dismiss based on standing). The *Levin* court discussed *NEMS PLLC*, and found that the “distinction drawn between the various provisions of CUIPA by the court in *NEMS PLLC* is contrary to *Carford*’s holding” *Id.* (“Whatever merit the distinctions drawn by the court in *NEMS PLLC* may have, this court is bound by *Carford*’s holding that all constraints imposed on claims settlement practices by CUIPA in § 38a-816(6) are aimed at the protection of insureds and do not impose on insurers

direct obligations to third-party claimants.”). The *Levin* court further noted that “[d]espite the numerous amendments to the statute after *Carford*, [the *Carford*] court’s construction of § 38a-816 has stood for eighteen years without any legislative action.” *Id.* at *8 n.9.

Nearly a year later, in *Cummings v. Alexander*, No. TTD-CV24-5018059-S, 2025 WL 685154, at *2–3 (Conn. Super. Ct. Feb. 25, 2025), the court followed *Levin* and *Carford* in granting a motion to dismiss a third-party claimant’s CUTPA claim against an insurer for lack of standing. (“The plaintiff fails to allege that he has subrogation rights under the insurance policy that would permit him to bring a CUTPA or CUIPA claim against the defendant. Moreover, there is no indication that there has been a judicial determination of the insured’s liability. Thus, the plaintiff does not have standing to bring a CUTPA claim against the defendant, GEICO.”).

Respectfully, the decisions of Connecticut state courts interpreting Connecticut law should prevail over *Murphy Medical Mullaney v. Wilbur*, 421 U.S. 684, 691 (1975) (“state courts are the ultimate expositors of state law”). Further, Judge Nagalaš recent decision in *Clark* is more persuasive than her earlier opinion in *NEMS PLLC*. Accordingly, Plaintiffs lack standing to bring their CUTPA/CUIPA against Aetna.

5. There is no evidence Aetna has violated CUIPA

Fifth, Aetna is entitled to summary judgment on Plaintiffs’ CUTPA claim because there is no evidence that Aetna did not attempt in good faith to effectuate timely payment of IDR awards. As the Court observed in ruling on the motions to dismiss, for Plaintiffs to sustain their “CUIPA cause of action under CUTPA,” Plaintiffs must establish “conduct that is proscribed by CUIPA.” MTD Ruling (ECF No. 264) at 35. “Plaintiffs allege that Defendants engaged in ‘unfair settlement practices in violation of [CUIPA], Conn. Gen. Stat. § 38a-816(6)(F).” *Id.* (quoting Compl. (ECF No. 109) at 13 (¶ 44)). Section 38a-816(6)(F) requires Plaintiff to prove that Aetna has not “attempt[ed] in good faith to effectuate prompt, fair and equitable settlements of claims in which

liability has become reasonably clear,” and that Aetna has done so “with such frequency as to indicate a general business practice.” *Id.* (citation modified). Plaintiffs cannot meet their burden.

CUIPA section 38a-816(6)(F) has an “intrinsic component of bad faith.” *Harrigan v. Fid. Nat’l Title Ins. Co.*, 282 A.3d 495, 507 (Conn. App. 2022). “To prove bad faith, a plaintiff must show that the defendant engaged in conduct designed to mislead or deceive, or that it neglected or refused to fulfill some duty or contractual obligation not prompted by an honest mistake.” *McCulloch v. Hartford Life & Acc. Ins. Co.*, 363 F. Supp. 2d 169, 177 (D. Conn. 2005), *adhered to on reconsideration*, No. 3:01CV1115 (AHN), 2005 WL 8165602 (D. Conn. Sept. 29, 2005). “Bad faith is not simply bad judgment or negligence, but rather it implies a conscious wrongdoing because of a dishonest purpose.” *Id.* That is, bad faith “contemplates a state of mind affirmatively operating with furtive design or ill will.” *Rodko v. Am. Strategic Ins. Grp.*, No. AAN-CV-24-6055628-S, 2025 WL 1111663, at *3 (Conn. Super. Ct. Apr. 7, 2025) (quotation omitted).

“Allegations of a mere coverage dispute or a negligent investigation by an insurer will not state a claim for bad faith.” *McCulloch*, 363 F. Supp. 2d at 177–78 (recognizing that a “bad faith claim cannot survive as a matter of law” if the defendant possessed a legitimate reason for action). Also, “when a good faith legal controversy exists” an insurer’s “withholding of the policy proceeds cannot be found to be in bad faith, even if the insurer’s position is ultimately found to be erroneous.” *McCauley Enters., Inc. v. N.H. Ins. Co.*, 716 F. Supp. 718, 723 (D. Conn. 1989). “[B]ad faith actions require the denial of benefits under the policy.” *Capstone Bldg. Corp. v. Am. Motorists Ins. Co.*, 67 A.3d 961, 987 (Conn. 2013).

Plaintiffs have no evidence that Aetna has acted in bad faith with regard to payment of IDR awards, i.e., that it has consciously failed to timely pay the awards because of a dishonest purpose. The undisputed evidence in the record demonstrates the opposite: Aetna has made significant and sustained investments in personnel, technology, and processes specifically designed to comply

with the NSA’s payment timing requirements. *See* § III.B, *supra*. Aetna has dedicated over [REDACTED] [REDACTED] to ensure NSA compliance, maintained a consistent policy of paying IDR determinations within 30 days,¹⁵ treated IDR claims as priority items, proactively tightened its internal turnaround goal from [REDACTED], and invested in new technology to accelerate processing. *Id.* This is plainly not the conduct of a company “affirmatively operating with furtive design or ill will.” *See Rodko*, 2025 WL 1111663, at *3 (quotation omitted).

Nor can Plaintiffs manufacture bad faith from the timing challenges that Aetna has faced. The NSA’s IDR process only became operational in April 2022, with a brand-new system that insurers like Aetna were required to navigate while simultaneously processing claims and developing compliance infrastructure. Rosso, CRS Report No. R48851. As Aetna’s expert, Ms. Knutson, testified, the NSA implementation “was a chaotic rollout” that “created instability in the process.” SOF ¶ 9. This chaos was compounded when litigation challenging the IDR regulations led to the IDR portal being shut down for nearly four months. SOF ¶ 11. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]. SOF ¶ 53. [REDACTED]

[REDACTED]

[REDACTED] SOF ¶ 54. [REDACTED]

[REDACTED]

¹⁵ Notably, Aetna has paid all but a few of the many thousands of IDR awards issued in Plaintiffs’ favor (even if some were paid after 30 days due to reasons described herein). Some claims that Plaintiffs submitted, however, simply were not eligible for the IDR process under the NSA, such as claims submitted under retiree-only plans. *See* 29 U.S.C. § 1191a(a). There can be no liability for payments of awards issued under an illegitimate IDR process. Further, it is important to note that the majority of the medical claims at issue relate to plans that are funded by employer and/or employee contributions (i.e., “self-funded plans”). Aetna does not insure these benefits and is issuing payment on behalf of self-funded plans. As such, Plaintiffs seek to collect payments from self-funded plans, even under an illegitimate IDR process.

[REDACTED]

[REDACTED] SOF ¶ 55. [REDACTED]

[REDACTED]

[REDACTED] SOF ¶ 56. [REDACTED]

[REDACTED] Plaintiffs cannot credibly argue that Aetna’s navigation of those same challenges constitutes bad faith.

During this shutdown, the volume of disputes was entirely unpredictable to insurers because providers control when and how many disputes are initiated. Notably, providers initiate nearly all disputes filed through the IDR process. Rosso, CRS Report No. R48851. Plaintiffs alone filed [REDACTED]

[REDACTED] SOF ¶¶ 13–14. Plaintiffs’ volume increased exponentially after the portal reopened, and [REDACTED]

[REDACTED] *See* § II.B–C, *supra*. That is not bad faith on Aetna’s part; it is the foreseeable consequence of Plaintiffs’ own conduct.

Aetna’s communications with CMS further conclusively establish that any timing challenges reflect good-faith efforts to comply, not a dishonest purpose. Aetna proactively requested reports from CMS to ensure it had records of all determined cases, sent CMS detailed breakdowns of its inventory when volume surged, reported that its team was “working overtime and on weekends” to meet turnaround deadlines, and submitted a formal proposal to regulate the volume of disputes received by non-initiating parties. SOF ¶¶ 18–19. Aetna also set up a dedicated email address to receive IDR awards and raised concerns with CMS when IDREs used incorrect addresses or omitted claim numbers. SOF ¶ 32. This is the conduct of a company engaged in good-faith problem-solving, not one operating with ill will or seeking to avoid its obligations.

Aetna’s commitment to “100 percent accuracy 100 percent of the time” reflects good-faith

diligence, not bad faith obstruction. SOF ¶ 6. Aetna invested heavily in compliance, responded swiftly when volume surged, proactively communicated with CMS, and continued to tighten its processes. The timing challenges it faced were caused by a dysfunctional federal system and by Plaintiffs' own filing practices, not by any "furtive design" on Aetna's part. Thus, Plaintiffs' CUIPA/CUTPA claim fails as a matter of law.

D. There is no basis to award Plaintiffs punitive damages

Plaintiffs seek punitive damages in connection with their CUTPA claim. *See* Compl. (ECF No. 109) at 14 (¶ 45). As Plaintiffs have no CUTPA claim (*see* § V.C, *supra*), questions of punitive damages are moot. *See Carroll v. Yankwitt*, 250 A.3d 696, 720 (Conn. App. 2021) ("As our Supreme Court has observed, because the defendant did not violate CUTPA, we need not address whether the trial court abused its discretion by not awarding . . . punitive damages to the plaintiffs as part of the CUTPA award." (citation modified)).

But even if Plaintiffs had a viable CUTPA claim, punitive damages would still be off the table. Under Connecticut law, to award punitive damages on a CUTPA claim the evidence "must reveal a reckless indifference to the rights of others or an intentional and wanton violation of those rights. In fact, the flavor of the basic requirement to justify an award of punitive damages is described in terms of wanton and malicious injury, evil motive and violence." *Gargano v. Heyman*, 525 A.2d 1343, 1347 (Conn. 1987) (internal citation omitted). There is no such evidence as to Aetna here. To the contrary, Aetna's attempts to deal with the unforeseen and unforeseeable onslaught of NSA-related claims, including by investing into personnel and systems to help deal with the administrative and logistical difficulties presented by the sheer volume of IDR initiations, shows good faith. Thus, there is no basis to award punitive damages.

V. CONCLUSION

Plaintiffs' remedies for Aetna's alleged (albeit nonexistent) wrongdoing in the IDR process

do not lie in court; they lie an administrative complaint with CMS. For the reasons set forth above, Aetna respectfully requests summary judgment in its favor on Plaintiffs' claims.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was filed electronically on March 19, 2026. Notice of this filing will be sent by operation of the Court's electronic filing system to all parties indicated on the electronic filing receipt.

/s/ M. Katherine Strahan

M. Katherine Strahan

**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

**AETNA’S LOCAL RULE 56(A)1 STATEMENT OF UNDISPUTED MATERIAL
FACTS IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT**

Pursuant to Local Rule 56(a)1, Defendants Aetna Health Inc., Aetna Life Insurance Co., and Aetna Health and Life Insurance Co. (collectively, “Aetna”) file this Statement of Undisputed Material Facts in support of its Motion for Summary Judgment:

1. On December 21, 2021, the Centers for Medicare and Medicaid Services (“CMS”) CMS sent a letter to the Governor of Connecticut and Commissioners from the Connecticut Insurance Department and the Department of Public Health, informing them that “CMS will directly enforce” the NSA “in Connecticut with respect to health insurance issuers, health care providers, facilities, and providers of air ambulance services.” Ex. 1 at 1.

2. The CMS letter further stated that “CMS will enforce the outcome of the federal independent dispute resolution process for such cases in Connecticut under section 2799A-2(b) of the PHS Act.” Ex. 1 at 5.

3. Aetna has instituted internal policies and procedures to ensure its compliance with the NSA’s requirements, including regarding the timing of payment of IDR awards. *See* Ex. 2 (describing procedures to ensure that Aetna “meet[s] the 30 calendar day turn-around time to issue

award amounts to the initiating party / provider”); Ex. 3 (specifying Aetna’s policy to issue payment “within 30 days of the date of the IDRE’s written decision”).

4. Among Aetna’s procedures are [REDACTED] including after an IDR award is issued, as a claim may be ineligible for payment for a number of reasons. Ex. 4 at 38:3-9.

5. These eligibility checkpoints include: [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED] Ex. 4 at 38:3-9.

6. Aetna’s corporate representative, Katherine O’Brien, testified on June 27, 2025, that Aetna “strive[s] for 100 percent accuracy 100 percent of the time.” Ex. 4 at 117:9-10; *see id.* at 117:19-21 (“We’re going to try to do our absolute best to be compliant with everything, all the timelines and procedures, 100 percent of the time.”).

7. “No one person at Aetna is responsible for th[e] entire process. Rather, the workflow is coordinated across multiple teams and departments, involving hundreds of different employees at Aetna.” Ex. 5 at ¶ 7.

8. When the NSA first took effect, Aetna’s Federal NSA team had approximately [REDACTED]

[REDACTED] Ex. 6 at 34:7-36:12.

9. The NSA’s implementation has created significant instability in the industry. Ex. 10 at 73:5-6 (testifying the implementation “was a chaotic rollout” that “created instability in the process.”).

10. During the initial years of IDR implementation, IDR entities (or “IDREs”) were “far behind in processing decisions,” and there have been “multiple disruptions in the process since implementation.” Ex. 10 at 73:8-17.

11. In 2023, litigation challenging the IDR regulations led to the federal IDR portal being shut down for nearly four months, during which initiating parties accumulated volume. Ex. 6 at 133:4-10; Ex. 10 at 73:14-16.

12. “The unanticipated volume of disputes” and the “temporary shutdown of the IDR portal early on in the process created a snowball effect introducing instability in the IDR process and resulting in substantial backlogs and uncertainty for providers and insurers.” Ex. 10 at 73:14-16, 79:23-80:3.

13. [REDACTED]

[REDACTED] Ex. 7 at 7-8, Figure 2.

14. [REDACTED]

[REDACTED] Ex. 7 at 7-8, Figure 2.

15. Because providers control the initiation of IDR disputes, there was no practical way for Aetna to anticipate the volume of disputes that would be filed after the federal IDR portal shutdown, and the staffing levels needed to process them. Ex. 6 at 133:14-25, 135:1-18.

16. Aetna’s incoming volume of IDR disputes increased exponentially after the federal IDR portal reopened. *See* Ex. 18 at 3 (Aetna’s email to CMS noting that for disputes initiated between October 6, 2023 and November 3, 2023, volumes grew “exponentially,” with 17,788 total applications received during that period). Ex. 21; Ex. 22.

17. Aetna’s incoming volume ultimately quadrupled within months after the federal IDR portal reopened. Ex. 6 at 129:13-20, 135:2-7.

18. On March 2, 2023, Aetna Senior Manager Brady O’Brien sent an email to CMS requesting a report from the Federal IDR Portal of all determined cases for air ambulance submissions. Ex. 19. The email stated that “some cases for air ambulance providers have been determined but we do not have record of them.” Ms. O’Brien explained that this information was

needed “[i]n order to be compliant with the Federal IDR Process and payment of amounts to the initiating parties where Aetna is not the prevailing party” and “to ensure no cases are missed.” Ex. 19.

19. Aetna reported to CMS that its team was “working overtime and on weekends” to meet turnaround deadlines, and submitted a formal proposal to regulate the volume of disputes received by non-initiating parties. *See* Ex. 18; Ex. 19 (requesting a report from CMS because “some cases for air ambulance providers have been determined but we do not have record of them,” and explaining this was needed “[i]n order to be compliant with the Federal IDR Process and payment of amounts to the initiating parties”); Ex. 20 (Aetna’s email to CMS proposing a new timeline to handle the influx). Ex. 21; Ex. 22.

20. In June and July 2024, Aetna [REDACTED]

[REDACTED] Ex. 6 at 135:11-18.

21. Aetna engaged its [REDACTED]

[REDACTED] Ex. 6 at 195:3-9.

22. Aetna then onboarded [REDACTED]

[REDACTED] to address the surge, and retains the ability to scale up and add additional personnel if needed. Ex. 6 at 73:21-25, 196:10-23, 200:1-4.

23. Aetna’s stateside Federal NSA team has [REDACTED]—a number that does not include employees working for other departments [REDACTED]

[REDACTED] Ex. 6 at 27:16-18, 40:22-25, 41:1-14, 137:24-25, 196:7-10.

24. In total, Aetna’s Federal NSA team currently has [REDACTED] which is the

[REDACTED] Ex. 6 at 136:6-12.

25. Aetna’s NSA team “does not issue payment on any claim.” Ex. 7 at 57:16-21.

26. The NSA team processes IDR claims in Aetna's tracking system, and if an IDR claim is valid and additional payment is due to the provider, the claim "is routed to a rework claim processor to have that claim reworked to pay out that additional amount." Ex. 7 at 57:22-25, 58:1-3.

27. Aetna's [REDACTED]
[REDACTED] Ex. 8 at 19:11-13.

28. Additional team members can be trained as needed to [REDACTED]. Ex. 8 at 19:25, 20:1-4.

29. Aetna treats IDR claims as "priority claims for handling," with the rework team "always trying to do their best to get it done as quickly as possible." Ex. 8 at 54:13-22, 55:5-8.

30. [REDACTED]
[REDACTED] Ex. 7 at 103:23-25.

31. For example, Aetna has invested in developing a [REDACTED] to "gain efficiencies" in processing IDR claims. Ex. 6 at 214:2-217:16.

32. Aetna also set up a dedicated email address to receive IDR awards and raised concerns with CMS when IDREs used incorrect addresses or omitted claim numbers. Ex. 5 at ¶ 7; Ex. 13.

33. Aetna's executive director of specialty claim and claim rework in commercial service operations, Amy Baillargeon, testified that Aetna [REDACTED]
[REDACTED] for IDR processing. Ex. 8 at 14:16-21, 65:10-11.

34. Aetna [REDACTED] for processing IDR awards through its claim system [REDACTED] because, in Baillargeon's words, "we wanted to ensure we got the claim out as quickly as possible because we wanted to tighten up that turnaround time." Ex. 8 at 58:19-23.

35. As of Ms. Baillargeon's December 2, 2025, deposition, the oldest IDR claim with Aetna's rework team was [REDACTED]. Ex. 8 at 40:22-24.

36. Providers can choose to bundle their mileage and transport claims into a single IDR claim. Ex. 10 at 57:14-17 ("Under batching rules items and services may be considered jointly or batched together if they are related to a treatment of a similar condition.").

37. [REDACTED]
[REDACTED] Ex. 9 at Guardian00009959.

38. [REDACTED]
[REDACTED] Ex.
9 at Guardian00009959 (emphasis in original).

39. [REDACTED]
[REDACTED]
[REDACTED] Ex. 9 at Guardian00009959.

40. [REDACTED]
[REDACTED] Ex. 9 at Guardian00009958.

41. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] Ex. 9 at Guardian00009958.

42. An analysis of data for 2023 and 2024 shows that Plaintiffs submitted [REDACTED]
[REDACTED]
[REDACTED] Ex. 10 at 57:5-9.

43. [REDACTED]

[REDACTED] Ex. 11.

44. “[T]he volume of disputes filed through the IDR process has been “well beyond what the federal government expected” and “well beyond anyone’s expectations,” and “has continued to increase.” Ex. 10 at 68:4-7, 69:11-13.

45. At times, IDR entities hold cases for months or even years, “and then start making decisions on them all at one time.” Ex. 4 at 84:2-13 (providing an example of a circumstance that “would flood [Aetna’s] process and would hinder our ability to issue payment within 30 calendar days”).

46. A single IDR entity submitted over 3,500 requests within a 2-day time period and more than 2,700 fee invoices to Aetna on a single day in June 2024. *See* Ex. 12; Ex. 21; Ex. 22.

47. IDR entities have also issued IDR awards without the claim number—which Aetna needs to coordinate potential payment of the awards. Ex. 6 at 180:1-181:4.

48. IDR entities have even sent awards to the wrong Aetna email address, rather than the dedicated email address that Aetna has set up to receive IDR awards from IDREs. *See* Ex. 5 at ¶ 7 (“Aetna has set up a dedicated e-mail address to receive IDR awards from IDREs; however, IDREs do not always use the correct e-mail address.”); Ex. 13 (November 2023 e-mail from O’Brien to CMS noting that IDR initiators are using incorrect email for Aetna). Ex. 21; Ex. 22.

49. The federal IDR portal has, at times, prevented submission of dispute responses. Ex. 14 (documenting a malfunctioning submit button that blocked submissions). Ex. 21; Ex. 22.

