UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

MURPHY MEDICAL ASSOCIATES, LLC; DIAGNOSTIC AND MEDICAL SPECIALISTS OF GREENWICH, LLC; NORTH STAMFORD MEDICAL ASSOCIATES, LLC; COASTAL CONNECTICUT MEDICAL GROUP, LLC; and STEVEN A.R. MURPHY, MD,	:	3:20-cv-01675-JBA
Plaintiffs,	:	
v.	:	
CIGNA HEALTH AND LIFE INSURANCE COMPANY and CONNECTICUT GENERAL LIFE INSURANCE COMPANY,	:	JUNE 1, 2021
Defendants.	:	

DEFENDANTS' REPLY MEMORANDUM OF LAW IN FURTHER SUPPORT OF MOTION TO DISMISS PLAINTIFFS' AMENDED COMPLAINT

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I. INTRODUCTION

This case amounts to nothing more than an out-of-network provider's strained attempt to create a novel independent legal right to obtain payment from Cigna of their exorbitant charges for a battery of unnecessary laboratory tests and services on people who simply wanted to know whether they had COVID. Plaintiffs have no contract with Cigna, they are not beneficiaries under any Cigna-administered health plan, and they have failed to plead facts establishing derivative ERISA standing through valid assignments.[1] Recognizing that they have no path to recovery under traditional legal concepts governing out-of-network reimbursement, Plaintiffs' alternative strategy is to argue that, in passing emergency legislation related to the COVID pandemic, Congress was primarily interested in ensuring that out-of-network providers got paid. On that basis, Plaintiffs assert an implied right to sue for payment.

As this reply demonstrates, Congress enacted the FFCRA and the CARES Act (the "Coronavirus Legislation") in an effort to provide comprehensive relief to Americans for the medical, economic, and national security harms resulting from the pandemic, not (as Plaintiffs baldly assert) to benefit providers by creating new payment rights in place of existing federal or state remedies. Plaintiffs warn the Court that if it does not sanction a new implied remedy for them, then "medical providers would be left remediless[.]" Opp. Br. at 20. This is false. If Plaintiffs are left remediless here, it is purely because their Amended Complaint ("AC") fails to plead viable claims to payment for services either under ERISA or alternative state law theories. In fact, this reply demonstrates

[1] For a provider to obtain ERISA standing, the provider must obtain a valid assignment of benefits from a patient, where such assignments are permitted under the patient's health plan. *Prof'l Orthopedic Assocs., P.A. v. 1199 SEIV Nat'l Benefit Fund*, 697 F. App'x 39, 40 (2d Cir. 2017) ("To proceed in the shoes of a beneficiary, the assignee must show that there is a valid assignment that comports with the terms of the benefits plan"). As a purported assignee, Plaintiffs can bring only those claims that could have been asserted by their patient-assignors. *Metcalf v. Blue Cross Blue Shield of Mich.*, 57 F. Supp. 3d 1281, 1293 (D. Or. 2014) ("An assignee's claims are limited to those that the Plan participants could bring themselves.").

that dismissal with prejudice is the correct outcome in this case. Plaintiffs have been afforded every opportunity to plead cognizable claims, but the AC is hopelessly deficient.

II. ARGUMENT

A. Plaintiffs Have No Right to Enforce the FFCRA and CARES Act

Because, as Plaintiffs have conceded, there is no express private right of action for them in the Coronavirus Legislation, Opp. Br. at 17, fn. 11, Plaintiffs must overcome the demanding obstacles to establish an implied federal cause of action. This they cannot do.

1. Courts rarely imply private rights of action in federal statutes and there is no basis to imply one here.

As Cigna has pointed out, analysis of implied private remedies in federal statutes begins with the premise that Congress rarely confers personal rights by implication. Cigna Br. at 13. Plaintiffs ignore this starting point, insisting that as a matter of statutory construction, a private remedy to obtain out-of-network reimbursement "can be readily inferred from the language and context of the FFCRA and the CARES Act[.]" Opp. Br. at 17. As discussed below, Supreme Court precedent and basic tenets of statutory construction dictate the opposite conclusion.