50. The federal IDR portal has also generated email volumes so high that Microsoft rejected more than 1,700 messages, placing Aetna at risk of missing critical communications. Ex. 15 (showing bulk email rejections due to volume limits). Ex. 21; Ex. 22

51. Further, the federal IDR portal has blocked uploads for final offers and application responses, resulting in complete work stoppages. Ex. 16 (describing system errors preventing document uploads). Ex. 21; Ex. 22.

52. “If [Aetna] receive[s] a written determination from the IDRE and the determination PDF has the claim numbers on them with the service codes and the award amounts, then we will handle within the required 30 calendar days.” Ex. 6 at 180:5-10 (describing this as Aetna’s “normal process”).

53. [REDACTED]

[REDACTED] Ex. 17 at 45:2-5.

54. [REDACTED]

[REDACTED] Ex. 17 at 196:1-8.

55. [REDACTED]

[REDACTED] Ex. 17 at 196:9-18.

56. [REDACTED]

[REDACTED] Ex. 17 at 105:3-8, 102:1-4.

Respectfully submitted, this the 19th of March, 2026.

By: /s/ John B. Shely

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INSURANCE COMPANY INC. AND
AETNA HEALTH AND LIFE
INSURANCE CO.**

APPENDIX: SUMMARY JUDGMENT EXHIBITS

1. CMS letter dated December 21, 2021, *available at* <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA-Enforcement-Letters-Connecticut.pdf>
2. Arb Rework Follow Up – Due Report (Escalations) (AET-0000295)
3. No Surprises Act > No Surprises Bill Act (NSA) Federal – Claim Processing > Rework: Independent Dispute Resolution (IDR) Written Determinations – All Products on ACAS – Aetna Loss/Provider Win (AET-0001875)
4. Excerpts from the deposition of Katherine O’Brien, taken June 27, 2025
5. Affidavit of Katherine O’Brien, sworn October 7, 2024 (ECF No. 161-2)
6. Excerpts from the deposition of Regina Yeager, taken April 23, 2025
7. Declaration of Lindsay Knutson
8. Excerpts from the deposition of Amy Baillargeon, taken December 2, 2025
9. Excerpts from the deposition of Katherine O’Brien, taken November 11, 2024
10. Excerpts from the deposition of Lindsay Knutson, taken December 1, 2025
11. GMR emails, sent December 16-18, 2023 (Guardian00009957–9964)
12. Email from Aetna to CMS, sent June 13, 2024 (AET-0016400)
13. Email from Aetna to CMS, sent November 20, 2023 (AET-0016379)
14. Email from Aetna to CMS, sent November 2, 2022 (AET-0016375)
15. Email from Aetna to CMS, sent October 29, 2025 (AET-0016360)
16. Email from Aetna to CMS, sent November 26, 2024 (AET-0016332)
17. Excerpts from the deposition of Barbara Berkowitz, taken February 25, 2026
18. Email from Aetna to CMS, sent November 3, 2023 (AET-0016376)
19. Email from Aetna to CMS, sent March 2, 2023 (AET-0016382)
20. Email from Aetna to CMS, sent September 18, 2024 (AET-0016396)
21. Declaration of Amy Hegg, executed March 13, 2026
22. Declaration of Katherine O’Brien, executed March 13, 2026

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was filed electronically on March 19, 2026. Notice of this filing will be sent by operation of the Court's electronic filing system to all parties indicated on the electronic filing receipt.

/s/ M. Katherine Strathan

M. Katherine Strahan

EXHIBIT 1
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201



December 21, 2021

The Honorable Ned Lamont
Governor of Connecticut
210 Capitol Avenue
Hartford, CT 06106

Commissioner Andrew N. Mais
Connecticut Insurance Department
153 Market Street, 7th Floor
Hartford CT 06103

Commissioner Manisha Juthani, MD
Department of Public Health
410 Capitol Avenue
Hartford CT 06134

Dear Governor Lamont, Commissioner Mais, and Commissioner Juthani:

The purpose of this letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) understands that Connecticut has authority and intends to enforce certain provisions of the Public Health Service Act (PHS Act) as extended or added by the Consolidated Appropriations Act, 2021 (CAA) with respect to health insurance issuers and health care providers and facilities, and that CMS will directly enforce certain PHS Act provisions extended or added by the CAA in Connecticut with respect to health insurance issuers, health care providers, facilities, and providers of air ambulance services. This letter also provides the circumstances in which the Connecticut independent dispute resolution and federal patient-provider dispute resolution processes will apply, as well as the circumstances in which such federal dispute resolution processes will apply. Additionally, this letter reflects CMS's determination that the Connecticut external review process currently does not have the capability to address adverse determinations related to the surprise billing protections of the No Surprises Act under section 2719 of the PHS Act, as extended by Section 110 of the No Surprises Act, consistent with 45 CFR 147.136, as amended by the Requirements Related to Surprise Billing; Part II (86 FR 55980).

The CAA was enacted on December 27, 2020.¹ Title I (No Surprises Act) and Title II (Transparency) of Division BB of the CAA amended Title XXVII of the PHS Act by establishing new protections for consumers related to surprise billing and transparency in health care. The CAA contains new requirements for health insurance issuers in the individual and group markets, health care providers and facilities, and providers of air ambulance services. It amended section 2723 of the PHS Act and added a new section 2799B-4 of the PHS Act such that these new requirements are generally enforced in the same manner as the market-wide reforms in Part A of Title XXVII.² Therefore, states have primary enforcement authority over these new requirements under the CAA with respect to health insurance issuers, health care providers and facilities, and providers of air ambulance services.

CMS, on behalf of the Department of Health and Human Services (HHS), has an obligation under section 2723 of the PHS Act to directly enforce the applicable provisions in Parts A and D of Title XXVII of the PHS Act that a state fails to substantially enforce. Similarly, HHS has an obligation under section 2799B-4 of the PHS Act to directly enforce the applicable requirements under Part E of Title XXVII of the PHS Act that a state fails to substantially enforce. Therefore, in June 2021, CMS asked each state to complete a written survey providing its assessment of whether the state has the authority and intends to substantially enforce the new consumer protections extended or added to the PHS Act by the CAA beginning on the applicable effective date (generally January 1, 2022). In addition, CMS asked each state whether it has an All-Payer Model Agreement or specified state law in order to determine whether the federal independent dispute resolution (IDR) process would apply in the state beginning on January 1, 2022. CMS also asked whether the state has any state resolution process for payment disputes between providers and uninsured (or self-pay) patients in order to determine whether the federal patient-provider dispute resolution will apply in Connecticut. We have included a copy of this survey as an appendix to this letter. The survey includes descriptions of each applicable provision's requirements. Please note, these descriptions are not an exhaustive list of all the new requirements and should not be used as a substitute for the statutory provisions or implementing regulations.

Enforcement

Based on the survey response and CMS communications with the Connecticut Insurance Department and the Department of Public Health staff, CMS understands that the Connecticut Insurance Department will enforce sections 2719 (as applied by section 110 of the No Surprises Act), 2746 (other than section 2746(c)), 2799A-1, 2799A-3, 2799A-4, and 2799A-5 of the PHS Act with respect to health insurance issuers; and the Connecticut Insurance Department will enforce section 2799B-2 with respect to health care providers and facilities.

However, the Connecticut Insurance Department stated it lacks authority to enforce sections 2799A-2 and 2799A-9 (other than section 2799A-9(a)(4)) of the PHS Act with respect to health insurance issuers; sections 2799B-1, 2799B-3, 2799B-8, and 2799B-9 with respect to health care

¹ Pub. L. 116-260 (Dec. 27, 2020).

² While the general enforcement framework is the same under sections 2723 and 2799B-4 of the PHS Act, there are differences in the federal civil money penalties that can be imposed for violations of provisions that fall under each statute. Compare, e.g., 42 U.S.C. 300gg-22(b)(2)(C) with 42 U.S.C. 300gg-134(b)(1).

providers and facilities; section 2799B-5 with respect to providers of air ambulance services; and sections 2799B-6 and 2799B-7 with respect to health care providers, facilities, and providers of air ambulance services. CMS will therefore directly enforce these provisions in Connecticut pursuant to sections 2723 and 2799B-4 of the PHS Act, as applicable.

Although CMS will assume direct enforcement of sections 2799A-2 and 2799A-9 (other than section 2799A-9(a)(4)) of the PHS Act with respect to health insurance issuers; sections 2799B-1, 2799B-3, 2799B-8, and 2799B-9 with respect to health care providers and facilities; section 2799B-5 with respect to providers of air ambulance services; and sections 2799B-6 and 2799B-7 with respect to health care providers, facilities, and providers of air ambulance services, we welcome the opportunity to accomplish our enforcement through a collaborative enforcement agreement with Connecticut. Under a collaborative enforcement agreement, the state will perform the compliance functions of policy form review, investigations, market conduct examinations, and consumer assistance, as applicable, with respect to the noted provisions of the PHS Act as extended or added by the CAA. Only in the event that Connecticut is unable to obtain voluntary compliance will CMS consider undertaking formal enforcement action against an health insurance issuers, health care providers, facilities, and providers of air ambulance services, to the extent warranted. Without such an agreement in place, CMS will perform these regulatory functions in Connecticut pursuant to sections 2723 and 2799B-4 of the PHS Act, as applicable. Although Connecticut did not indicate an interest in entering into a collaborative enforcement agreement with CMS in its survey responses, we welcome the opportunity to do so with respect to any of the noted PHS Act provisions at any time.

In the September 16, 2021 Notice of Proposed Rulemaking (NPRM) entitled, *Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement* (86 FR 51730), HHS proposed to have direct enforcement authority for new CAA provisions that require issuers to submit information to HHS regarding agent and broker compensation, air ambulance services, pharmacy benefits and drug costs, and compliance with the prohibition on gag clauses on price and quality information, unless the state notifies CMS of its intent to enforce. Therefore, if the September 16, 2021 NPRM is finalized as proposed, CMS expects to directly enforce sections 2746(c), 2799A-8, 2799A-9(a)(4), and 2799A-10 of the PHS Act with respect to issuers in Connecticut unless Connecticut notifies CMS of its intent to enforce.

We ask for your cooperation in working with CMS to effectively enforce the new PHS Act consumer protections extended or added by the CAA in Connecticut. If, in the future, Connecticut should act to assume enforcement authority of any of the provisions that CMS is currently responsible for enforcing, CMS will enter into discussions with Connecticut on the process for an effective transition to state enforcement under 45 CFR 150.221. We look forward to working with Connecticut to ensure that your residents are afforded all the protections in title XXVII of the PHS Act that were extended or added by the CAA.

I want to take this opportunity to thank the staff in the Connecticut Insurance Department and the Department of Public Health for the productive conversations and survey responses related to authority and enforcement of these new consumer protections. The existing PHS Act enforcement structure is very much a partnership between states and the federal government, and we recognize and support the fundamental role states play in protecting consumers. This letter

does not change Connecticut's role as primary enforcer of the other market-wide reforms codified in Parts A, B, and C of Title XXVII of the PHS Act with respect to health insurance issuers that issue, sell, renew or offer health insurance coverage in the individual or group market in Connecticut.³

Independent Dispute Resolution

Section 2799A-1 of the PHS Act governs the out-of-network rate that plans and issuers are generally required to pay nonparticipating providers and facilities for emergency services, and nonparticipating providers for non-emergency services performed at certain participating facilities. Section 2799A-2 of the PHS Act governs the out-of-network rate that plans and issuers are generally required to pay nonparticipating providers of air ambulance services for covered air ambulance services. The out-of-network rate under these sections may be determined by an All-Payer Model Agreement under section 1115A of the Social Security Act, or if the state does not have an All-Payer Model Agreement, a "specified state law," as defined in section 2799A-1(a)(3)(I) of the PHS Act and 45 CFR 149.30. In order for an All-Payer Model Agreement or specified state law to determine the out-of-network rate, it must apply to the nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services; the plan, issuer, or coverage (including where a state law applies because the state has allowed a plan that is not otherwise subject to applicable state law an opportunity to opt in, subject to section 514 of the Employee Retirement Income Security Act); and the item or service involved.

If neither an All-Payer Model Agreement nor specified state law apply, the out-of-network rate is an amount agreed upon between the plan or issuer and the provider, facility, or provider of air ambulance services. If the plan or issuer and the provider, facility, or provider of air ambulance services do not agree upon an amount and therefore enter into the federal independent dispute resolution process, the out-of-network rate is the amount determined by a certified independent dispute resolution entity. Sections 2799A-1(c) and 2799A-2(b) of the PHS Act require the Departments of HHS, Labor, and the Treasury to establish a federal independent dispute resolution process. In order to determine whether this federal independent dispute resolution process will apply in Connecticut and in what circumstances, in its written survey, CMS solicited information regarding state All-Payer Model Agreements and state laws that may be consistent with the federal definition for a "specified state law."

Connecticut does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response, CMS research, and CMS communications with the Connecticut Insurance Department and the Department of Public Health staff, CMS understands that CGS Sec. 38a-477aa, is a specified state law that will apply for purposes of determining the out-of-network rate with respect to certain health care services by out-of-network health care providers at an in-network facility or an out-of-network clinical laboratory upon referral of an in-network provider and emergency services furnished to individuals with

³ This includes the patient protections regarding choice of health care professional from section 2719A(a), (c), and (d) of the PHS Act, recodified by the No Surprises Act as new section 2799A-7 of the PHS Act. This also includes the internal claims and appeals requirements of section 2719(a) and the external review requirements of section 2719(b) of the PHS Act, as added by section 1001 of subtitle A of Title I of the Affordable Care Act.

coverage from health carriers in Connecticut.⁴ The federal independent dispute resolution process under section 2799A-1(c) of the PHS Act and 45 CFR 149.510 will apply for purposes of determining the out-of-network rate with respect to any items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Connecticut by nonparticipating providers and nonparticipating emergency facilities to which CGS Sec. 38a-477aa does not apply. The federal independent dispute resolution process under section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the out-of-network rate with respect to services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Connecticut by nonparticipating providers of air ambulance services. Connecticut will enforce the outcome of the federal independent dispute resolution process for such cases in Connecticut under section 2799A-1(c) of the PHS Act. CMS will enforce the outcome of the federal independent dispute resolution process for such cases in Connecticut under section 2799A-2(b) of the PHS Act.

Patient-Provider Dispute Resolution

Section 2799B-7 of the PHS Act requires HHS to establish a patient-provider dispute resolution process through which uninsured (or self-pay) individuals who, under section 2799B-6 of the PHS Act, receive a good faith estimate of the cost of a scheduled service from a provider, facility, or provider of air ambulance services and are then billed charges substantially in excess of that estimate can seek a determination from a dispute resolution entity for the amount of charges to be paid. Under the regulations implementing this statute, uninsured (or self-pay) individuals have 120 calendar days from receiving the initial bill containing charges for the item or service that is substantially in excess of the expected charges in the good faith estimate to initiate the patient-provider dispute resolution process and obtain a binding payment amount determination from a selected dispute resolution entity.

Under 45 CFR 149.620(h), HHS will defer to a state's patient-provider dispute resolution process if the state has a state law that meets the following minimum requirements with respect to the item or service for which payment is in dispute:

- Payment determinations made through the state process are binding, unless the provider, facility, or provider of air ambulance services offers for the uninsured (or self-pay) individual to pay a lower payment amount than the determination amount;
- The dispute resolution process takes into consideration a good faith estimate, that meets the minimum standards established in 45 CFR 149.610, provided by the provider, facility, or provider of air ambulance services to the uninsured (or self-pay) individual;
- If the state charges a fee to uninsured (or self-pay) individuals to participate in the patient-provider dispute resolution process, the fee must be equal to or less than the federal administrative fee; and
- The state must have in place a conflict-of-interest standard that, at a minimum, meets the requirements at 45 CFR 149.620(d) and (e).

⁴ The terms used are per Connecticut state law.

CMS will review changes to the state process on an annual basis (or at other times if CMS receives information from the state that would indicate the state process no longer meets the minimum federal requirements) to ensure the state process continues to meet or exceed the minimum federal standards.

In the event that the state process is terminated, or CMS determines that it no longer meets the minimum federal requirements described in 45 CFR 149.620(h)(2), CMS will make the federal process available to uninsured (or self-pay) individuals in that state to ensure that the state's residents have access to a patient-provider dispute resolution process that meets the minimum federal requirements.

In order to determine whether this federal patient-provider dispute resolution will apply in Connecticut and in what circumstances, CMS solicited information regarding any state resolution process for payment disputes between providers, facilities, or providers of air ambulance services and uninsured (or self-pay) patients as part of CMS's written survey.

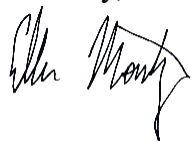
Connecticut did not indicate that any applicable state resolution process for payment disputes between providers and patients currently exists. Therefore, the federal patient-provider dispute resolution process under section 2799B-7 of the PHS Act and 45 CFR 149.620 will apply for purposes of determining the amount an uninsured (or self-pay) individual must pay a provider, facility, or provider of air ambulance services for an item or service for which the billed charges are substantially in excess of the good faith estimate of the expected charges that the applicable provider, facility, or provider of air ambulance services provided the individual prior to furnishing such item or service. CMS will enforce the outcome of the federal patient-provider dispute resolution process in Connecticut.

Please notify your CMS state engagement coordinators, Victoria Bernardini and Patti Farris, at Victoria.Bernardini@cms.hhs.gov and Patricia.Farris@cms.hhs.gov of any changes with respect to Connecticut's authority or intent to enforce any of the specified PHS Act provisions, and any changes with respect to the specified state law and state dispute resolution process.

If you have any questions or would like additional information regarding this letter, please do not hesitate to contact CMS State Engagement Coordinators at Victoria.Bernardini@cms.hhs.gov and Patricia.Farris@cms.hhs.gov, or Mary Nugent at 301-503-9718 or Mary.Nugent@cms.hhs.gov.

Thank you for your cooperation as we prepare, together, to make sure health care consumers across the country receive the full protections of the law.

Sincerely,

A handwritten signature in black ink, appearing to read "Ellen Montz", written in a cursive style.

Ellen Montz

Director, Center for Consumer Information and Insurance Oversight

Appendix

Background and Purpose Statement

This written survey is intended to capture the state's authority and intention to enforce specified provisions in Title XXVII of the Public Health Service Act (PHS Act), as amended by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021, which establish new protections for consumers related to surprise billing and transparency in health care.

With respect to health insurance issuers, facilities, and providers (including air ambulance services providers), states have primary enforcement authority over these new requirements. The Centers for Medicare & Medicaid Services (CMS) has a statutory obligation under sections 2723 and 2799B-4 of the PHS Act to directly enforce any provision (or provisions) that a state fails to substantially enforce. If the applicable state authority lacks the authority but wants to participate in the enforcement of a provision (or provisions), the applicable state authority may enter into a collaborative enforcement agreement (CEA) with CMS. Under a CEA, the applicable state authority agrees to seek voluntary compliance from health insurance issuers, providers, facilities, and/or air ambulance service providers, and refer to CMS for possible enforcement action any potential violation for which the state is not able to obtain voluntary compliance.

CMS will use the state's responses to this survey to determine, for each applicable provision and regulated entity, whether the applicable state authority will enforce the requirements directly or through a CEA, or whether CMS will be responsible for enforcement. To aid in the assessment of the state's authority and intention to enforce each applicable provision, a description of the requirements is included. Please note this description is not an exhaustive list of all the new requirements and should not be used as a substitute for the statutory provisions. The state should independently review each provision in the statute to determine whether it has sufficient authority to enforce the requirements with respect to each of the different regulated entities.

The Consolidated Appropriations Act, 2021 is available at:
<https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf>.

Title XXVII of the Public Health Service Act, as amended by the Consolidated Appropriations Act, 2021, is available at: <https://www.govinfo.gov/content/pkg/COMPS-8798/pdf/COMPS-8798.pdf>.

This survey also requests information regarding applicable state laws and regulations. To the extent that the state enacts legislation or issues a regulation that impacts the state's authority to enforce any of the specified provisions with respect to any of the regulated entities after submission of this survey, please notify your CMS state engagement coordinators.

Survey

PHS Act Sec. 2719 Appeals Process, as extended by Section 110 of the No Surprises Act

Applicability Date: This provision is applicable with respect to adverse benefit determinations related to surprise billing in plan years beginning on or after January 1, 2022.

Provision Description

Health plan participants and beneficiaries and health insurance policy enrollees must be permitted to request an external review as described under section 2719(b) of the PHS Act for adverse benefit determinations by a plan or issuer under sections 2799A-1 and 2799A-2 of the PHS Act, including decisions related to whether an item or service for which the adverse benefit determination was made is subject to the requirements under those sections.