Plaintiffs' argument relies almost entirely on a snippet from Section 3202(a) of the CARES Act stating that health plans "shall reimburse the provider" for COVID testing. Op. Br. at 18 (asserting it "directs insurers … to pay out-of-network providers who furnish COVID testing" and describes "the amount such providers must be paid"). But section 3202 is contained in Title III, Part II of the CARES Act, entitled: "Access to Health Care for COVID-19 Patients"—evidencing that Congress' intent was to assist the American people in obtaining necessary health care, including access to COVID tests. Moreover, there is a vast difference between imposing a payment obligation on health plans that might benefit some providers, and creating a new federal *right* to payment for providers. *See Universities Research Assn., Inc. v. Corfu*, 450 U.S. 754, 772 (1981)

(rejecting a claim of implied private right of action where a statute "requires that certain stipulations be placed in federal construction contracts for the benefit of mechanics and laborers, but it does not confer rights directly on those individuals.").

Even if this language created a private *right* for providers, it is not sufficient to give Plaintiffs a private *remedy*. Thus, "[t]he 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." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001); *see also Wisniewski v. Rodale, Inc.*, 510 F.3d 294, 301 (3d Cir. 2007), *cert. denied*, 555 U.S. 814 (2008) (Test whether to imply a private right focuses on the questions: "(1) Did Congress intend to create a personal right? and (2) Did Congress intend to create a private remedy?").

In short, statutory language broadly addressing pricing and payment for COVID testing does nothing to pass the tests necessary to imply a federal *remedy* in favor of Plaintiffs. *See Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002) (implied right of action requires more than a showing that "the plaintiff falls within the general zone of interest that the statute is intended to protect"). Plaintiffs explicitly avoid addressing this key factor, merely asserting, conclusorily: "It is only logical to assume that if the group is denied the right granted to it by Congress, they will have a remedy." Opp. Br. at 19. Clear and binding precedent precludes that leap of purported logic.

Consideration of legislative intent further dispels the notion that Plaintiffs have an implied private right of action. First, Congress knows how to grant private rights of action, because it did so in the FFCRA to remedy improper denials of emergency paid employee leave, by expressly incorporating the FLSA and FMLA enforcement provisions. *See* FFCRA §§ 3102, 5102, 5105, 29 C.F.R. § 826-150(b), 151(b). *See Corfu*, 450 U.S. at 773 ("when Congress wished to provide a private damages remedy, it knew how to do so, and did so expressly." [quotation marks omitted]).

Congress took no such action under section 3202 of the CARES Act. Instead, it took the alternative path of delegating authority to remedy statutory violations to a trio of federal agencies. Cigna Br. at 14. Contrary to Plaintiffs' speculation that agency enforcement powers are limited to imposing a fine, nothing in the Coronavirus Legislation limits the scope of regulatory enforcement or suggests that it would be inadequate. *See Profiles, Inc. v. Bank of Am. Corp,* 453 F. Supp. 3d 742, 751 (D. Md. 2020) (Nothing prevents SBA administrator from seeking the expediated injunctive relief requested by private plaintiff to remedy PPP misconduct).

Plaintiffs attempt to minimize the significance of the express delegation of agency enforcement authority, arguing that it is no more than a "suggestion" of the absence of private rights. To the contrary, delegated enforcement language is a "strong indication that Congress intended to preclude private enforcement." *Acara v. Banks*, 470 F.3d 569, 571 (5th Cir. 2006) (Patient had no implied private right of action under Affordable Care Act to remedy improper disclosure of medical records because ACA delegated enforcement to HHS).

Second, Plaintiffs dismiss as inapposite the multitude of prior cases rejecting private attempts to sue under various provisions in the Coronavirus Legislation. Opp. Br. at 22. Plaintiffs are wrong. It is not at all inapposite that courts have rebuffed every attempt to imply a private right of action in emergency legislation intended to provide billions of dollars in benefits to small businesses, hospitals, and the unemployed: "Every court to address whether the CARES Act created an implied private right of action has held that it does not." Cigna Br. at 14, fn. 13.