Survey Questions

With respect to this provision (Sec. 2719 of the PHS Act, as extended by Section 110 of the No Surprises Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
 - a. If yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Does the state intend to enforce this provision against issuers?
3. Does the state currently have an external review process that applies to adverse benefit determinations under sections 2799A-1 and 2799A-2 of the PHS Act?
 - a. If yes, please provide the applicable citation(s) to state law or regulations.
 - i. Does the state believe the state's current standards are at least as consumer protective as the federal standards?
 - b. If no, will the state codify or promulgate such standards by the applicability date of this section (January 1, 2022)?

PHS Act Sec. 2746. Disclosure to Enrollees of Individual Market Coverage, as enacted by Section 202 of Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021

Applicability Date: This provision is applicable one year after the date of enactment except contracts executed prior to the applicability date of this provision are exempt from reporting and disclosure.

Provision Description

Issuers of individual health insurance coverage and short-term, limited-duration insurance coverage are required to disclose to enrollees prior to plan selection the amount of any direct or indirect compensation that the plan will pay to the agent or broker associated with that enrollment. This disclosure must also be included on any documentation confirming the enrollment. Additionally, issuers must annually report to the Secretary of Health and Human Services (HHS), prior to open enrollment, any direct or indirect compensation provided to an agent or broker associated with enrolling individuals in such coverage.

Survey Questions

With respect to this provision (Sec. 2746 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
 - a. If yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by December 27, 2021?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority (such as whether state authority is limited to issuers of individual health insurance coverage or short-term, limited-duration insurance).
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against issuers?

PHS Act Sec. 2799A-1 (a), (b), (d), (e) and (f). Preventing Surprise Medical Bills, as enacted by Sections 102, 107, and 111 of the No Surprises Act

Applicability Date: These requirements are applicable to all group health plans and health insurance coverage, including grandfathered health plans, for plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Provision Description

Limitations on Out-of-Pocket Costs for Out-of-Network Emergency Services

- If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to emergency services in the emergency department of a hospital or in an independent freestanding emergency department, the plan or issuer must cover emergency services without regard to whether the provider is a participating provider or facility and without prior authorization or any other limitation on coverage that is more restrictive than that applied for in-network emergency services.
- The cost sharing for out-of-network emergency services must count toward any in-network deductible or out-of-pocket maximums.

Cost-Sharing and Out-of-Network Payment Amounts

- The cost sharing is calculated as if the total amount that would have been charged for the emergency services by the out-of-network provider or facility were equal to the “recognized amount.” If the state has an All-Payer Model Agreement, the recognized amount is the amount the state approves under that system. If not, it is an amount determined under a “specified state law;” or if no such state law exists, it is the “qualifying payment amount.”
 - The term ‘specified state law’ means, with respect to a state, an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance

coverage offered by a health insurance issuer, a state law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively (to the extent such state law applies to such plan, coverage, or issuer, subject to section 514 of the Employee Retirement Income Security Act of 1974) in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility.

- The “qualifying payment amount” is an amount calculated using a methodology to be specified in rulemaking by CMS and the Departments of Labor and the Treasury (the Departments).
- The out-of-network rate that plans and issuers are required to pay may be the amount the state approves under an All-Payer Model Agreement or an amount determined under a specified state law. If neither of these two rates apply, providers are paid an amount agreed upon through a 30-day open negotiation period between the plan and the provider or the amount determined by an independent dispute resolution entity.
- Within 30 calendar days of receiving a claim subject to the surprise billing protections, plans and issuers must make an initial payment or send a notice of denial of payment.

Emergency Services Definition and Non-Emergency Services Provided by an Out-of-Network Provider at an In-Network Facility

- The definition of “emergency services” is expanded to include:
 - Such services provided by an independent freestanding emergency department, which is defined as a health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable state law, and provides emergency services.
 - Certain post-stabilization and observation services unless the provider determines the patient is able to travel using non-medical or non-emergency medical transport, satisfies consumer notice and consent requirements, and meets any other conditions specified by the Departments. The patient must be in a condition to receive the provider notice and provide informed consent in accordance with applicable state law.
- The consumer protections that apply to emergency services also apply to non-emergency services provided by an out-of-network provider at an in-network facility, unless, for some services, the provider satisfies certain notice and consent requirements.

Consumer Protections related to Price Transparency and Other Information

- Plans and issuers are required to include information about deductibles and out-of-pocket maximums and a customer service phone number and internet website on consumers’ insurance ID cards.
- Plans and issuers are required to provide an Advance Explanation of Benefits notice prior to scheduled services. This notice must include whether or not the provider or facility is in-network; a good faith estimate of the cost of the service, including the estimated amount the plan or coverage would be responsible for paying and the estimated cost-sharing amount the patient would be responsible for paying; information about what the enrollee has accrued toward meeting deductibles or out-of-pocket limitations; and whether the item or service is subject to medical management. If the provider or facility is in-network, the Advance Explanation of Benefits must include the contracted rate for

the service. If the provider or facility is out-of-network, the Advance Explanation of Benefits must describe how the patient may obtain information on participating providers and facilities.

Survey Questions

With respect to these provisions (Sec. 2799A-1(a), (b), (d), (e) and (f) of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
 - a. If yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision(s).
3. Please provide information about any “specified state law(s)” as defined above. Please describe the items, services, providers, facilities, and payers to which the specified state law applies.
4. Does the state have an All-Payer Model Agreement, and if so, please describe the items, services, providers, facilities, and payers to which the Agreement applies.
5. Please provide any applicable state law or regulation that determines an individual’s ability to provide informed consent.
6. Please provide any state laws or regulations governing authorized representatives.
7. Does the state intend to enforce this provision against issuers?

PHS Act Sec. 2799A-1(c). Preventing Surprise Medical Bills, Independent Dispute Resolution (IDR) Process, as enacted by Section 103 of the No Surprises Act

Applicability Date: These requirements are applicable for plan years beginning on or after January 1, 2022.

Provision Description

- The out-of-network rate that plans and issuers are required to pay providers for claims subject to surprise billing protections under PHS Act section 2799A-1 subsection (a)(1) or (b)(1), regarding coverage of emergency services and coverage of non-emergency services performed by nonparticipating providers at certain participating facilities, respectively, is (1) an amount determined by an applicable All-Payer Model Agreement under Social Security Act section 1115A, (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law, or (3) if there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by plan or issuer and the provider or facility, or (4), if none of those three conditions apply, an amount determined by an IDR entity.
- During the 30-day period beginning on the day the provider receives an initial payment or notice of denial of payment from the plan or coverage, the plan or issuer or provider may

initiate open negotiations. After 30 days, if there is no agreement, the parties may choose to enter an IDR process.

- Initiation of IDR process: A provider or plan or issuer may, during the 4-day period beginning on the day after the open negotiation period, initiate the IDR process by submitting a notification to the other party and the applicable Department.
- Certification of IDR entities: the Departments shall establish a process to certify (and recertify) every five years, and can revoke certifications, to ensure entities:
 - 1) have sufficient expertise and staffing to make payment determinations;
 - 2) are not a group health plan or health insurance issuer, or provider, or facility, or an affiliate or subsidiary of such, or an affiliate or subsidiary of a professional or trade association of such;
 - 3) carry out the required responsibilities;
 - 4) meet appropriate indicators of fiscal integrity;
 - 5) maintain confidentiality of individually identifiable health information;
 - 6) do not carry out any determinations for which they are not eligible for selection under the method specified by the Departments; and
 - 7) meet such other requirements as determined appropriate by the Departments.
- Selection of certified IDR entities: Under the IDR process, the plan or issuer and provider can jointly select an IDR entity, not later than the last day of the 3-business day period following the date of the initiation of the process. If there is no agreement on an IDR entity by the two parties, the applicable Department will select an entity not later than the 6 business days after initiation. IDR entities are required to make a decision on a payment amount within 30 days of being selected.
- Submission of offers and IDR determination: Not later than 10 days after the date of selection of the IDR entity, the parties are required to submit to the IDR entity an offer for a payment amount for the item or service. The IDR entity is required to select one offer to be the amount of payment for the item or service. In evaluating the offers, the IDR entity is required to consider:
 - 1) the qualifying payment amount for the item or service; and
 - 2) other additional information such as the level of training of the provider, quality and outcomes measurements, the market share held by the plan or provider, the acuity of the patient or complexity of providing the item or service to the patient, the teaching status and case mix of the facility, and demonstrations of good faith efforts made by the plan or provider to enter into a contract with the other party during the prior 4 years.
- In evaluating the offers, the IDR entity is prohibited from considering:
 - 1) the plan's usual and customary charges;
 - 2) the amount that would apply if surprise billing protections did not apply to the service; and
 - 3) the payment rate to that provider for the service from public payers including Medicare, Medicaid, CHIP, Tricare and VA coverage.
- Determinations by the IDR entity are binding and not subject to judicial review, except in cases of a fraudulent claim or evidence of misrepresentation of the facts presented to the IDR entity. The party that submitted the notification of initiation of the IDR process may not submit another notification to the same other party initiating the IDR process for an

item or service that was the subject of the initial notification for 90 days. The party may submit such a notification by the 30th day following the 90-day period.

- Costs of the IDR process: The party whose offer is not chosen must pay all fees charged by the IDR entity. In cases where a settlement is reached, IDR entity fees would be split between the parties, unless they agree otherwise. Both parties also must pay an administrative fee for participating in the IDR process set by the applicable Department based on the estimated expenditures made by the applicable Department for the year to carry out the IDR process.
- The provision also allows parties to batch claims brought to the IDR process to promote administrative efficiency.

Survey Questions

With respect to this provision (Sec. 2799A-1(c) of the PHS Act), please provide responses to each of the below questions.

1. Does the state have a state law or regulation that provides for a method for determining total out-of-network payment amounts?
 - a. If yes, please provide the applicable citation(s) to state law or regulations and describe the items, services, providers, facilities, and payers to which the specified state law or regulation applies. Is the state law or regulation binding on the parties?
2. Does the state currently have an IDR process for payment disputes between plans or issuers and providers?
 - a. If yes, please provide the applicable citation(s) to state law or regulations.
 - i. Please describe the items, services, providers, facilities, and payers to which the state law or regulation applies. Is the state law or regulation binding on the parties?
 - ii. Does the state have an IDR opt-in option for self-insured plans and/or enrollees of self-insured plans?
 - iii. Does the state intend on continuing to provide for IDR for plans, issuers and providers once the Federal process is in place?
3. If the state does not have an All-Payer Model Agreement under section 1115A of the Social Security Act or a state law or regulation that provides for a method for determining total out-of-network payment amounts (such as an IDR process), does the state plan to codify or promulgate such standards and make available to plans, issuers and providers?
 - a. If yes, will the state be able to do so by the applicability date of this section?
 - i. If not, when does the state anticipate establishing such standards for plans, issuers and providers?
 - b. If no, does the state have the authority to enforce Federal IDR process standards against issuers, providers, and facilities?
 - ii. If yes,
 1. provide the applicable citation(s) with respect to each regulated entity.
 2. Please note any limitations or relevant information on authority.

3. Does the state intend to enforce this provision against issuers, providers, and facilities?
- iii. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 1. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?

PHS Act Sec. 2799A-2(a). Ending Surprise Air Ambulance Bills, as enacted by Section 105 of the No Surprises Act

Applicability Date: These requirements are applicable for services furnished during plan years that begin on or after January 1, 2022.

Provision Description

Group health plans and health insurance issuers are generally required to apply the same surprise billing requirements that apply to out-of-network emergency services to out-of-network air ambulance services, if the plan or issuer provides coverage of air ambulance services provided by an in-network provider.

Survey Questions

With respect to this provision (Sec. 2799A-2(a) of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
 - a. With respect to each regulated entity, if yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against issuers?

PHS Act Sec. 2799A-2(b). Ending Surprise Air Ambulance Bills Independent Dispute Resolution Process, as enacted by Section 105 of the No Surprises Act

Applicability Date: These requirements are applicable for services furnished during plan years that begin on or after January 1, 2022.

Provision Description

The Secretaries of HHS, Labor, and the Treasury are required to establish an IDR process similar to that for emergency services for determining out-of-network rates to be paid by plans and issuers to out-of-network air ambulance service providers.

Survey Questions

With respect to this provision (Sec. 2799A-2(b) of the PHS Act), please provide responses to each of the below questions.

1. If the state has an applicable All-Payer Model Agreement under section 1115A of the Social Security Act for payments for air ambulance providers, please provide the applicable citation(s) to state law or regulations and describe the items, services, providers, facilities, and payers to which the specified state law or regulation applies.
2. Does the state have a state law or regulation for air ambulance providers that provides for a method for determining total out-of-network payment amounts for air ambulance provider services?
 - a. If yes, please provide the applicable citation(s) to state law or regulations and describe the items, services, providers, facilities, and payers to which the specified state law or regulation applies. Is the state law or regulation binding on the parties?
3. Does the state currently have an IDR process for payment disputes between plans or issuers and air ambulance providers?
 - a. If yes, please provide the applicable citation(s) to state law or regulations.
 - i. Please describe the items, services, providers, facilities, and payers to which the state law or regulation applies. Is the state law or regulation binding on the parties?
 - ii. Does the state have an IDR opt-in option for self-insured plans and/or enrollees of self-insured plans?
 - iii. Does the state intend on continuing to provide for IDR for plans, issuers and air ambulance providers once the Federal process is in place?
4. If the state does not have an All-Payer Model Agreement under section 1115A of the Social Security Act or a state law or regulation that provides for a method for determining total out-of-network payment amounts (such as an IDR process), does the state plan to codify or promulgate such standards and make available to plans, issuers and air ambulance providers?
 - a. If yes, will the state be able to do so by the applicability date of this section?
 - i. If not, when does the state anticipate establishing such standards for plans, issuers and air ambulance providers?
 - b. If no, does the state have the authority to enforce Federal IDR process standards against issuers and air ambulance providers?
 - ii. If yes,
 1. Provide the applicable citation(s) with respect to each regulated entity.
 2. Please note any limitations or relevant information on authority.
 3. Does the state intend to enforce this provision against issuers and air ambulance providers?
 - iii. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 1. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?

PHS Act Sec. 2799A-3. Continuity of Care, as enacted by Section 113 of the No Surprises Act

Applicability Date: These requirements are applicable for plan years beginning on or after January 1, 2022.

Provision Description

If an enrollee is a continuing care patient, and the contractual relationship between the plan or issuer and the provider is terminated, benefits with respect to the provider or facility are terminated because of a change in terms of participation of the provider or facility, or a contract between a plan and an issuer is terminated – resulting in a loss of benefits with respect to a provider or facility, then the plan or issuer must, within a timely manner, notify the enrollee of the contract or benefit termination and his or her right to receive transitional care from that provider under the same terms and conditions that would have otherwise applied for the shorter of 90 days or when the enrollee is no longer a continuing care patient.

Survey Questions

With respect to this provision (Sec. 2799A-3 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
 - a. If yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against issuers?

PHS Act Sec. 2799A-4. Maintenance of Price Comparison Tool, as enacted by Section 114 of the No Surprises Act

Applicability Date: These requirements are applicable for plan years beginning on or after January 1, 2022.

Provision Description

Plans and issuers must offer price comparison guidance, by phone and on their website, to allow enrollees to compare the cost sharing for items and services furnished by any participating provider in a geographic region for the applicable plan year.

Survey Questions

With respect to this provision (Sec. 2799A-4 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?

- a. If yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against issuers?

PHS Act Sec. 2799A-5. Protecting Patients and Improving the Accuracy of Provider Directory Information, as enacted by Section 116 of the No Surprises Act

Applicability Date: These requirements are applicable for plan years beginning on or after January 1, 2022.

Provision Description

- Plans and issuers are required to establish a database on their public website that includes a list of participating providers and facilities and their provider directory information (name, address, specialty, telephone number and digital contact information). Plans and issuers must also establish a process to verify the provider directory information at least every 90 days.
- Plans and issuers are required to establish a process to confirm a provider's network status for enrollees upon request. If the request is made via telephone, plans and issuers must respond in writing within one business day and retain the communication in the enrollee's file for at least two years.
- Any directory that contains provider directory information, other than the required database, must include a notification that the information contained in the directory was accurate as of the date of publication and refer enrollees to the database for the most current provider directory information.
- Nothing in this section shall be construed to preempt any provision of state law relating to health care provider directories.
- If an enrollee is furnished, by a nonparticipating provider or a nonparticipating facility, an item or service that would otherwise be covered if provided by a participating provider or facility, and the enrollee relied on the provider directory information or information regarding the provider's network status provided by the plan or issuer which incorrectly indicated that the provider is in-network, the enrollee is only responsible for the in-network cost sharing amount, and the deductible and out-of-pocket maximum must apply as if the item or service was provided in-network.
- Plans and issuers must include on each Explanation of Benefits for an item or service subject to the surprise billing protections under section 2799A-1, information on the requirements and prohibitions under 2799B-1 and 2799B-2, and information on how to report potential provider or facility violations to the appropriate state and federal agencies. The Explanation of Benefits must also include any other requirements under state law regarding the amounts providers and facilities may charge for an item or service

provided out-of-network after receiving payment from the plan or coverage and any cost sharing from the enrollee.

Survey Questions

With respect to this provision (Sec. 2799A-5 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
 - a. If yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Please provide any state law or regulation regarding health care provider directories.
4. Please provide any state law or regulation regarding the amounts providers and facilities may charge for an item or service provided out-of-network after receiving payment from the plan or coverage and any cost sharing from the enrollee.
5. Does the state intend to enforce this provision against issuers?

PHS Act Sec. 2799A-9. Increasing Transparency by Removing Gag Clauses on Price and Quality Information, as enacted by Section 201 of Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021

Applicability Date: This provision was applicable upon enactment (December 27, 2020).

Provision Description

- Group health plans and issuers offering group health insurance coverage are prohibited from entering into agreements with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that restrict the plan or issuer from sharing provider-specific cost or quality of care information to referring providers, the plan sponsor, enrollees, or prospective enrollees; electronically accessing de-identified claims and encounter information for each enrollee in compliance with federal privacy laws; or sharing such information or directing that it be shared with a business associate.
- Issuers offering individual health insurance coverage are prohibited from entering into agreements with a health care provider, network or association of providers, or other service provider offering access to a network of providers that restrict the issuer from sharing provider-specific price or quality of care information to referring providers, the plan sponsor, enrollees, or prospective enrollees; or sharing such information for plan design, plan administration, and plan, financial, legal, and quality improvement activities with a business associate in compliance with federal privacy laws.

Survey Questions

With respect to this provision (Sec. 2799A-9 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
 - a. If yes, provide the applicable citation(s).
 - b. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - c. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce against issuers?
 - a. If so, as of when, given that the provision is already applicable?

PHS Act Sec. 2799B-1. Balance Billing in Cases of Emergency Services, as enacted by Section 104 of the No Surprises Act

Applicability Date: These requirements are applicable for services furnished during plan years that begin on or after January 1, 2022.

Provision Description

Nonparticipating providers and facilities that provide emergency services are prohibited from billing and holding patients liable for amounts greater than the in-network cost sharing that is based on the “recognized amount.”

Survey Questions

With respect to this provision (Sec. 2799B-1 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against providers and facilities?
 - a. With respect to each regulated entity, if yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against providers and facilities?

PHS Act Sec. 2799B-2. Balance Billing in Cases of Non-Emergency Services Performed by Nonparticipating Providers at Certain Participating Facilities, as enacted by Section 104 of the No Surprises Act

Applicability Date: These requirements are applicable for services furnished during plan years that begin on or after January 1, 2022.

Provision Description

- Nonparticipating providers who, in a participating facility, provide non-emergency items and services for which benefits are covered under the patient's plan or coverage are prohibited from billing and holding patients liable for amounts greater than the in-network cost sharing that is based on the "recognized amount," unless the provider satisfies certain notice and consent requirements. This exception does not apply to ancillary services, as defined in statute and rulemaking, or when there is no participating provider who can furnish the item or service at the facility.
- A nonparticipating provider or nonparticipating facility satisfies the notice and consent requirements in the following circumstances:
 - If the patient makes an appointment to receive items and services at least 72 hours in advance, the provider or facility provides the patient a written or electronic notice not later than 72 hours in advance of the appointment. If the patient makes an appointment within 72 hours of the appointment date, the provider or facility provides the notice on the date the appointment is made. The notice must:
 - Inform the patient that the provider or facility is a nonparticipating provider or facility;
 - Provide a good faith estimate of the charges for the scheduled items and services;
 - State that the provision of such estimate or consent to be treated does not constitute a contract with respect to the estimated charges;
 - In the case of a nonparticipating provider in a participating facility, include a list of and notice of the option for the patient to be referred to any participating providers at the facility who are able to provide the items and services;
 - Include information about whether prior authorization or other medical management may be required in advance of receiving the items and services;
 - Clearly state that consent to receive the items and services from the nonparticipating provider or nonparticipating facility is optional, and the patient may seek care from a participating provider or at a participating facility, in which case the charges to the patient would not exceed the applicable in-network cost sharing; and
 - Be available in the 15 most common languages in the geographic region.
- Nonparticipating providers and facilities are required to obtain written consent from and provide a signed copy of such consent to the patient. The nonparticipating provider or facility must retain a copy of the consent for at least seven years. The Secretary of HHS, in consultation with the Secretary of Labor, is directed to specify through guidance a document that constitutes such consent.

Survey Questions

With respect to this provision (Sec. 2799B-2 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against providers and facilities?
 - a. With respect to each regulated entity, if yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against providers and facilities?

PHS Act Sec. 2799B-3. Provider Requirements with Respect to Disclosure on Patient Protections against Balance Billing, as enacted by Section 104 of the No Surprises Act
Applicability Date: These requirements are applicable January 1, 2022.

Provision Description

Each health care provider and facility must make publicly available, post on their website, and provide consumers a one-page notice. The notice must contain information on the applicable balance billing requirements and prohibitions under sections 2799B-1 and 2799B-2, any other applicable state law requirements regarding how much the provider or facility can charge a patient for out-of-network services, and how to contact the appropriate federal agencies if the consumer believes that the provider or facility has violated the balance billing requirements and prohibitions.

Survey Questions

With respect to this provision (Sec. 2799B-3 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against providers and facilities?
 - a. With respect to each regulated entity, if yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Please note any applicable state legislation or regulation regarding cost-sharing limitations for out-of-network services.
4. Does the state intend to enforce this provision against providers and facilities?

PHS Act Sec. 2799B-5. Air Ambulance Services, as enacted by Section 105 of the No Surprises Act

Applicability Date: These requirements are applicable for services furnished during plan years that begin on or after January 1, 2022.

Provision Description

Air ambulance services providers are prohibited from billing or holding consumers liable for amounts greater than the in-network cost-sharing amount.

Survey Questions

With respect to this provision (Sec. 2799B-5 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against air ambulance services providers?
 - a. If yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against air ambulance services providers?

PHS Act Sec. 2799B-6. Provision of Information Upon Request and for Scheduled Appointments, as enacted by Section 112 of the No Surprises Act

Applicability Date: These requirements are applicable January 1, 2022.

Provision Description

When an individual schedules an item or service at least three business days in advance, providers and facilities must, within one business day of the date of scheduling, ask about the individual's insurance coverage status and whether the individual is seeking to have a claim submitted to the individual's plan or coverage, and provide a good-faith estimate of the expected charges to the plan or issuer or to the individual if they are not insured or are not seeking to have a claim submitted to their plan or coverage. If the individual schedules the item or service at least 10 business days in advance, the provider or facility must meet these requirements within three business days of the date of scheduling.

Survey Questions

With respect to this provision (Sec. 2799B-6 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against providers and facilities?
 - a. With respect to each regulated entity, if yes, provide the applicable citation(s).

- b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against providers and facilities?

PHS Act Sec. 2799B-7. Patient-Provider Dispute Resolution, as enacted by Section 112 of the No Surprises Act

Applicability Date: These requirements are applicable January 1, 2022.

Provision Description

- The Secretary is required to establish a patient-provider dispute resolution process where uninsured individuals who receive a good-faith estimate of the cost of a scheduled service from a provider (pursuant to 2799B-6), but who are billed charges substantially in excess of the estimate can seek a determination from a dispute resolution entity for the amount of charges to be paid. The Secretary will certify such entities that meet at least the requirements under 2799A-1(c). The process must establish a method of selection of a dispute resolution entity that is not a party to a dispute (or an employee or agent of such party, or have a material, familial, financial, or professional relationship with such party, or other conflict of interest).
- Uninsured individuals are those who, with respect to an item or service, do not have coverage under a group health plan or group or individual health insurance policy or a federal health care program or the federal employee health benefit program, or those who do have such coverage but do not have coverage for such item or service, or those who do not wish to seek coverage for the claim from their health plan or health insurance issuer for such item or service. The Secretary shall establish a fee for use of the process that does not act as a barrier to the uninsured individual's participation.

Survey Questions

With respect to this provision (Sec. 2799B-7 of the PHS Act), please provide responses to each of the below questions.

1. Does the state currently have a dispute resolution process for payment disputes between providers and patients?
 - a. If yes, please provide the applicable citation(s) to state law or regulations.
 - a. Does the state believe the state's current standards are consistent with section 2799B-7 of the PHS Act?
 - b. If no, can the state codify or promulgate such standards by the applicability date of this section?
 - c. If no, does the state plan to codify or promulgate such standards and make available to plans, issuers and providers an IDR process as defined in the statute?

- a. If yes, will the state be able to do so by the applicability date of this section?
 1. If not, when does the state anticipate establishing an IDR process for providers and patients?
2. If the state does not have an IDR process for providers and patients and does not plan to establish one by the applicability date of this statute, does the state have the authority to enforce Federal IDR process standards against providers?
 - a. If yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
 - e. Does the state intend to enforce this provision against providers?

PHS Act Sec. 2799B-8. Continuity of Care, as enacted by Section 113 of the No Surprises Act

Applicability Date: These requirements are applicable for plan years beginning on or after January 1, 2022.

Provision Description

In the case of services provided to a continuing care patient, providers are required to accept payment from plans and issuers and, if applicable, cost sharing from patients under their prior contract terms as payment in full, and must continue to adhere to all policies, procedures, and quality standards imposed under the prior contract.

Survey Questions

With respect to this provision (Sec. 2799B-8 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against providers?
 - a. If yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against providers?

PHS Act Sec. 2799B-9. Provider Requirements to Protect Patients and Improve the Accuracy of Provider Directory Information, as enacted by Section 116 of the No Surprises Act

Applicability Date: These requirements are applicable January 1, 2022.

Provision Description

- Providers and facilities are required to establish business processes to ensure the timely provision of provider directory information to plans and issuers. Such provider directory information must be provided when the provider or facility enters into or terminates a network agreement and when there are material changes to the provider directory information.
- If a nonparticipating provider or facility bills an enrollee an amount that exceeds the in-network cost sharing amount for an item or service that would otherwise be covered if provided by a participating provider or facility, in a manner that would be prohibited under § 2799A-5(b), the provider must refund the enrollee any amount he or she paid in excess of the in-network cost sharing amount, plus interest, at a rate determined by the Secretary.
- This section does not prohibit a provider from requiring in a contract or contract termination with a plan or issuer that the plan or issuer remove the provider from the provider directory upon termination of such contract or that the plan or issuer bear the financial responsibility for providing inaccurate network status information to an enrollee.
- Nothing in this section shall be construed to preempt any provision of state law relating to health care provider directories.

Survey Questions

With respect to this provision (Sec. 2799B-9 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against providers and facilities?
 - a. With respect to each regulated entity, if yes, provide the applicable citation(s).
 - b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
 - c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
 - d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against providers and facilities?

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-0702. The time required to complete this information collection is estimated to average 2.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:

OMB Control No. 0938-0702
Expiration Date: 12/31/2022

CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05,
Baltimore, Maryland 21244-1850.

EXHIBIT 2
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

Arb Rework Follow Up - Due Report (Escalations)

Friday, January 19, 2024 2:24 PM

To meet the 30 calendar day turn-around time to issue award amounts to the initiating party / provider, follow up is required when an award claim was sent for rework but has not yet been completed.



EXHIBIT 3
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

No Surprises Act > No Surprises Bill Act (NSA) Federal - Claim Processing > Rework: Independent Dispute Resolution (IDR) Written Determinations - All Products on ACAS - Aetna Loss/Provider Win

When the IDRE finishes their review of the IDR application and all documentation sent by both parties, the provider (the initiating party) and the health care company (Aetna), the IDRE decides the right OON rate to allow for the service(s)/item(s) included. They send us the decision in writing through email. It's called a written determination. The written determination, the decision made by the IDRE, is binding on all parties.

When the provider prevails (provider win, our loss): We issue payment of the difference between our portion of our original allowed amount and the IDR written determination award amount. We do this within 30 days of the date of the IDRE's written decision. We have to pay the award amount in full without any increase in the member's cost-

EXHIBIT 4
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

Case No. 3:24-cv-00680-MPS

GUARDIAN FLIGHT LLC, et al.,

Plaintiffs,

vs.

AETNA LIFE INSURANCE COMPANY,

et al.,

Defendants.

* * * HIGHLY CONFIDENTIAL * * *

* * * SUBJECT TO PROTECTIVE ORDER * * *

VIDEOTAPED DEPOSITION OF KATHERINE O'BRIEN

DATE TAKEN: June 27, 2025

TIME: 10:10 a.m. EST - 5:38 p.m. EST

ON BEHALF OF: Plaintiffs

PLACE: Via Zoom

TAKEN BY: Tami Cline, RMR, CRR

1 things.

2 BY MR. CHANG:

3 Q. I'm using your term. What do you mean by
4 "eligibility" here?

5 A. Is the participant covered on the plan for
6 the date of service? Is the service or supply
7 covered by the plan? Were all steps in the IDR
8 process represented correctly? There are multiple
9 eligibility checkpoints for the IDR process.

10 Q. And does Aetna perform some of these --
11 excuse me. Let me try that again.

12 Does Aetna assess eligibility for some of
13 these checkpoints that you mentioned after the IDR
14 determination has been issued?

15 A. Yes.

16 Q. Tell me all of the eligibility assessments
17 that Aetna makes after the IDR determination has
18 been issued.

19 MS. STRAHAN: Objection. Overly broad.

20 THE WITNESS: Yeah, I don't -- I don't have
21 them all memorized.

22 BY MR. CHANG:

23 Q. Tell me all of the eligibility assessments
24 that you can recall sitting here today that Aetna
25 makes after the IDR determination has been issued?

1 BY MR. CHANG:

2 Q. Setting aside errors on claims, is there any
3 other reason why Aetna wouldn't be able to pay an
4 award on eligible claims within 30 days?

5 MS. STRAHAN: Objection. Asked and answered.
6 Overly broad. Calls for speculation as worded,
7 and it's also vague and multifarious.

8 THE WITNESS: An influx of inventory all at
9 one time, you know, where IDR entities help cases
10 for 18 months, two years, two and a half years and
11 then started making decisions on them all at one
12 time would flood the process and would hinder our
13 ability to issue payment within 30 calendar days.

14 BY MR. CHANG:

15 Q. Any other reasons you can think of?

16 A. Not off the top of my head.

17 Q. Let's talk about the steps between receiving
18 the IDR determination and payment issuing. At a
19 high level, Aetna first has to receive a written
20 determination from an IDR entity, correct?

21 A. At this point in time the federal IDR portal
22 issues the email with the IDR determination on it,
23 but it is generated from the decision made by that
24 IDR entity.

25 Q. All right. So the first step between an IDR

1 BY MR. CHANG:

2 Q. Sometimes things fall through, at which point
3 an IDR determination might be issued and then
4 Aetna -- Aetna's SBRT team might catch it after the
5 determination is issued; is that right?

6 MS. STRAHAN: Objection. Calls for
7 speculation. Lack of foundation.

8 THE WITNESS: In a perfect world, that would
9 never happen. We strive for 100 percent accuracy
10 100 percent of the time. But can things slip
11 through? Absolutely. And when they do, we, you
12 know, correct our mistakes and try to do better.

13 BY MR. CHANG:

14 Q. "We strive for 100 percent accuracy
15 100 percent of the time." Is that true for getting
16 payment out for eligible claims for IDR
17 determinations?

18 A. Well, I would say that's true of any area of
19 Aetna. We're going to try to do our absolute best
20 to be compliant with everything, all the timelines
21 and procedures, 100 percent of the time.

22 Q. You're not aware of an acceptable rate of
23 error for the rework team, for example, getting
24 decisions out or payment out within 30 days?

25 MS. STRAHAN: Objection. Assumes facts not

CERTIFICATE OF REPORTER

STATE OF FLORIDA

COUNTY OF DUVAL

I, Tami Cline, Registered Merit Reporter, Certified Realtime Reporter, and Florida Professional Reporter, do hereby certify that I was authorized to and did stenographically report the examination of the witness named herein; that a review of the transcript was requested; and that the foregoing transcript is a true record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, or attorney, or counsel for any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the outcome of this action.

DATED THIS July 7, 2025, at Lakeland, Polk County, Florida.



Tami Cline, RMR, CRR, FPR

EXHIBIT 5
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

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

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

Plaintiffs,

v.

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

Defendants.

Case No. 3:24-cv-00680-MPS

AFFIDAVIT OF KATHERINE O'BRIEN

STATE OF FLORIDA

COUNTY OF DUVAL

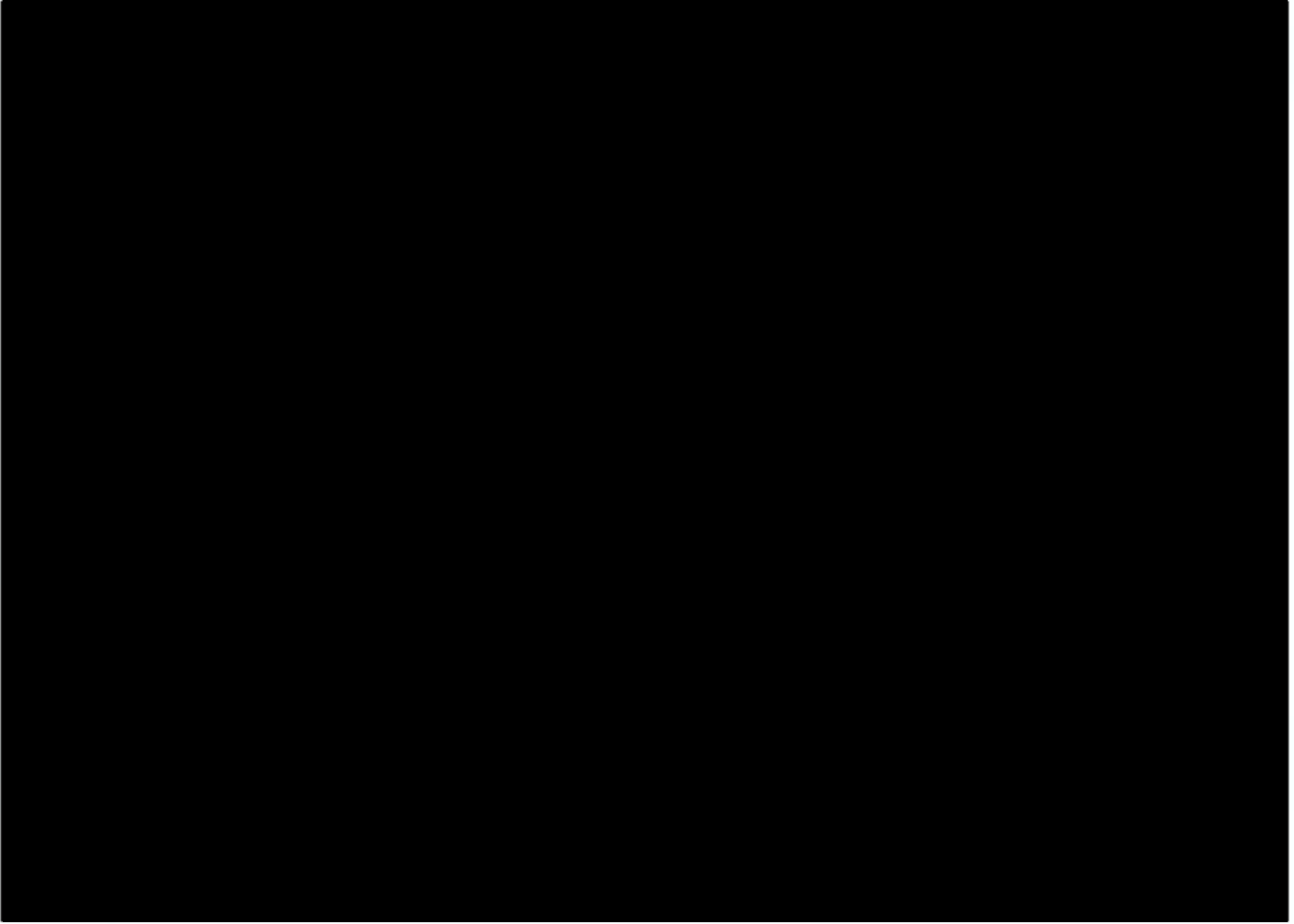
BEFORE ME, the undersigned authority, on this day personally appeared Katherine O'Brien, being duly sworn on her oath, deposed and stated the following:

1. My name is Katherine O'Brien. I am over the age of twenty-one and am fully able and competent to make this affidavit. I make this affidavit upon my personal knowledge, and all statements contained herein are true and correct.

2. I am employed on behalf of Aetna Life Insurance Company (“Aetna”) as a Senior Manager, Project Management, CSO Strategic Initiatives. I am located in Jacksonville, Florida. I have been employed by Aetna since December of 1997.

3. In my role at Aetna, I am familiar with the federal No Surprises Act (“NSA”) and the Independent Dispute Resolution (“IDR”) process established thereunder. I am also personally

generally familiar with (i) Aetna's processes for preparing and submitting Aetna's proposed payment amounts to IDR entities ("IDREs") during the IDR process, including Aetna's processes for calculating the proposed payment amounts, and (ii) Aetna's processes regarding how IDR awards (i.e., written payment determinations) are received, reviewed, and processed for payment.

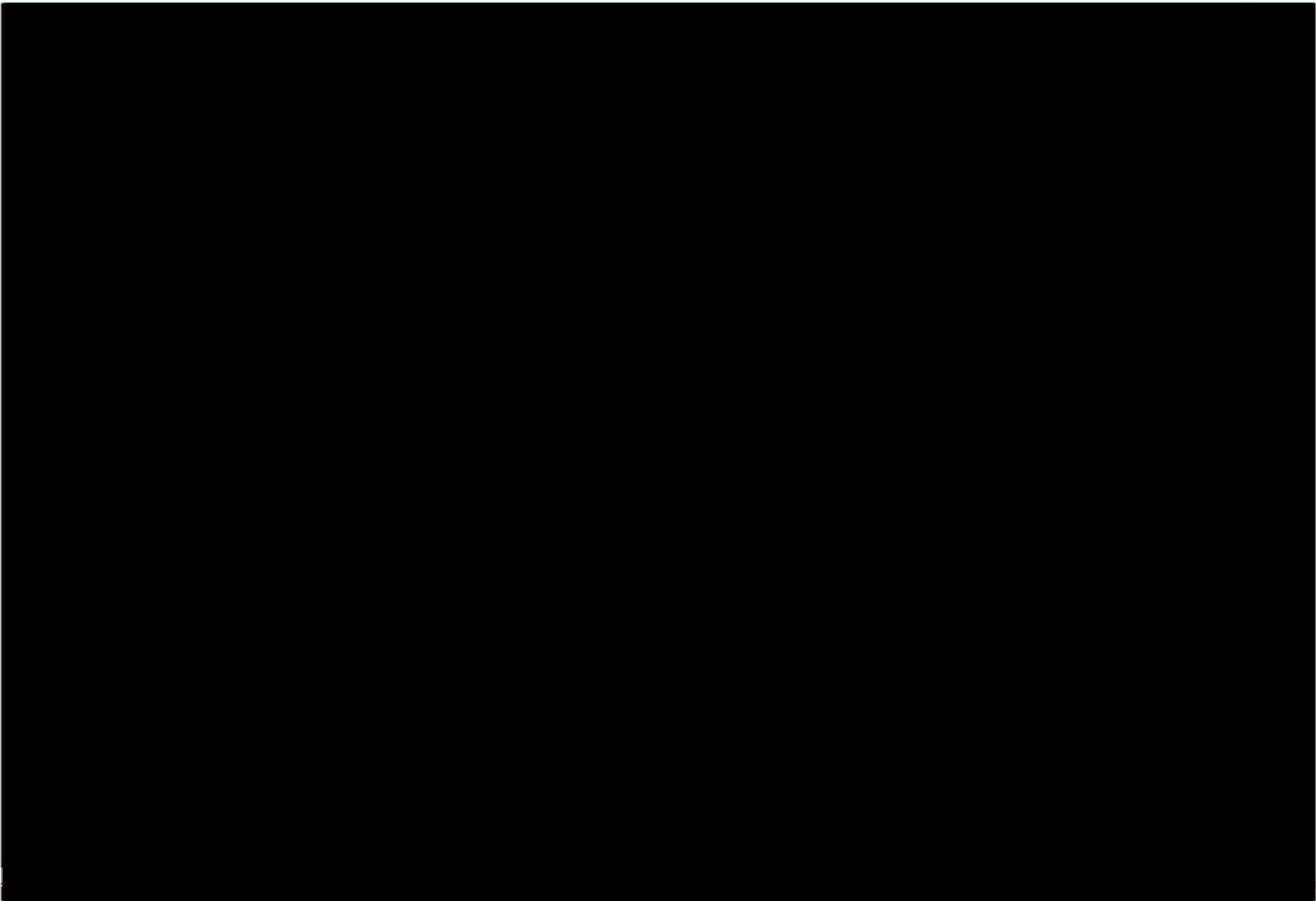


7. Aetna has set up a dedicated e-mail address to receive IDR awards from IDREs; however, IDREs do not always use the correct e-mail address. Once Aetna receives an IDR award, the award is reviewed and processed, including processes for additional payment. No one person at Aetna is responsible for this entire process. Rather, the workflow is coordinated across multiple teams and departments, involving hundreds of different employees at Aetna. Any given IDR award

typically involves handling by four different individuals across those teams and departments, and therefore, a hundred or so IDR awards could involve potentially hundreds of persons who handled all those awards at some point in the process.