2. Regulatory guidance confirms that providers have no guarantee to COVID testing reimbursement.

Plaintiffs posit that Cigna violated the Coronavirus Legislation by making "voluminous" requests for records to substantiate the necessity and appropriateness of the services they billed for tests and Cigna members. Plaintiffs incorrectly characterize Cigna as engaging in prohibited

"medical management." Opp. Br. at 12-13. But the Coronavirus Legislation's suspension of pre-authorization requirements in no way imposes limits on a health plan's ability to ensure proper billing for plan benefits and to detect and prevent fraud.

Even if Plaintiffs had a valid implied federal remedy to obtain payment (which they do not), that does not eliminate the requirement that billed services be supported by appropriate documentation establishing that the services were actually provided, who provided them, and that the services were medically necessary under the circumstances. Significantly, regulatory guidance confirms that the Coronavirus Legislation does ***not*** restrict a health plan's ability to ensure that COVID testing claims are proper. Providers of COVID testing services are required make "an individualized clinical assessment to determine whether [testing] is medically appropriate for the individual in accordance with current accepted standards of medical practice." *FAQs about [FFCRA] and [CARES] Act Implementation Part 43*, June 23, 2020, Q4. A health plan's coverage obligation to reimburse for such testing is contingent upon the test being "diagnostic and medically appropriate for the individual, as determined by an attending health care provider in accordance with current accepted standards of medical practice." *Id.* at Q. 6.[2]

Furthermore, the Coronavirus Legislation in no way precluded fraud detection efforts. In fact, federal regulators were concerned about the unintended byproduct of the Coronavirus Legislation that this lawsuit presents: the emergence of profiteering providers. The government has acknowledged "that some providers … are using the public health emergency as an opportunity to impose extraordinarily high charges." *FAQs About [FFCRA] and [CARES] Act Implementation*

[2] Plaintiffs wrongly interpret this guidance as authorizing Dr. Murphy to ignore generally accepted medical standards in favor of his own invented standard of care: "Through research and personal experience, the Murphy Practice concluded that solely performing a COVID test failed to adhere to the requisite standard of care. To properly treat a patient, other diagnostic testing was required." Opp. Br. at 7. Dr. Murphy was (allegedly) *testing* people, not *treating* patients. In any event, the Coronavirus Legislation does not require coverage for COVID *treatment*.

Part 44, February 26, 2021, Q. 6. In February 2021, the U.S. Treasury noted that law enforcement and financial institutions have detected numerous instances of COVID potential frauds on health plans and insurers, identifying red flag indicators such as "ordering or submitting claims for expensive tests that do not test for COVID, oftentimes in conjunction with COVID testing, such as medically unnecessary and expensive respiratory testing" and overbilling for testing. FINCEN Advisory (FIN-2021-A001, Feb. 2, 2021). And on May 26, 2021, the Department of Justice announced criminal charges against multiple defendants for "various health care fraud schemes that exploited the COVID-19 pandemic" including submitting claims for "medically unnecessary, and far more expensive … respiratory pathogen panel tests."[3] Accordingly, regulatory guidance makes it clear that in administering claims for COVID testing, health plans "may continue to employ programs designed to detect and address fraud and abuse." *FAQs, Part 44*, Q. 2. That is what Cigna has done.

B. Plaintiffs' ERISA Claims Lack Plausibility

1. Plaintiffs have no derivative standing to sue for plan benefits.

Plaintiffs make a series of disconnected, internally inconsistent arguments in support of a purported "right" to ERISA–afforded relief.[4] None of these contradictory arguments has merit.

Plaintiffs first assert that the Murphy Practice satisfies the assignment requirement for derivative ERISA standing "because it routinely receives broad assignments of benefits from its patients in exchange for emergency health services." Opp. Br. at 25. Plaintiffs merely parrot their

[3] *https://www.justice.gov/opa/pr/doj-announces-coordinated-law-enforcement-action-combat-health-care-fraud-related-covid-19*.