9. Based on my experience at Aetna, I am also personally familiar with Aetna's general operations regarding claim payments to providers and how historical payment information is maintained in recent years.



Further Affiant sayeth not.



Katherine O'Brien

SWORN TO AND SUBSCRIBED before me on this the 7th day of October, 2024, to certify which witness my hand and official seal of office.



Notary Public in and for the State of Florida

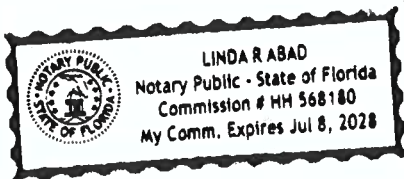


EXHIBIT 6
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment
UNREDACTED VERSION FILED
UNDER SEAL

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UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

GUARDIAN FLIGHT, LLC, et al,) No.
Plaintiff) 3:24-cv-00680-MPS
vs.)
AETNA LIFE INSURANCE)
COMPANY,)
Defendant)

VIDEOTAPED DEPOSITION OF REGINA YEAGER

Taken in the offices of Veritext Legal
Solutions, 5100 Tilghman Street, Suite 205,
Allentown, Pennsylvania, on Wednesday, April 23,
2025, commencing at 9:00 a.m., by Leandra M.
Stoudt, RPR, CBC, CCP, CRR, CCR-NJ, Notary Public.

APPEARANCES:

By: Abraham Chang, Esq.
NORTON ROSE FULBRIGHT US LLP
1550 Lamar Street, Suite 2000
Houston, TX 77010
abraham.chang@nortonrosefulbright.com
-- for the Plaintiff

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1 would say manages the Federal NSA team?

2 A. Team for the responsibilities that I
3 oversee?

4 Q. Yes.

5 A. No.

6 Q. And what responsibilities do you
7 oversee?

8 A. So I manage the open negotiations
9 managers. And all of the IDR phases of the
10 Federal NSA and that manager.

11 Q. Does that include payment of IDR
12 awards?

13 MS. STRAHAN: Objection. Vague.

14 A. So the -- my team does not rework IDR
15 awards.

16 Q. And I think we went over that.

17 But there is a different team that
18 managed the rework for IDR awards, is that right?

19 A. That's correct.

20 Q. And remind me what that team is
21 called.

22 A. The provider rework team.

23 Q. Provider rework team.

24 And do you know who oversees the
25 provider rework team?

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1 them?

2 A. I don't know.

3 Q. Let's take a look at this email you
4 sent October 14th, 2022, 10:13 a.m.

5 Do you see where it says, staffing?

6 A. I do.

7 Q. And in the subbullets, you have, [REDACTED]
8 [REDACTED] supporting open negotiations. Do you
9 see that?

10 A. I do.

11 Q. [REDACTED] supporting IDR. Do you
12 see that?

13 A. Yes.

14 Q. [REDACTED] assist as AOP from
15 provider rework. Do you see that?

16 A. I do.

17 Q. What does AOP mean here?

18 A. It is assisting other processing
19 unit. It's assisting from another organization to
20 come in and help with the work.

21 Q. As I understand this, am I
22 understanding correctly that there was [REDACTED]
23 [REDACTED] from the provider rework team that
24 were dedicated to the Federal NSA program?

25 A. Not dedicated, no.

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1 folks who focus on IDR additional information
2 emails?

3 A. [REDACTED]

4 Q. How many project managers in internal
5 FTEs are assisting your Federal NSA team?

6 A. [REDACTED]

7 Q. And do you know approximately how
8 many colleagues now assist as AOP from the
9 provider rework team?

10 A. [REDACTED]

11 Q. [REDACTED]

12 A. [REDACTED]

13 Q. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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1 Q. Okay. If I'm understanding
2 correctly, though, [REDACTED]

3 [REDACTED]

4 [REDACTED]

5 [REDACTED]

6 [REDACTED]

7 MS. STRAHAN: Objection.

8 Mischaracterizes testimony.

9 You can answer.

10 A. [REDACTED]

11 [REDACTED]

12 [REDACTED]

13 [REDACTED]

14 [REDACTED]

15 Q. I understand now. Thank you for
16 that.

17 A. Uh-huh.

18 Q. It seems like of all the staffing
19 growth you've had on the Federal NSA team, the
20 greatest amount of growth has been on the IDR
21 determination side. Is that right?

22 A. That's correct.

23 Q. [REDACTED]

24 [REDACTED]

25 A. Explain review.

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1 A. Yes.

2 Q. Does she conduct trainings for the
3 team?

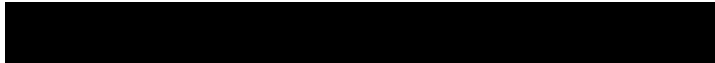
4 A. No.

5 Q. Does she interface with any of the
6 consultants or analysts?

7 MS. STRAHAN: Objection. Calls for
8 speculation.

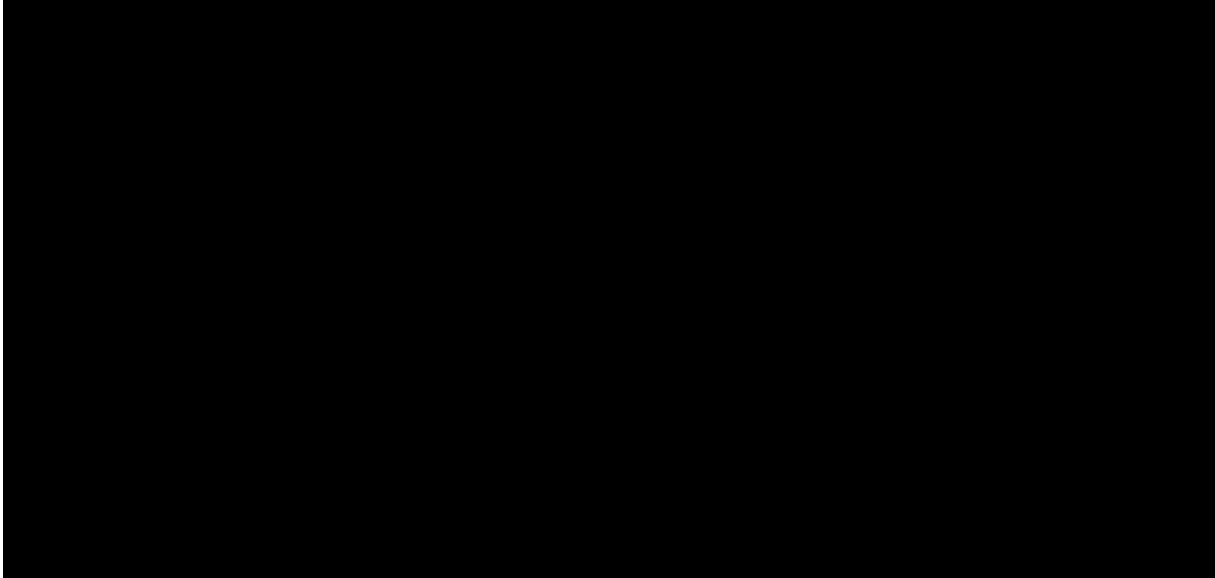
9 A. I'm not really sure. Unless if I'm
10 part of an email, there may be occasions that she
11 may reach out to an analyst.

12 Q. How many consultants are on the FED
13 NSA team?

14 A. 

15 Q. How many analysts?

16 A. 

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1 A. Correct.

2 Q. Would you tell me what those options
3 are?

4 A. They could -- it's either -- it
5 indicates who the prevailing party is, whether the
6 noninitiating or the initiating party. It could
7 be that the case was closed because it was
8 ineligible, or it could be dismissed because the
9 initiating party withdrew the case.

10 Q. And in what situation would an
11 initiating party withdraw a case? Do you know?

12 A. I do not.

13 Q. Okay. So either the initiating party
14 withdraws the case or the claim is ineligible or
15 one of the parties wins. Is that -- do I have
16 that right?

17 A. Yes.

18 Q. Let's talk about the -- the situation
19 in which a claim is ruled ineligible. In that
20 scenario --

21 MR. SMITH: Are we back on the
22 record? Because the Zoom participants can't hear
23 anything.

24 THE VIDEOGRAPHER: Stand by.

25 We're back on the record, and we're

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1 determinations within 30 days of receipt?

2 A. So that's very broad. All is a big
3 word. And so the answer to that is not all of
4 them. It all depends on the situation.

5 Q. What does it depend on?

6 A. So it depends on, as a -- an example
7 was when we received a very high volume of
8 incoming determinations after the federal portal
9 was closed down in the fourth quarter of '23. And
10 the IDREs and the initiating parties started
11 submitting massive loads of applications, and the
12 IDREs held onto those claims.

13 So when the floodgate opened for
14 Aetna was in that June/July timeframe of 2024. At
15 that time, our incoming volume spiked because of
16 the portal being shut down, as you're probably
17 aware of, for air ambulance four months in the
18 fourth quarter of 2023. It was also shut down for
19 two months for all of the singles and all of the
20 bundles.

21 So initiating parties stocked up on
22 their volume. And then when the -- when the
23 portal opened back up at the end of December, all
24 of that work got submitted.

25

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1 handle based upon CMS guidelines, that's what we
2 received. What that volume looks like, I don't
3 have that right now.

4 Q. But you remember from third quarter,
5 fourth quarter of 2023 to about mid 2024, there
6 were issues with the portal being shut and it --
7 just right there. You were aware of issues with
8 the portal being shut?

9 A. Yes, I was well aware the portal was
10 shut down because of the TMA lawsuit.

11 Q. Were you also aware that there were
12 IDR awards building up?

13 A. I had no line of sight.

14 Q. So you had no inkling that there were
15 IDR determinations building up while the portal
16 was shut down?

17 A. Well, so while the portal was shut
18 down, the only -- the only sight that we had were
19 the ones that determinations that were active
20 cases that were initiated prior to the four
21 months. Initiating parties could not submit
22 anything in the portal for the time the portal was
23 shut down. So there was no line of sight on
24 where -- what that volume looked like from the
25 initiating parties.

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1 Q. And that was happening every month?

2 A. Yes, it was happening every month.

3 But the volumes fluctuated, you know, day over

4 day, week over week, when we get the data dumps of

5 3,000 one day and 200 another day. So there was

6 no steady state to see the line of sight on what

7 [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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1 Q. What's the greatest number of
2 individuals that have been on the FED NSA team at
3 any point?

Category	Sub-category	Value
4	Category 4.1	Value 4.1.1
	Category 4.2	Value 4.2.1
	Category 4.3	Value 4.3.1
	Category 4.4	Value 4.4.1
	Category 4.5	Value 4.5.1
	Category 4.6	Value 4.6.1
	Category 4.7	Value 4.7.1
	Category 4.8	Value 4.8.1
	Category 4.9	Value 4.9.1
	Category 4.10	Value 4.10.1
3	Category 3.1	Value 3.1.1
	Category 3.2	Value 3.2.1
	Category 3.3	Value 3.3.1
	Category 3.4	Value 3.4.1
	Category 3.5	Value 3.5.1
	Category 3.6	Value 3.6.1
	Category 3.7	Value 3.7.1
	Category 3.8	Value 3.8.1
	Category 3.9	Value 3.9.1
	Category 3.10	Value 3.10.1

18 Q. It sounds like you have some idea of
19 when all the additional folks were on boarded, is
20 that right?

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1 Q. Do you know what the basis of her
2 statement was when she said that?

3 MS. STRAHAN: Objection. Calls for
4 speculation.

5 A. What she's stating is, our normal
6 process. If we receive a written determination
7 from the IDRE and the determination PDF has the
8 claim numbers on them with the service codes and
9 the award amounts, then we will handle within the
10 required 30 calendar days. And the reason that
11 she has this on here is because there are times,
12 and have been times, when we get a determination
13 and we have DLI numbers that mean nothing to Aetna
14 and we don't have claim numbers.

15 Q. And what's a DLI number?

16 A. I don't even really know what it
17 stands for because it's a -- something that the
18 portal and the IDREs use. So they'll -- they --
19 instead of giving us a determination, here are all
20 of your claim ID numbers, they use -- it's called
21 DLI number and it's like a five-digit number that
22 means nothing to a health plan.

23 Q. And Aetna needs the claim number to
24 determine whether an award should be paid?

25 A. Aetna needs the claim ID in order to

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1 | the exhibits since we're using EHI.

2 BY MR. CHANG:

3 [REDACTED]

[REDACTED] [REDACTED]

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1 Q. Are there -- does [REDACTED] have the
2 ability to scale up and add people to the team if
3 need be?

4 A. Yes.

5 Q. Do you know how much Aetna has spent
6 standing up the FED NSA team?

7 A. I do not. That's a very broad
8 question. Because there's a lot of areas that had
9 to put a lot of effort into standing up the FED
10 NSA from, you know, claim platforms to EOBs to
11 pricing to it's -- that's a huge, huge effort that
12 we as a company have completed. Like, you see our
13 EOBs, right, they look great. They have your
14 funding type on there, you got your disclaimer on
15 there, so they look -- that looks great. So we
16 did invest a lot of money to ensure that we are
17 compliant with all aspects of that.

18 Q. Have you heard the term surprise bill
19 review team?

20 A. Yes.

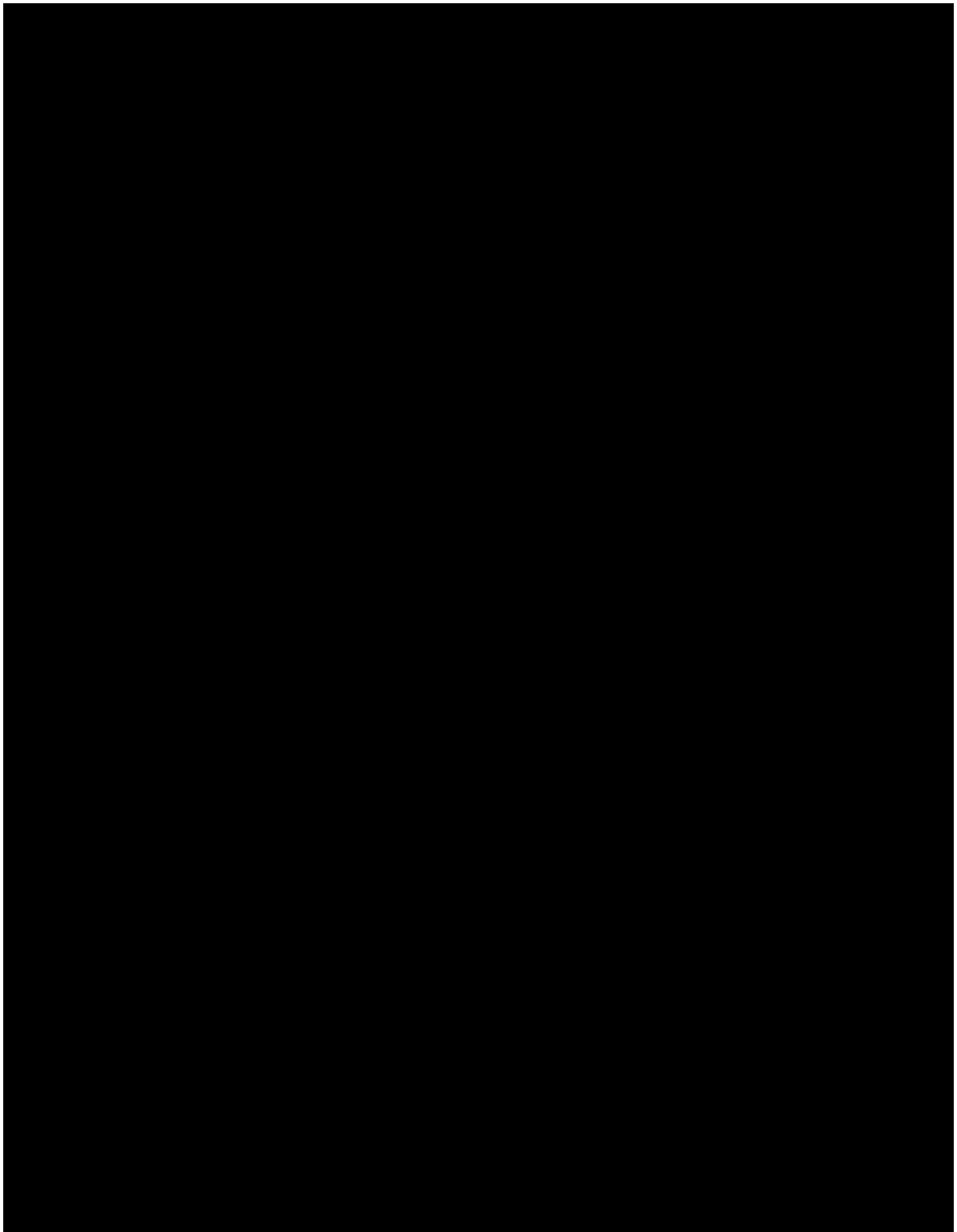
21 Q. And I know we've been talking about
22 IDR determinations or the IDR team. What is this
23 SBRT team in relation to what we've been
24 discussing today?

25 A. So -- well, let me ask you. Because

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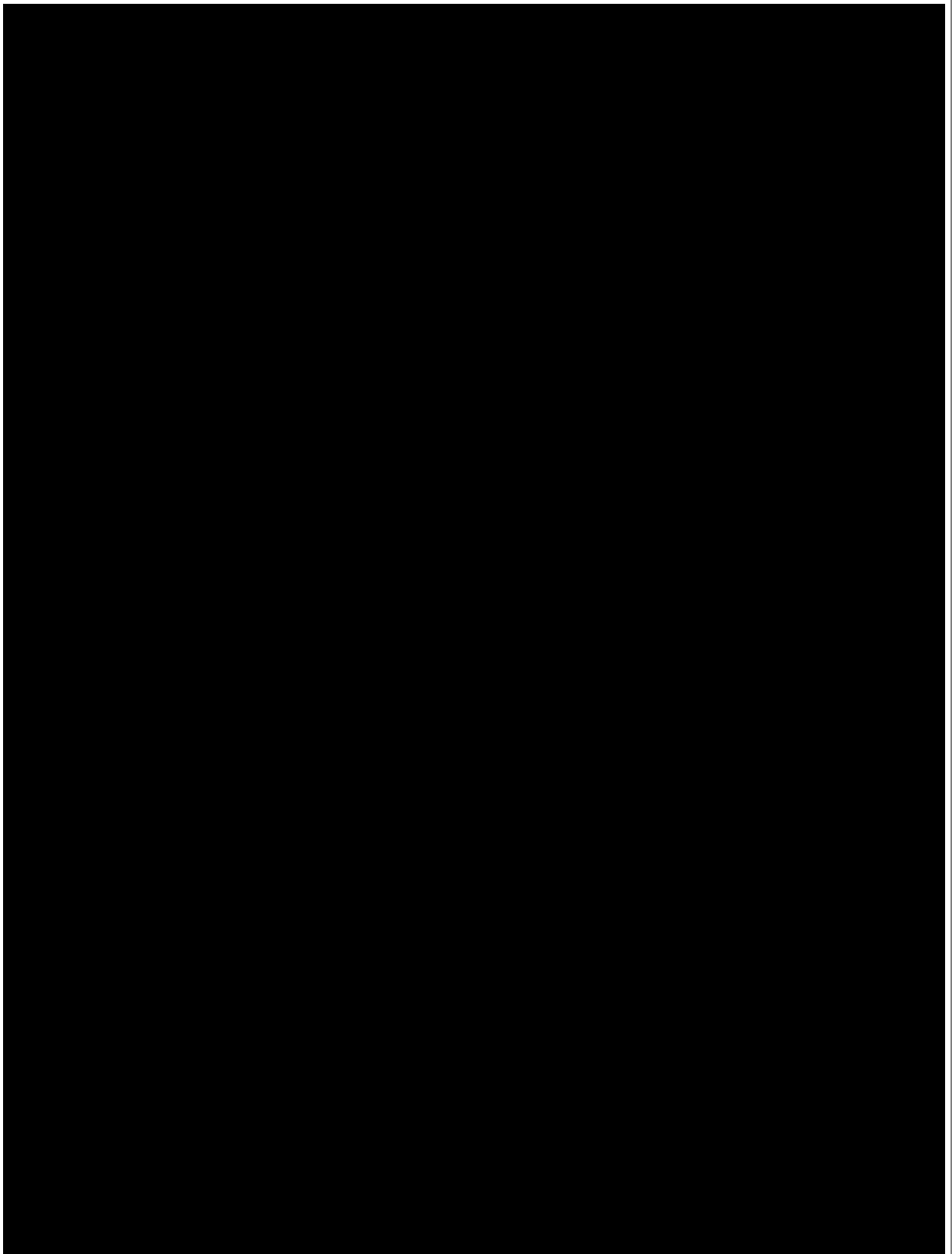
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CONFIDENTIAL

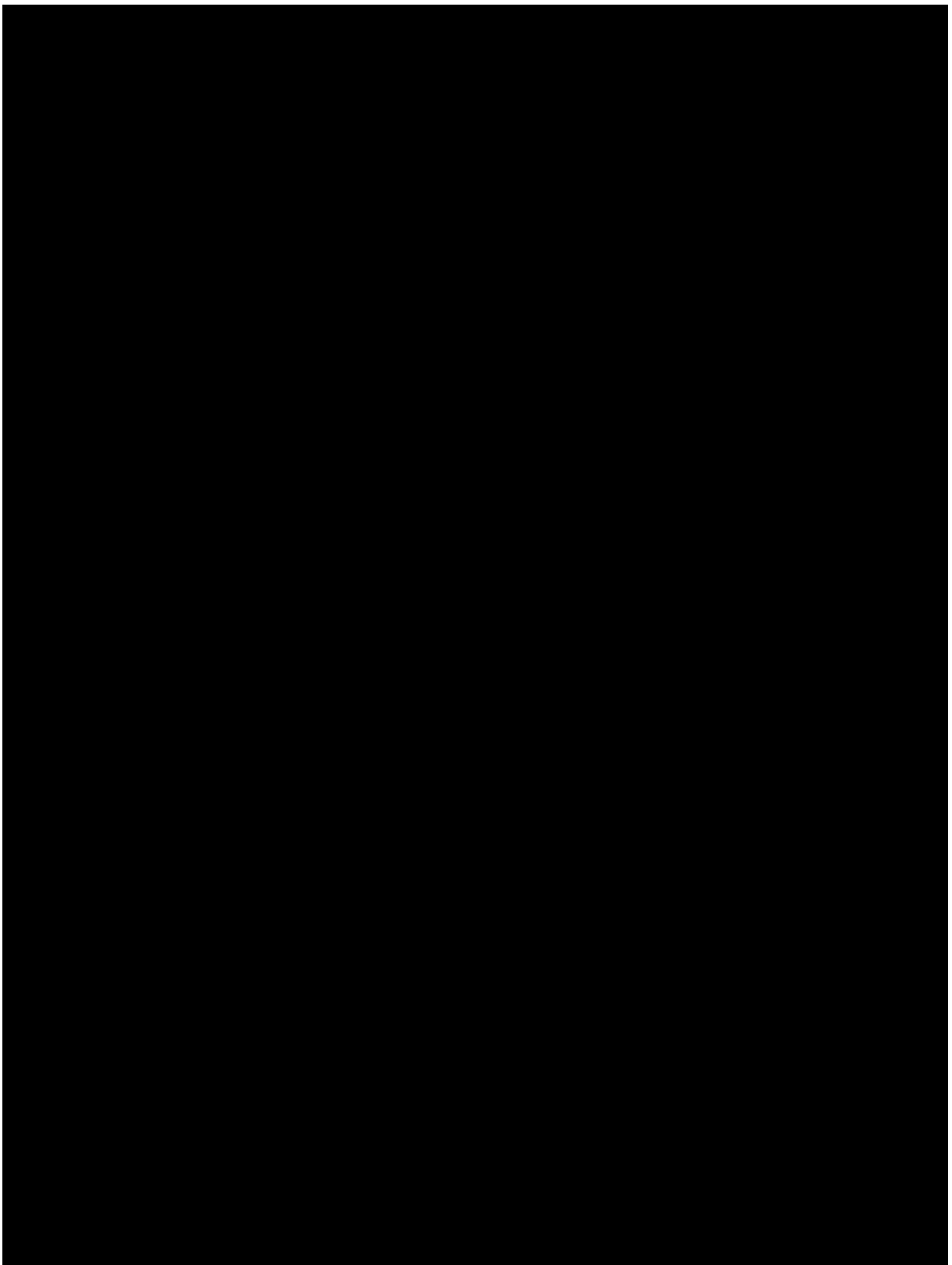
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CONFIDENTIAL

1 Q. And suffice to say that some things
2 got delayed?

3 A. Yes.

4 Q. Okay. This here is an estimate of
5 costs to develop the application. Is that right?

6 A. No. The development of the
7 application [REDACTED] The -- this estimated
8 cost is the annual cloud cost because it's a
9 cloud-based application [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

14 A. My IT partner. [REDACTED]

[REDACTED]
[REDACTED]
17 [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

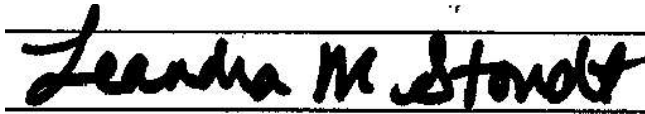
21 A. Uh-huh.

22 Q. There are some costs laid out in this
23 email. Are those also, I'll call them, variable
24 costs and what I'm saying is costs to operate this
25 application?

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CERTIFICATE

I do hereby certify that the aforesaid testimony was taken before me, pursuant to notice, at the time and place indicated; that said deponent was by me duly sworn to tell the truth, the whole truth, and nothing but the truth; that the testimony of said deponent was correctly recorded in machine shorthand by me and thereafter transcribed under my supervision with computer-aided transcription; that the deposition is a true and correct record of the testimony given by the witness; and that I am neither of counsel nor kin to any party in said action, nor interested in the outcome thereof.

A handwritten signature in black ink, reading "Leandra M. Stoudt", is written over a horizontal line.

Leandra Stoudt, RPR, CRR
CBC, CCP, CCR, Notary Public

EXHIBIT 7
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment
FILED UNDER SEAL

EXHIBIT 8
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment
UNREDACTED VERSION FILED
UNDER SEAL

CONFIDENTIAL - S ANT TO OTECTIVE O DE

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

GUARDIAN FLIGHT LLC, ET
AL.,

PLAINTIFFS,

CIVIL ACTION NO.
3:24-CV-00680-MPS

V.

AETNA LIFE INSURANCE
COMPANY, ET AL.,

DEFENDANTS.

CONFIDENTIAL - PURSUANT TO PROTECTIVE ORDER

REMOTE AND VIDEOTAPED DEPOSITION OF
AMY BAILLARGEON
DECEMBER 2, 2025

REMOTE AND VIDEOTAPED DEPOSITION OF AMY
BAILLARGEON, produced as a witness at the instance
of the Plaintiffs and duly sworn, was taken in the
above styled and numbered cause on Tuesday,
December 2, 2025, from 9:38 a.m. to 11:42 a.m.,
before TAMARA CHAPMAN, CSR, RPR-CRR in and for the
State of Texas, reported remotely by computerized
stenotype machine in Austin, Texas, pursuant to the
Texas Rules of Civil Procedure and the provisions
stated on the record herein.

Job No. TX 7747015

Page 1

CONFIDENTIAL - S ANT TO OTECTIVE O DE

1 what?

2 A. And the output of those tools.

3 Q. And how long were you in this role for?

4 A. Just shy of three years.

5 Q. Does the mandates implementation team
6 still exist?

7 A. Not in the form of when I had it. I
8 believe it still is, yes, functioning under --
9 combined with another team.

10 Q. What's that other team?

11 A. A compliance team within service
12 operations.

13 Q. Okay. And so you spent about three years
14 in the mandates implementation team. What came
15 next?

16 A. Then I came into the role that I'm in
17 today.

18 Q. And what role is that?

19 A. That is the executive director of
20 specialty claim and claim rework in commercial
21 service operations.

22 Q. So you fall under the commercial service
23 operations umbrella. Is that fair to say?

24 A. Yes.

25 Q. Is that what the branch or the team is

Page 14

CONFIDENTIAL - S ANT TO OTECTIVE O DE

1 rework, are they two different functions that you
2 oversee?

3 A. Yes.

4 Q. Does the specialty part of the business
5 ever touch the IDR process?

6 A. No.

7 Q. I think for today, then, most of our
8 questions will apply to claim rework. Do you
9 understand that?

10 A. I agree.

11 Q. So how big is your claim rework team?

12 A. [REDACTED] would be touching IDR
13 claims.

14

15

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17

18 Q. Got it.

19 So you've got [REDACTED]
20 processors. Is that -- am I getting that right?

21 A. Yes.

22 Q. And you have [REDACTED]
23 overall. Is that also right?

24 A. Yes.

25 Q. And if those [REDACTED] are

Page 19

CONFIDENTIAL - S ANT TO OTECTIVE O DE

1 underwater, let's say, could the other -- I'm not
2 going to try to do the math here, but could the rest
3 of the [REDACTED] jump in and help?

4 A. With training.

5 Q. So what -- what kind of training do these
6 [REDACTED] get?

7 [REDACTED]
8 [REDACTED]
9 [REDACTED]
10 [REDACTED]
11 [REDACTED]
12 [REDACTED]
13 [REDACTED]
14 [REDACTED]

15 MS. STRAHAN: Objection; vague.

16 A. [REDACTED]
[REDACTED]

18 Q. And what does it involve?

19 A. I can't answer that because I'm not --
20 I've not been in the training itself.

21 Q. You haven't been through the training,
22 but you know that your processing team goes through
23 about [REDACTED]

24 A. Yes, I know the timeline of the training.

25 Q. And then after the [REDACTED] of training,

Page 20

CONFIDENTIAL - S ANT TO OTECTIVE O DE

1 Q. Who reviews -- strike that.

2 Who conducts the quality review?

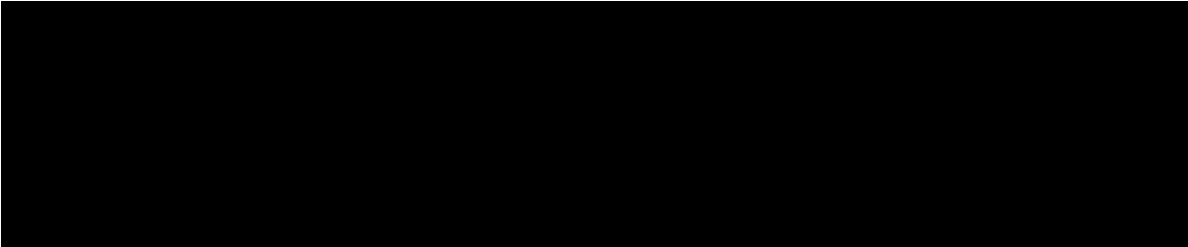
3 MS. STRAHAN: Objection; lack of
4 foundation.

5 A. There's a quality team within service
6 operations.

7 Q. You don't oversee that team. Correct?

8 A. No.

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13 A. For IDR claims, yes.

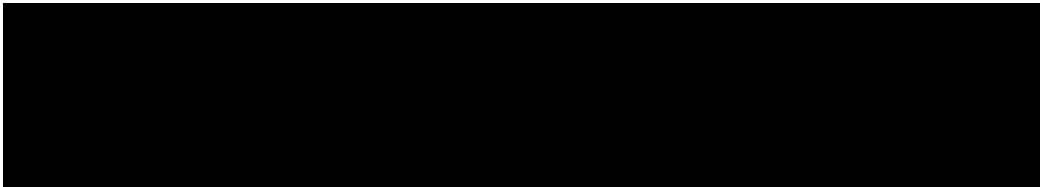
14 Q. You reviewed the report that you get
15 every day about your team's progress and metrics.
16 Correct?

17 A. Yes.

18 Q. What is the oldest IDR claim that has
19 been with your team?

20 MS. STRAHAN: Objection; overly
21 broad, asked and answered.

22
23
24

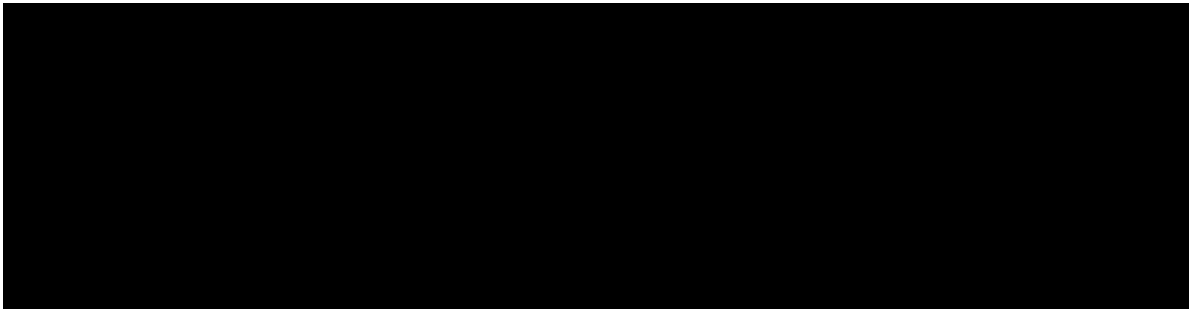


25 Q. Do you have any insight into what steps

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CONFIDENTIAL - S ANT TO OTECTIVE O DE

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Q. And what's your basis for saying --

A. -- meet that turnaround time.

Q. What's your basis for saying that it's likely tomorrow that it'll be down to [REDACTED]?

A. Because as of Friday it was [REDACTED].

Q. Every week do you try to get it down to [REDACTED]?

A. Every day they're striving to do their best. It's a --

Q. So is their --

A. -- priority.

Q. -- best --

MS. STRAHAN: Let her finish.

Q. I'm sorry. I cut you off.

A. These are priority claims for handling. They're always trying to do their best to get it done as quickly as possible.

Q. Are there nonpriority claims that are IDR awards?

MS. STRAHAN: Objection;

CONFIDENTIAL - S ANT TO OTECTIVE O DE

1 argumentative.

2 A. No, I don't believe I --

3 Simultaneous speaking.)

4 A. -- said that.

5 Q. And by "these are our priority claims,"
6 you are referring to all IDR awards. Am I
7 understanding that correctly?

8 A. Yes.

9

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MS. STRAHAN: Objection; asked and
answered, argumentative. And I also object to the
sidebar and the testifying. Whatever you're trying
to do with that question.

A. I don't know how to answer your question
because it's subjective.

Q. We're using your words. What do you
think is a good job?

MS. STRAHAN: Objection; that
mischaracterizes the testimony. She's -- she's
asked and answered this several times now.

MR. CHANG: Counsel, she hasn't
answered the question.

MS. STRAHAN: No. Yes, she has.

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1 been that way for the lion's share of this year.

2 Q. This year. It -- it was instituted this
3 year?

4 A. I don't recall the specifics. It was

5

6

7

8

9 A. Yes.

10 Q. And then at some point in the last year
11 or two it changed [REDACTED] Am I understanding
12 that correctly?

13 A. Yes.

14 Q. Were you involved in that change?

15 A. Yes.

16 Q. What was your involvement?

17 A. As part of a discussion with [REDACTED]

[REDACTED]

19 Q. Do you know why the change was made from
20 [REDACTED]?

21 A. We wanted to ensure we got the claim out
22 as quickly as possible because we wanted to tighten
23 up that turnaround time.

24 Q. In your view has changing it from [REDACTED]
25 [REDACTED] made an appreciable difference?

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1 minutes.

2 THE VIDEOGRAPHER: We are off the
3 record. The time is 11:28 a.m.

4 Break.)

5 THE VIDEOGRAPHER: We are back on the
6 record. The time is 11:39 a.m.

7 Q. Have you ever asked for additional
8 resources to help your IDR rework processing team
9 meet its [REDACTED] turnaround goal?

10 A. [REDACTED]
[REDACTED]

12 Q. Is there anything that you would change,
13 for instance, to get more resources to help your
14 team meet this [REDACTED]?

15 MS. STRAHAN: Objection; confusing,
16 overly broad.

17 A. Yeah, I'm not sure I understand the
18 question.

19 Q. Are you able to ask for additional
20 resources, if you need them, to help you meet this
21 [REDACTED] turnaround goal?

22 MS. STRAHAN: Objection; overly
23 broad.

24 A. We have a hiring process.

25 Q. Do you have room in your budget to hire

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CONFIDENTIAL - S ANT TO OTECTIVE O DE

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

GUARDIAN FLIGHT LLC, ET
AL.,

PLAINTIFFS,

CIVIL ACTION NO.
3:24-CV-00680-MPS

V.

AETNA LIFE INSURANCE
COMPANY, ET AL.,

DEFENDANTS.

REPORTER'S CERTIFICATION
DEPOSITION OF AMY BAILLARGEON
TA EN DECEMBER 2, 2025

I, TAMARA CHAPMAN, Certified Shorthand Reporter in
and for the State of Texas, hereby certify to the
following:

That the witness, AMY BAILLARGEON, was duly sworn
by the officer and that the transcript of the oral
deposition is a true record of the testimony given
by the witness;

That the original deposition was delivered to
ABRAHAM CHANG;

That a copy of this certificate was served on all
parties and/or the witness shown herein on

.

I further certify that pursuant to FRCP No.
30 f) i) that the signature of the deponent:

Page 69

CONFIDENTIAL - S ANT TO OTECTIVE O DE

1 was requested by the deponent or a party before
2 the completion of the deposition and that the
3 signature is to be returned within 30 days from date
4 of receipt of the transcript. If returned, the
5 attached Changes and Signature Page contains any
6 changes and the reasons therefor;

7 X was not requested by the deponent or a party
8 before the completion of the deposition.

9 I further certify that I am neither counsel for,
10 related to, nor employed by any of the parties in
11 the action in which this proceeding was taken, and
12 further that I am not financially or otherwise
13 interested in the outcome of the action.

14 Certified to by me this 8th day of December, 2025.
15
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19



20 Tamara Chapman, CSR, RPR-CRR
21 CSR NO. 7248; Expiration Date: 12-31-25
22 Veritext Legal Solutions
23 Firm Registration No. 571
24 300 Throckmorton Street, Suite 1600
25 Fort Worth, Texas 76102
800-336-4000

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EXHIBIT 9
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment
UNREDACTED VERSION FILED
UNDER SEAL

CONFIDENTIAL

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

GUARDIAN FLIGHT, LLC, et al.,

Plaintiffs,

vs.

CASE NO.:

3:24-cv-00680-MPS

AETNA LIFE INSURANCE COMPANY,

et al.,

Defendants.

CONFIDENTIAL

VIDEOTAPED DEPOSITION OF

ATHERINE O'BRIEN

Taken on behalf of Plaintiffs

DATE TAKEN: November 11, 2024

TIME: 12:15 p.m. - 2:59 p.m.

PLACE: Veritext

1300 Riverplace Boulevard, Suite 610
Jacksonville, Florida 32207

Examination of the witness taken before:

Bobbie A. Umstead

Registered Professional Reporter

Florida Professional Reporter

Page 1

1 cross-trained, so if you're really busy, you can pull
2 other people in, right?

3

4

5 Q But there are [REDACTED] employees who are
6 permanently assigned the process of reviewing and
7 ultimately, if appropriate, paying IDR award within 30
8 days right?

9 MS. STRAHAN: Objection. Compound and
10 mischaracterizes the prior testimony.

11 BY MR. SCHRAMME :

12 Q You can answer.

13 A So I'm going to split that up, if you don't
14 mind, if that's okay.

15 Q Sure.

16 A So there are currently [REDACTED]

17

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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MS. STRAHAN: Can we take a break?

5

MR. SCHRAMME : Sure.

6

MS. STRAHAN: Thank you.

7

Brief recess.)