[4] "Where a plaintiff's own pleadings are internally inconsistent, a court is neither obligated to reconcile nor accept the contradictory allegations in the pleadings as true in deciding a motion to dismiss." *Carson Optical Inc. v. eBay Inc.*, 202 F. Supp. 3d 247, 255 (E.D.N.Y. 2016).

conclusory assignment allegations in paragraphs 78 and 79 of the AC, which contain no assignment language or facts supporting their claimed right to stand in the shoes of plan members.

Plaintiffs then argue the opposite – that the Coronavirus Legislation obliterated decades of court decisions enforcing assignment requirements. Opp. Br. at 28 (Congress purportedly "obviate[d] the ordinary requirement that for an out-of-network provider to have standing to sue under ERISA, there must be a valid assignment."). Next, Plaintiffs contradictorily assert that, instead of eliminating the need for assignments, "*Congress has assigned the right to reimbursement to the Murphy Practice.*" *Id.* at 28 (emphasis in original). Plaintiffs later modify this position, claiming that the Coronavirus Legislation only "*effectively*" – rather than actually – assigned the right to reimbursement to them. *Id.* at 29.

Finally, Plaintiffs assert that the issue of assignments is irrelevant, claiming that "under the unique circumstances of this case," the Coronavirus Legislation itself affords them "standing to sue" under ERISA. *Id.* at 26. However, the express terms of Section 6001(b) of FFCRA dispose of that argument, because Congress empowered only the Secretary of Labor to enforce certain FFCRA provisions "as if included" in ERISA Part 7.

Stated simply, none of these arguments provide an escape from the "narrow exception" granting providers ERISA standing only if a "beneficiary has assigned his [benefit] claim in exchange for health care." Cigna Br. at 16 (citation omitted).

2. The Amended Complaint fails to plead any plausible ERISA claims.

Plaintiffs mistakenly characterize Cigna's concerns regarding the failure to plead sufficient facts under ERISA as "nitpicks [that] are absurd." Opp. Br. at 16. At the same time, they seek recovery for benefits under ERISA plans for thousands of patients without identifying a single plan, its terms, or facts establishing exhaustion of administrative remedies. Cigna Br. at 9-10, 16-18. Plaintiffs acknowledge that many benefit plans prohibit assignment, Opp. Br. at 27, but the AC

provides Cigna with no notice of the assignment provisions in the benefit plans at issue or the benefits granted by plan language. Cigna Br. at 16-18. *Pascack Valley Hosp., Inc. v. Local 464A UFCW Welfare Reimb. Plan*, 388 F.3d 393, 400 (3d Cir. 2004) (ERISA benefits claim must establish a "right to benefits that is legally enforceable against the plan and that the plan administrator improperly denied those benefits"). The AC must be dismissed because Cigna is deprived of notice of those essential facts. *Salahudlin v. Cuomo* 86, F.2d 40, 42 (2d. Cir. 1988) (Function of Fed. R. Civ. P. 8 is to provide adverse party with fair notice of the claim).

Finally, Plaintiffs now argue against a strawman, claiming that Cigna seeks dismissal because the list of claims was not physically attached to the complaint. Opp. Br. at 15. Cigna has not made that argument. Rather, it has argued that Plaintiffs' partial post-pleading disclosures cannot overcome their pleading deficiencies. Cigna Br. at 8-11.

C. The State Law Claims Fail as a Matter of Law or are Impermissibly Vague

1. ERISA preempts alternative state law claims for plan benefits.

The AC's core allegation is that Cigna has "repeatedly refused to pay providers, like the Murphy Practice, for services . . . even after it has been established that Cigna patients received the COVID tests to which they were entitled." Opp. Br. at 3. Plaintiffs admit that, if they "could have brought [their] claim[s] under ERISA § 502(a)(1)(B)," the claims are preempted. *Id*. at 33. Plaintiffs have not identified a single claim where the person tested was not covered by an ERISA-governed plan. Plaintiffs attempt to overcome preemption of alternative state law claims for plan benefits by claiming that the Coronavirus Legislation imposes an "independent legal duty" on Cigna to pay them. Opp. Br. at 33-34 ("the Murphy Practice's state law causes of action all arise from the independent legal duty that is the centerpiece of this action: the duty of Cigna to obey the FFCRA and the CARES Act.").