8

BY MR. SCHRAMME :

9

Q All right, Ms. O'Brien. When we broke, we

10

were talking about when an IDR determination comes in,

11

and if it's assigned to someone to work up, right?

12

A When it's received by the e-mail box.

13

Q And I want to focus on the

14

who are assigned to work on the IDR
determinations.

15

16

Are you with me?

17

A

18

19

A Of the surprise bill review team.

20

Q What do you call that subgroup?

21

A The written determination folks.

22

Q Folks.

23

A Sorry. Southern.

24

MS. STRAHAN: It's okay.

25

MR. SCHRAMME : I'm with you, but we're in

1 up the details from that report, and then mass routes
2 all of those claims to be reworked instead of an
3 individual sitting there doing them one by one by one.

4 Q When it does the mass send to rework the
5 claims, is that to another software system, versus a
6 human, being to rework the claims?

7 A [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

12 Q But it sounds to me -- tell me if I'm wrong --
13 that the goal of this automated system, at least for
14 simple claims, is that if someone on the IDR team -- the
15 IDR determination folks say, "Reprocess. It's a simple
16 claim," it's going to be automated and paid; is that
17 fair?

18 MS. STRAHAN: Objection. Confusing.

19 [REDACTED]
20 [REDACTED]
21 [REDACTED]
22 [REDACTED]
23 [REDACTED]
24 [REDACTED]
25 [REDACTED]

C E R T I F I C A T E

STATE OF FLORIDA)
COUNTY OF DUVAL)

I, Bobbie A. Umstead, Registered Professional Reporter, certify that I was authorized to and did stenographically report the deposition of Catherine O'Brien; that a review of the transcript was not discussed; and that the transcript is a true and complete record of my stenographic notes.

I further certify that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorneys or counsel connected with the action, nor am I financially interested in the action.

DATED this 16th day of November, 2024.



Bobbie A. Umstead, RPR

EXHIBIT 10
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

CONFIDENTIAL

7
UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT
GUARDIAN FLIGHT LLC, ET
AL.,
CIVIL ACTION NO.
PLAINTIFFS, 3:24-CV-00680-MPS
V.
AETNA LIFE INSURANCE
COMPANY, ET AL.,
DEFENDANTS.
CONFIDENTIAL - PURSUANT TO PROTECTIVE ORDER

REMOTE AND VIDEOTAPED DEPOSITION OF
LINDSAY NUTSON
DECEMBER 1, 2025

REMOTE AND VIDEOTAPED DEPOSITION OF LINDSAY
NUTSON, produced as a witness at the instance of
the Plaintiffs and duly sworn, was taken in the
above styled and numbered cause on Monday,
December 1, 2025, from 9:33 a.m. to 12:47 p.m.,
before TAMARA CHAPMAN, CSR, RPR-CRR in and for the
State of Texas, reported remotely by computerized
stenotype machine in Austin, Texas, pursuant to the
Texas Rules of Civil Procedure and the provisions
stated on the record herein.

Job No. TX 7747010

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1 to the next page.

2 Q. Ms. nutson, do you see the bottom
3 highlighted portion of this paragraph, the first
4 full sentence states:

5 My analysis of the IDR PUF data for 2023
6 and 2024 shows that Plaintiffs/Counterclaim Defendants
7 submitted codes separately instead of batched
8 100 percent of the time.

9 A. I see that, yes.

10 Q. And then in the first sentence of that
11 paragraph which is highlighted, you state: Since
12 August 23rd, 2023, disputes for air ambulance
13 services for a single air ambulance transport may be
14 submitted as a batch dispute. Under batching rules
15 items and services may be considered jointly or
16 batched together if they are related to a treatment
17 of a similar condition.

18 Do you see that?

19 A. I do.

20 Q. So plaintiffs and providers generally are
21 allowed to submit base and mileage rates disputes in
22 separate IDR proceedings. Is that correct?

23 MS. TRENAMAN: Objection; form. I'm
24 sorry. Vague, scope.

25 A. Well, just --

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1 necessary. Yet, my analysis of the 2024 IDR data
2 shows that air ambulance providers initiate the IDR
3 process nearly 100 percent of the time despite the
4 IDR fees. In addition, the volume of disputes filed
5 through the IDR process has been well beyond what
6 the federal government expected and has continued to
7 increase.

8 Do you see that?

9 A. I do.

10 Q. Is it your opinion that had the federal
11 government more accurately forecast the amount of
12 IDR disputes, Aetna would have been more prepared to
13 handle the volume of the IDR process?

14 MS. TRENAMAN: Objection; overly
15 broad, lack of foundation.

16 A. So, again, as stated in my report,
17 despite Aetna's policy to pay eligible
18 determinations within 30 calendar days, Aetna was
19 hampered by multiple external factors and one of
20 those factors is that the volume of disputes were
21 well beyond what was anticipated.

22 Q. So would your opinion change if the
23 federal government had been more accurate in
24 forecasting the number of IDR disputes that were
25 being filed?

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1 So how did TMA I impact Aetna's ability
2 to timely pay IDR determinations?

3 A. So this section is talking about the
4 general state of the NSA rollout and the IDR
5 process. It was a chaotic rollout. It created
6 instability in the process.

7 There's also information produced by CMS
8 in 2025 that the IDR entities were behind in
9 processing decisions, far behind in processing
10 decisions.

11 So all of this is talking about the state
12 of the NSA implementation and the IDR process
13 causing confusion. The portal was shut down, as I
14 described, for a number of months -- I believe it
15 was four months -- in relation to air ambulance
16 claims. So there have been multiple disruptions in
17 the process since implementation.

18 Q. So you're not offering an opinion that
19 TMA I, you know, by itself prevented Aetna from
20 timely paying binding IDR determinations?

21 A. I'm generally giving information on the
22 industry and how the industry was affected by that
23 rollout. And in terms then if you go down to
24 Figure 8, you can see that the volume -- so due to
25 some of these rulings, the portal being shut down --

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1 federal IDR portal to process all dispute types,
2 including previously initiated batch disputes, new
3 batch disputes, and new single disputes involving
4 air ambulance services on December 15th, 2023.

5 Do you see that?

6 A. I do.

7 Q. So the IDR Portal was closed and
8 temporarily suspended from August 2023 to
9 December 15th 2023. Is that right?

10 A. Correct.

11 Q. And that closure resulted in what you say
12 in the next sentence of that third paragraph: The
13 unanticipated volume of disputes filed coupled with
14 the fact that the IDR portal was closed for nearly
15 four months resulted in payors having to review and
16 process a larger number of cases than they were
17 prepared for. Is that right?

18 A. Yes.

19 Q. You say in the -- in the very bottom
20 paragraph that's cut off --

21 MR. GONSOULIN: Jake, you can scroll
22 down.

23 Q. You say: The unanticipated volume of
24 disputes and a temporary shutdown of the IDR portal
25 early on in the process created a snowball effect

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UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

GUARDIAN FLIGHT LLC, ET
AL.,

PLAINTIFFS,

V.

AETNA LIFE INSURANCE
COMPANY, ET AL.,

DEFENDANTS.

CIVIL ACTION NO.
3:24-CV-00680-MPS

REPORTER'S CERTIFICATION
DEPOSITION OF LINDSAY NUTSON
TA EN DECEMBER 1, 2025

I, TAMARA CHAPMAN, Certified Shorthand Reporter in
and for the State of Texas, hereby certify to the
following:

That the witness, LINDSAY NUTSON, was duly sworn
by the officer and that the transcript of the oral
deposition is a true record of the testimony given
by the witness;

That the original deposition was delivered to
DEWEY JUDE GONSOULIN, II;

That a copy of this certificate was served on all
parties and/or the witness shown herein on

.

I further certify that pursuant to FRCP No.
30 f) i) that the signature of the deponent:

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1 was requested by the deponent or a party before
2 the completion of the deposition and that the
3 signature is to be returned within 30 days from date
4 of receipt of the transcript. If returned, the
5 attached Changes and Signature Page contains any
6 changes and the reasons therefor;

7 X was not requested by the deponent or a party
8 before the completion of the deposition.

9 I further certify that I am neither counsel for,
10 related to, nor employed by any of the parties in
11 the action in which this proceeding was taken, and
12 further that I am not financially or otherwise
13 interested in the outcome of the action.

14 Certified to by me this 8th day of December, 2025.

15
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19


20 Tamara Chapman, CSR, RPR-CRR

CSR NO. 7248; Expiration Date: 12-31-25

21 Veritext Legal Solutions

Firm Registration No. 571

22 300 Throckmorton Street, Suite 1600

Fort Worth, Texas 76102

23 800-336-4000
24
25

EXHIBIT 11
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment
FILED UNDER SEAL

EXHIBIT 12
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

Message

From: Hegg, Amy J [ajhegg@aetna.com]
Sent: 6/13/2024 8:57:59 PM
To: Federal IDR Questions [federalidrquestions@cms.hhs.gov]
CC: Dawson, Kirstin [DawsonK1@cvshealth.com]; Yeager, Regina [YeagerR@aetna.com]; O'Brien, Brady (Katherine) [OBrienK5@aetna.com]
Subject: Concerns with IDRE behavior - EdiPhy

Importance: High

Good afternoon,

I would like to address some concerns regarding recent IDR submissions and what we feel is bad behavior on the part of IDR entity EdiPhy.

We have been receiving very large volumes of Additional Information requests from EdiPhy over the past month. Recently, over 3,500 requests were received within a 2-day time period with a turnaround time (specified by the entity) of 5 business days. Many of the inquiries were regarding funding type, which is documented on the Explanation of Benefits. I sent a request on June 3 for an extension on these, but to date I have not received a response.

Yesterday, EdiPhy submitted 2,734 invoices for fees. There is a range of 5 months (application submission dates) within this submission. The oldest is DISP-826229 which was initiated on December 16, 2023. The most recent is DISP-1391262 which was initiated on May 31, 2024.

We feel this is poor behavior from EdiPhy, and it appears to be a continuing trend with them. They are not meeting their turnaround times in submitting invoices and final offer requests, which makes it very difficult to plan for incoming work volumes.

We will need an extension to process all these invoices, as we cannot meet the 10-day turnaround time with this volume and have requested this with EdiPhy.

We strive to be a good business partner with all the IDR entities, so it is distressing to encounter this type of behavior towards us as the health plan.

Thank you for your time.

Amy Hegg
 Manager, Project Management
 Federal Surprise Bill team



A  CVS Health company



Our Common Purpose

Advocate for our members' best health by helping them get the most from their benefits, building trust and always providing a clear path to care

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EXHIBIT 13
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

Message

From: O'Brien, Brady (Katherine) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=CB72B3FF9FD5452EAC69B6B85AABDA82-A789416]
Sent: 11/20/2023 2:03:39 PM
To: Federal IDR Questions [federalidrquestions@cms.hhs.gov]
Subject: Federal IDR Portal should not accept @Aetna.com mailbox address unless specified

CMS – Providers / Initiating parties continue to use email addresses for Aetna that are not aligned to the Federal No Surprises Act. We need you do update the Federal IDR Portal so that the only email address that will be accepted when a Notice of IDR Initiation is entered is: FederalNSAIDR@Aetna.com.

Aetna, along with the other health plan administrators I'm sure, have hundreds – thousands – of email addresses issued for various reasons and programs that we administer. Federal NSA is just one. And not all our employees are aligned to working on the Federal NSA as we have other business needs that must be supported. So engaging every employee in every department who works for the Aetna administered health plans in the Federal NSA process, and how they should correct provider / initiating party errors because the Federal IDR Portal won't stop the provider / initiating party errors on the front end, is not possible.

We provide our single email address – FederalNSAIDR@Aetna.com – to all providers during the Federal NSA IDR Processes Open Negotiation Notice phase; there is no acceptable reason for any provider / initiating party to submit a Notice of IDR Initiation on the Federal IDR Portal to an incorrect email address.

We have reached out to providers on multiple occasions but the situation is getting worse, not better. Since the Federal IDR process has been set up by the departments to be “driven” by the providers / initiating parties, we require you to work with them, and improve your technology, so that only our recognized and purpose-built email address is permitted to be the “health plan” on the Portal.

Cases filed under an incorrect @Aetna.com email mailbox, and which result in a summary / default judgment to the provider / initiating party who filed the case under the incorrect email mailbox, will be refuted and forwarded to our legal team.

Thank you,

Brady O'Brien | Senior Manager, Project Management, CSO Strategic Initiatives
 p 860-273-9391



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EXHIBIT 14
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

Message

From: FederalNSAIDR [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0F1EBAE3813444A1892FC0CF1E6EB1B8-FEDERALN02]
Sent: 11/2/2022 4:11:56 PM
To: FederalIDRQuestions@cms.hhs.gov
CC: O'Brien, Brady (Katherine) [OBrienK5@aetna.com]; Hegg, Amy J [ajhegg@aetna.com]; FederalNSAIDR [FederalNSAIDR@AETNA.com]
Subject: HASTE- SUBMIT BUTTON NOT WORKING IN PORTAL

Importance: High

Good afternoon,

Our team is attempting to submit our responses for disputes, but the portal is not accepting click of the submit button. There is no error message, and all needed fields are completed.

Please advise immediately.

Thank you for your time,

Sarah E. Molle | [Quality Assurance Specialist, Federal IDR Team](#)
p 860-808-3644



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Our Common Purpose: Advocate for our members' best health by helping them get the most from their benefits, building trust and always providing a clear path to care.

EXHIBIT 15
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

Message

From: Hegg, Amy J [ajhegg@aetna.com]
Sent: 10/29/2025 2:35:54 PM
To: Federal IDR Questions [federalidrquestions@cms.hhs.gov]
CC: Yeager, Regina [YeagerR@aetna.com]; O'Brien, Brady (Katherine) [OBrienK5@aetna.com]
Subject: Limitation from Microsoft - email volume exceeded

Importance: High

Good morning,

We received notification from Microsoft yesterday afternoon that our incoming volume from email address: **auto-reply-federalidrquestions=cms.hhs.gov** exceeded the Microsoft limitations. Microsoft has a 1200-messages-received-per-hour per single sender in Outlook that MUST be followed. It is unacceptable for CMS to send more than 1200 emails within an hour, as this puts Aetna at risk of not receiving emails. Over 1700 were rejected, and unfortunately we don't know what emails were rejected. That now puts us at risk of not completing the requests that we did not receive.

Can you explain why there were so many emails sent yesterday (10/28/25) that went against Microsoft's policy? Was this due to the updates to the CMS portal last week?

We look forward to your prompt response.

Thank you.

Amy J. Hegg (She.Her.Hers)
Manager, Project Management

Remote - IL (Central Standard)



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EXHIBIT 16
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

Message

From: FederalNSAIDR [FederalNSAIDR@AETNA.com]
Sent: 11/26/2024 2:17:27 PM
To: federalidrquestions@cms.hhs.gov
CC: Hegg, Amy J [ajhegg@aetna.com]; O'Brien, Brady (Katherine) [OBrienK5@aetna.com]; Yeager, Regina [YeagerR@aetna.com]
Subject: HASTE IDR Portal blocking uploads

Importance: High

Good morning,

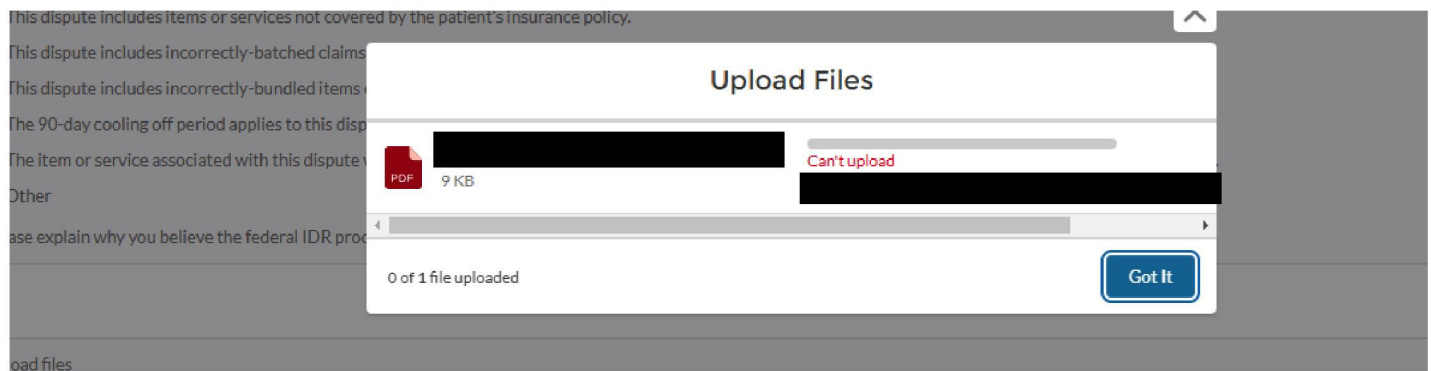
The IDR portal, for both Final Offers and application responses, are blocking uploads. This is causing a work stoppage for ALL final offers. Application responses are delayed since cases can not be worked First-in, first-out.

1. Please correct the portal urgently and
2. Issue extensions on all "Action Required: Certified IDR entity selection agreement or disagreement needed" cases due today, and for any day this issue continues
3. Issue extensions on all "Your IDR Notice of Offer Submission is Due" that are due today, and for any day this issue continues

Upload Files

 Aetna PROFESSIONAL_IDR POSITION STAT... Can't upload Aetna PROFESSIONAL_IDR POSITION STATEMENT 2024.docx.
 111 KB

0 of 1 file uploaded



This dispute includes items or services not covered by the patient's insurance policy.

This dispute includes incorrectly-batched claims

This dispute includes incorrectly-bundled items

The 90-day cooling off period applies to this dispute

The item or service associated with this dispute is

Other

Please explain why you believe the federal IDR process

Upload Files

 9 KB Can't upload

0 of 1 file uploaded

Got It

Sarah E. Molle
 Quality Assurance Specialist

Remote - PA (Eastern Standard)



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EXHIBIT 17
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment
FILED UNDER SEAL

EXHIBIT 18
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

Message

From: Hegg, Amy J [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=52FC75D5DC2B475AA067112025DD35BF-A621980]
Sent: 11/3/2023 9:14:50 PM
To: Federal IDR Questions [federalidrquestions@cms.hhs.gov]
CC: Hegg, Amy J [ajhegg@aetna.com]; O'Brien, Brady (Katherine) [OBrienK5@aetna.com]; Yeager, Regina [YeagerR@aetna.com]
Subject: Health Plan concerns regarding TATs and other concerns

Good afternoon,

Our NSA-IDR team has significant concerns regarding the return of the three day turnaround time on November 4. Below is a snapshot of our IDR inventory. Based on current volume and trying to stay in compliance with the high volume, we are very concerned we will miss deadlines starting 11/9/2023. Our critical ask of CMS is to extend the application 10 business day extension through the remainder of 2023.

This is our current application inventory with due dates:

11/6/23 - 289
 11/7/23 - 303
 11/8/23 - 413
 11/9/23 - 321
 11/13/23 - 410
 11/14/23 - 902
 11/15/23 - 2553
 11/16/23 - 1663
 11/17/23 - 1702

As you can see, we continue to receive a very high number of disputes on a daily basis. Our team is working overtime and on weekends, and with a 10-day turnaround time we are meeting the goal, but barely. Moving to a 3-day turnaround time would be detrimental to our ability to actively participate in the process, and we desire to be a good business partner in trying to follow guidance.

Independent Dispute Resolution

- IDR applications (ON HOLD) 1,846 holding, were received prior to portal closing; errors generating when access previous links; email sent to CMS
 - No response from CMS to date
- Final offer letter inventory: 3,491 emails
- Invoice inventory: 1,566 emails

We have had to shift staff to care for the large influx of final offers and invoices as the disputes move through the total process. No additional time for turnaround was granted to these processes.

Batched Disputes Submitted by Initiating Party is against CMS Guidance

CMS: Processing of in-progress batched disputes, new batched disputes, and new air ambulance disputes remains temporarily suspended while the Departments update batching and air ambulance guidance and operations to align with the district court's opinions and orders in *TMA III* and *TMA IV*.

ALERT: We are now receiving IDR batches through the portal (see last attachment). The bad batch rejection reason has been removed from the portal.

RECOMMENDATION: CMS should be reviewing these disputes and if they are batches they should reject, these should not come to the Health Plan to review.

These are the IDR steps with volumes, concerns, and recommendations. At the bottom of the email is a visual of our inventory tracker.

IDR Application Inventory – 1st IDR Step

CMS: For new disputes initiated between October 6, 2023, and November 3, 2023, the deadline for certified IDR entity selection will be 10 business days after initiation, and the deadline to submit fees and offers will remain 10 business days after certified IDR entity selection.

- **CONCERNS:**
 - Per CMS: Disputes initiated starting 11/4 have no extension and go back to the 3 BD deadline
 - Ongoing digging out of inventory from disputes initiated between 10/6 – 11/3 and inability to achieve the 3 BD deadline starting with 11/4 applications
 - **We are receiving batched disputes which are temporarily on hold per CMS, CMS should be rejecting these prior to coming to Aetna**
 - Submission of batched disputes and air ambulance opening within this timeframe will create unmanageable inventory
- **RECOMMENDATIONS:**
 - CMS extend the 10 business days to 15 business days extension for application until January 1, 2024
 - CMS should put a cap on the number of disputes that can be initiated daily. Without that control in place, we cannot plan for staffing needs. If a cap cannot be added, suggestion to automatically allow additional time for completion of large submissions. For example, if an initiating party submits more than 250 disputes in one day, an automatic extension of one additional day is added per 100 disputes. So if the cap is 250 and an initiating party submits 450 disputes, the health plan has 2 additional days to review. Ideally, this would be automatic and not a manual request for an extension, which would eliminate additional steps for both the health plan and CMS.
 - CMS/portal should be rejecting batched disputes up front prior to coming to Aetna

Final Offers / Invoices – 2nd & 3rd IDR Steps

CMS: The deadline to submit fees and offers will remain 10 business days after certified IDR entity selection.

- The high volume of disputes will move to these steps
- We will need to shift resources to attempt to meet the 10 BD deadline
- **CONCERNS:**
 - No extensions were granted for final offers and invoices and based on application volume this will be challenging to maintain the 10 BD deadline
 - Shifting resources from applications to support these two steps will create a bottle neck in the continuing increase in applications
- **RECOMMENDATION:** CMS to reconsider extensions to 15 BD deadline based on unforeseen volumes

Additional Information Email Requests From Entities – 4th Step

- Anticipating increase in additional information requests from entities based on application volumes
- **RECOMMENDATIONS:**
 - Entities should provide additional time for Aetna to respond to their inquiries; The Entities set the due dates so communication to them for consideration is greatly appreciated.
 - For efficiency, there should be a CMS issued template that all entities have to use to eliminate duplication of information that was entered on the portal by either party with a clear, fair due date.
 - Aetna should have 100% discovery of documents of correspondence between the entities and initiating parties

Payment Determinations – 5th Step

- High volume of disputes will also result in the same volume for determinations
- **CONCERNS:**
 - No extensions were granted for determinations and based on application volume this will be challenging to maintain the 30 calendar days deadline to issue additional payment
- **RECOMMENDATION:** CMS to reconsider extensions to 35 calendar day deadline based on unforeseen volumes

DEMAND LETTER EMAILS:

ALERT: In addition to handling the unforeseen application volumes including batches we have received 7,600 Demand [REDACTED] We are seeing a high volume of duplicate emails for the same claims. This is not a regulation requirement for a Health Plan to perform a reconciliation process for providers. We are not staffed nor should we be responsible to handle providers reconciliation process.

Here is the grid of our incoming volume for all IDR areas. As you can clearly see, our volume has grown exponentially in less than a month.

	10/2/2023	10/3/2023	10/4/2023	10/5/2023	10/6/2023	10/9/2023	10/10/2023	10/11/2023	10/12/2023	10/13/2023	10/16/2023	10/17/2023	10/18/2023	10/19/2023	10/20/2023	10/23/2023	10/24/2023	10/25/2023	10/26/2023	10/27/2023	10/30/2023	10/31/2023	TOTALS
Applications	0	0	0	0	124	268	247	229	1675	3716	4517	369	505	411	453	372	303	413	321	410	902	2593	17788
Invoices	55	55	31	3	4	1	135	38	70	40	60	185	58	84	187	426	235	355	194	423	529	477	3645
Offer Letters Due	114	151	45	75	53	54	123	91	164	172	116	14	83	131	395	456	289	429	239	482	548	490	4894
Additional Information	38	54	134	45	49	11	34	36	47	61	80	65	82	71	66	79	50	53	58	55	35	63	1266
Determinations	89	50	37	144	101	38	80	81	166	173	115	175	145	162	195	187	132	211	214	126	312	234	3117

	11/1/2023	11/2/2023	11/3/2023	11/6/2023	11/7/2023	11/8/2023	11/9/2023	11/13/2023	11/14/2023	11/15/2023	11/16/2023	11/17/2023	11/20/2023	11/21/2023	11/22/2023	11/24/2023	11/27/2023	11/28/2023	11/29/2023	11/30/2023	TOTALS
Applications	1663	1702																			3365
Invoices	710	595																			1305
Offer Letters Due	684	580																			1264
Additional Information	79	104																			183
Determinations	266	210																			476

EXHIBIT 19
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

Message

From: O'Brien, Brady (Katherine) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=CB72B3FF9FD5452EAC69B6B85AABDA82-A789416]
Sent: 3/2/2023 1:43:41 PM
To: Federal IDR Questions [federalidrquestions@cms.hhs.gov]
Subject: Federal IDR Portal Report Request

Hello CMS,

Aetna is requesting a report from the Federal IDR Portal of all determined cases for air ambulance submissions. It has been brought to our attention that some cases for air ambulance providers have been determined but we do not have record of them. In order to be compliant with the Federal IDR Process and payment of amounts to the initiating parties where Aetna is not the prevailing party, we need to ensure no cases are missed.

We are asking for the following details:

DISP case number
Initiating party name
Certified IDR Entity name
Claim number(s) filed under the case
Service code(s) filed under the case
Written Determination Date
Written Determination decision, at the service code(s) level

Thank you,

Brady O'Brien | Senior Manager, Project Management, CSO Strategic Initiatives
p 860-273-9391



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EXHIBIT 20
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

Message

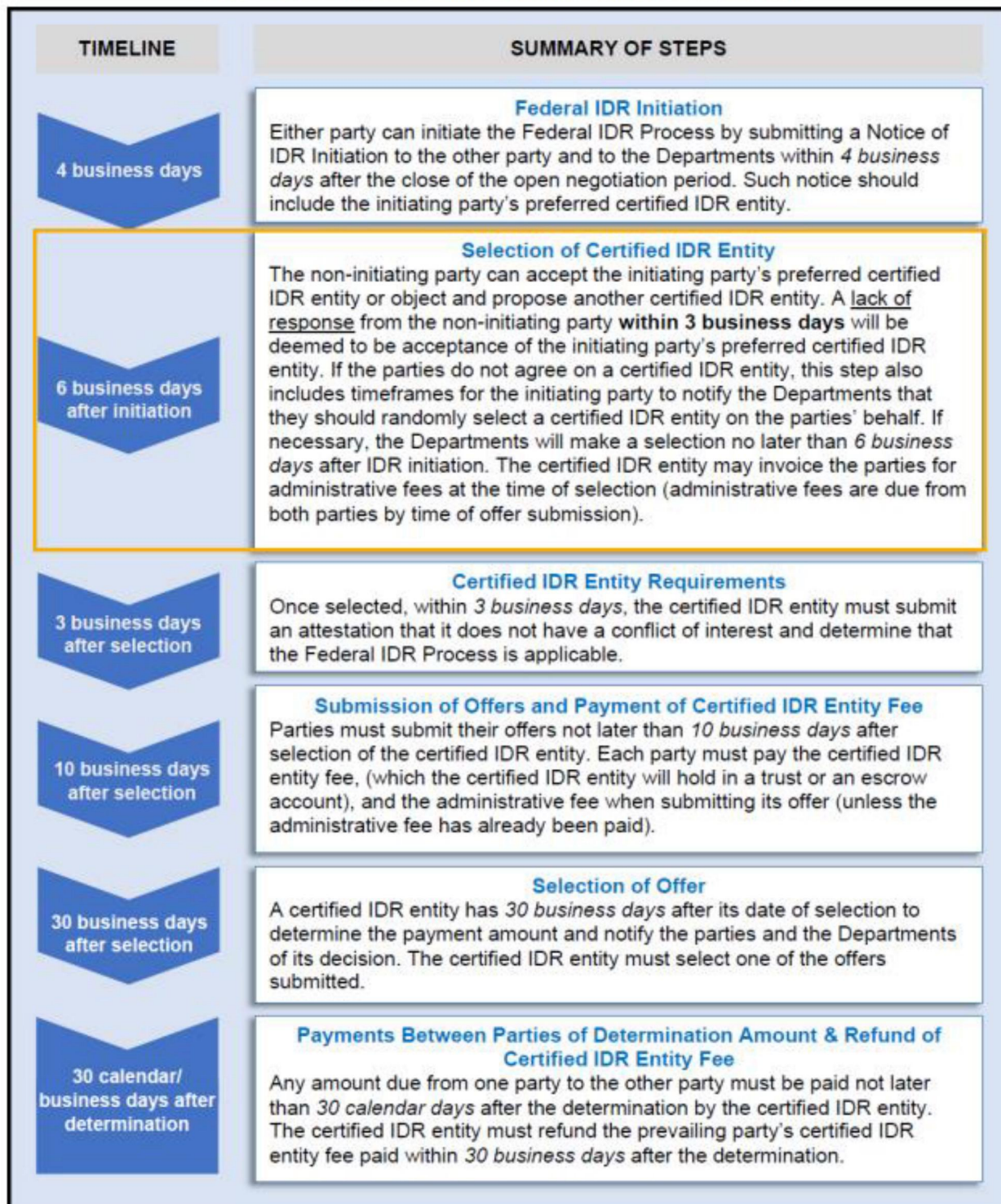
From: Hegg, Amy J [ajhegg@aetna.com]
Sent: 9/18/2024 10:27:57 PM
To: Federal IDR Questions [federalidrquestions@cms.hhs.gov]
CC: Dawson, Kirstin [DawsonK1@cvshealth.com]
Subject: Proposal to regulate dispute volumes

Proposal to Regulate the Volume of Disputes Received by Non-Initiating Parties in the Independent Dispute Resolution Process

This proposal stems from our desire to actively participate in the Independent Dispute Resolution process. With the extreme fluctuation in incoming inventories and the inconsistencies with receiving timely invoices, final offers, and determinations from the IDR entities, it is difficult for us as the health plan to adequately plan for staffing needs to complete the work within our mandated turnaround times.

Current timeline for Independent Dispute Resolution:

Figure 1: Federal IDR Process Timeline and Summary of Steps



With this proposal, Initiating Parties would still have 4 business days from the end of the Open Negotiation period to initiate an Independent Dispute Resolution application.

The federal portal would regulate how many IDR applications are then assigned to the health plans (NIPs) daily, with a threshold set by CMS (example: no more than 500 total IDR applications would be assigned to a single NIP per day. **It is important to note that within the 3-day timeframe allotted for entity selection, we are also checking for eligibility of the claims within the dispute.*

The NIPs clock would start the day the IDR application is assigned. Example: The IP initiates an IDR application on Monday 9/9. The portal submits DISP-12345 to the NIP on Friday 9/13. The NIP's deadline to respond in the portal is Wednesday 9/18. In this way, IDR applications can be regulated, and a continuous volume of work will move through the portal in a steady consistent manner that will allow health plans and IDR entities to be able to plan for staffing appropriately. This will dramatically decrease missed deadlines. This would also prevent certain providers', such as radiology groups, large submissions (sometimes over a thousand IDR applications in a single day) from overwhelming the staff and our technology and causing losses due to default.

For example: in one week we had a day in which 1,178 applications were received; the next day 167 applications were received; the following day 2,155 applications were received. With no oversight or control on the volume that can be submitted by IP's, it is virtually impossible for the health plans to plan for staffing. It is also causing a large backlog at the entities. Entities are now submitting multiple months of invoices and final offers to the health plans, with the expectation of a ten-day turnaround. Having a regulated, consistent inventory volume would allow for timely handling of disputes in all phases of IDR by the health plan and by the entities.

Here is an example/breakdown of how this proposal would work:

- Multiple IPs initiate IDR requests within 4 BD from end of Open Negotiation period – 2,800 total received for NIP Aetna on 10/1/2024
- Federal portal allows 500 disputes to be assigned to the NIP on 10/1. The remaining 2,300 are in a queue to be released at 500 per day, so 500 more are assigned on 10/2 and so forth. Additional incoming disputes go into the queue as well.
- The NIPs received date would be the date the dispute is assigned
- Timelines for entity selection, invoice payment, final offer submission, and determinations remain unchanged.

This is a proposal that would help alleviate the backlog at the entities and at the health plans. It would keep the volume of disputes balanced and allow for the planning of adequate staffing.

I thank you for taking the time to consider this proposal, and I hope to have the opportunity to discuss further for positive changes for everyone in this process.

Amy J. Hegg (She.Her.Hers)
Manager, Project Management

Remote - IL (Central Standard)



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EXHIBIT 21
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

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

DECLARATION OF AMY HEGG

I, Amy Hegg, declare:

1. My name is Amy Hegg. I am over the age of twenty-one and am fully able and competent to make this declaration. I make this declaration upon my personal knowledge, and all statements contained herein are true and correct.

2. I am employed on behalf of Aetna Life Insurance Company (“Aetna”) as a Manager, Project Management. I am located in Danville, Illinois area. I have been employed by Aetna for 13 years. In my role at Aetna, I am also a custodian of records for Aetna, and I am familiar with the manner in which Aetna’s business records are created and maintained by virtue of my duties and responsibilities for Aetna.

3. Attached as **Exhibit 10** to Aetna’s Motion for Summary Judgment (“MSJ”) being filed contemporaneously herewith is a true and correct copy of an email I sent to the Centers for Medicare and Medicaid Services (“CMS”) designated email address [federalidrquestions@cms.hhs.gov] on June 13, 2024 notifying CMS of the unexpected volume of Independent Dispute Resolution submissions that Aetna was receiving.

4. Exhibit 10 is an exact duplicate of the original email maintained in Aetna's normal course of business, and it was the regular course of business of Aetna for an employee or representative of Aetna, with knowledge of the act, event, or condition recorded in these records, to make the record or to transmit the information thereof to be included in such record. It is the regular practice of Aetna to make this type of record at or near the time of each act or event set forth in these documents. It is also the regular practice of Aetna for this type of record to be made by, or from information transmitted by, persons with knowledge of the matters set forth in them. Finally, it is the regular practice of Aetna to keep this type of record in the course of regularly conducted business activity.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 13, 2026, at Danville, Illinois.



Amy Hegg

EXHIBIT 22
to Aetna's Local Rule 56(a)1 Statement of
Undisputed Material Facts in Support of
Its Motion for Summary Judgment

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

DECLARATION OF KATHERINE O'BRIEN

I, Katherine O'Brien, declare:

1. My name is Katherine O'Brien. I am over the age of twenty-one and am fully able and competent to make this declaration. I make this declaration upon my personal knowledge, and all statements contained herein are true and correct.

2. I am employed on behalf of Aetna Life Insurance Company ("Aetna") as a Senior Manager, Project Management, CSO Strategic Initiatives. I am located in Jacksonville, Florida area. I have been employed by Aetna since December 1997. In my role at Aetna, I am also a custodian of records for Aetna, and I am familiar with the manner in which Aetna's business records are created and maintained by virtue of my duties and responsibilities as the Senior Manager, Project Management, CSO Strategic Initiatives for Aetna.

3. Attached as **Exhibit 2** to Aetna's Motion for Summary Judgment ("MSJ") being filed contemporaneously herewith is a true and correct copy of Aetna's policies regarding a claim that was sent to rework following an Independent Dispute Resolution ("IDR") award.

4. Attached as **Exhibit 3** to Aetna's MSJ is a true and correct copy of Aetna's electronic policy to issue payment within 30 days after a written decision is received.

5. Attached as **Exhibit 11** to Aetna's MSJ is a true and correct copy of an email I sent to the Centers for Medicare and Medicaid Services ("CMS") designated email address [federalidrquestions@cms.hhs.gov] on November 20, 2023, notifying CMS that providers are not using Aetna's correct email address and requesting that CMS disallow providers from submitting Notices of IDR Initiations to the incorrect email address.

6. The Exhibits 2, 3 and 11 are exact duplicates of the original documents maintained in Aetna's normal course of business, and it was the regular course of business of Aetna for an employee or representative of Aetna, with knowledge of the act, event, or condition recorded in these records, to make the record or to transmit the information thereof to be included in such record. It is the regular practice of Aetna to make this type of record at or near the time of each act or event set forth in these documents. It is also the regular practice of Aetna for this type of record to be made by, or from information transmitted by, persons with knowledge of the matters set forth in them. Finally, it is the regular practice of Aetna to keep this type of record in the course of regularly conducted business activity.

7. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on March 13, 2026, at Jacksonville, Florida.

Katherine O'Brien
Katherine O'Brien

General Information

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

**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, AIR EVAC EMS, INC., and
AIRMED INTERNATIONAL LLC,,

Plaintiffs,

v.

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

Defendants.

CIVIL ACTION NO. 3:24-cv-00680-MPS

**DEFENDANT CIGNA HEALTH AND LIFE INSURANCE COMPANY'S NOTICE OF
ADOPTION BY REFERENCE OF ARGUMENTS SET FORTH IN CO-DEFENDANT
AETNA'S MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT**

Defendant Cigna Health and Life Insurance Company ("Cigna"), by and through its undersigned counsel and pursuant to Local Civil Rule 7(a), hereby gives notice that it adopts by reference the following arguments set forth in the Aetna Defendants' Memorandum in Support of Motion for Summary Judgment (the "Aetna MSJ"), as if fully set forth herein. Cigna submits this Notice in furtherance of its own Motion for Summary Judgment and Memorandum of Law in Support thereof, filed contemporaneously herewith, and to avoid unnecessary duplication of legal argument while ensuring that the Court has the benefit of the full scope of defenses available to both Defendants.

ARGUMENTS ADOPTED BY REFERENCE

Cigna adopts by reference the following arguments from the Aetna MSJ, each of which presents a legal question applying with equal force to Cigna. This adoption is without waiver of any argument in Cigna's own summary judgment briefing.

CUIPA Does Not Apply to IDR Award Payments.

Cigna adopts Aetna's argument that CUIPA § 38a-816(6) does not apply to IDR award payments because an IDR determination is a binding arbitration award, not a "settlement" within the meaning of the statute.

Plaintiffs Lack Statutory Standing Under ERISA § 502(a)(1)(B).

Cigna adopts Aetna's argument that Plaintiffs' claims fall outside the "zone of interests" of § 502(a)(1)(B) because, by Plaintiffs' own admission, their claims derive from 29 U.S.C. §§ 1185e and 1185f rather than from the terms of any ERISA-governed plan.

ERISA Cannot Circumvent the NSA's Exclusive Enforcement Regime.

Cigna adopts Aetna's argument, grounded in *Bushell v. UnitedHealth Group Inc.*, 2018 WL 1578167 (S.D.N.Y. Mar. 28, 2018), that because the NSA does not create a private right of action, Plaintiffs cannot enforce 29 U.S.C. § 1185f under the guise of § 1132(a)(1)(B).

The NSA Preempts Plaintiffs' CUTPA Claim Under 42 U.S.C. § 300gg-22.

Cigna adopts Aetna's argument that § 300gg-22 preempts Plaintiffs' CUTPA claim—an issue this Court acknowledged was not briefed at the motion-to-dismiss stage and as to which the Court indicated it might have reached a different conclusion. The exclusive federal enforcement framework established by that provision would be usurped by judicial imposition of CUTPA penalties.

Punitive Damages.

Cigna adopts Aetna's argument that punitive damages are unavailable absent evidence of "reckless indifference" or "intentional and wanton violation" of Plaintiffs' rights. When applied to Cigna's own good-faith compliance record, the same conclusion follows.

RESERVATION OF RIGHTS

Cigna's adoption of the foregoing arguments is in addition to, and without waiver of, any argument in Cigna's own summary judgment briefing. To the extent any argument adopted herein is inconsistent with any position in Cigna's own papers, Cigna's own papers shall control.

CONCLUSION

For the foregoing reasons, Defendant Cigna Health and Life Insurance Company respectfully requests that the Court consider the arguments identified herein as adopted by reference and incorporated into Cigna's summary judgment briefing as if fully set forth therein.

Respectfully submitted,

CIGNA HEALTH AND LIFE INSURANCE COMPANY

By: Its Attorneys

Respectfully submitted,
Attorneys for Defendant CIGNA HEALTH
AND LIFE INSURANCE COMPANY,
By: its Attorneys

/s/ Ruel W. Smith

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Dated: March 19, 2026

CERTIFICATE OF SERVICE

I, Ruel W. Smith, hereby certify that the documents filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non-registered participants on March 19, 2026.

/s/ Ruel W. Smith

Ruel W. Smith