Plaintiff's independent duty argument fails on two grounds. First, as Cigna has demonstrated, Plaintiffs have no implied private right or remedy under the Coronavirus Legislation, and they cannot circumvent that by pointing to these federal statutes as the basis for independent state statutory and common law rights. Second, even if such rights existed, Plaintiffs admit they are not independent from ERISA. Opp. Br. at 29. Accordingly, because Plaintiffs have alleged that Cigna violated ERISA by wrongfully denying payment of plan benefits, their alternative state law enforcement mechanisms fail as a matter of law. Cigna Br. at 27.

2. The state law causes of action fail to plead sufficient facts.

If treated as alternatively pleaded theories of recovery, the state law claims fail in any event because – even after amendment – the AC simply parrots threadbare recitals of legal elements for each claim, which is insufficient to meet basic pleading standards: "To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (*quoting Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.*

Plaintiffs acknowledge that their quantum meruit claim "arises out of the need to avoid unjust enrichment to a party," Opp. Br. at 35, but cannot explain away the well-established authority that they must allege that they provided a benefit *to Cigna* rather than to patients. Cigna Br. at 29. This claim additionally fails because they allege no facts showing that Cigna knowingly accepted Plaintiffs' services, or that Cigna promised Plaintiffs it would pay. *Burns v. Koellmer*, 11 Conn. App. 375, 385-84 (1987) ("[t]he pleadings must allege facts to support the theory that the defendant, by knowingly accepting the services of the plaintiff and representing to her that she would be compensated in the future, impliedly promised to pay").

Plaintiff's CUIPA/CUTPA claim, AC, ¶ 152-179, includes nothing more than threadbare statutory quotes rather than facts. AC ¶ 157 ("Cigna's actions constitute unfair claims settlement practices in violation of the Connecticut Unfair Insurance Practices Act"). Plaintiffs' claim is flawed because CUIPA violations must be pleaded "with particularity to allow evaluation of the legal theory upon which the claim lies." *Ferrari v. U.S. Equities Corp.*, No. 3:13-CV-00395 (JAM); 2014 WL 5144736, at *3 (D. Conn. Oct. 14, 2014) (quoting *Sorisio v. Lenox, Inc.*, 701 F. Supp. 950, 962 (D. Conn. 1988)).

Finally, with respect to the tortious interference claim, Plaintiffs assert that "Cigna's reliance on [the] defamation pleading standard is inapplicable." Opp. Br. at 40. In the next breath, Plaintiffs tell the Court that their claim is viable because "[t]he Murphy Practice properly alleged that Cigna was telling patients and testing location sponsors that [Plaintiffs] were a fraudulent enterprise." *Id*. This claim fails because the AC pleads no facts that "interference resulted from [Cigna's] commission of a tort [through defamatory conduct]." Cigna Br. at 31. (Quoting *Robert S. Weiss Assoc., Inc. v Wiederlight*, 208 Conn. 525, 535 (1988)).

III. CONCLUSION

Despite having the opportunity to amend their original complaint and to explain the basis for their novel legal theories, Plaintiffs' claims cannot survive beyond the pleading stage. Cigna therefore requests that the Court dismiss the Amended Complaint, with prejudice and without leave to amend. Further, Cigna requests that the Court award Cigna its fees and costs under 29 U.S.C. § 1132(g).

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CERTIFICATE OF SERVICE

I hereby certify that on June 1, 2021, a copy of the foregoing Reply Memorandum in Support of Defendants' Motion to Dismiss was filed electronically. Notice of this filing will be sent by email to all parties by operation of the Court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System.

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