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, M.D., Plaintiffs, vs. CIGNA HEALTH AND LIFE INSURANCE COMPANY and CONNECTICUT GENERAL LIFE INSURANCE COMPANY, Defendants.	:	Docket No. 3:20-cv-01675-JBA

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS THE AMENDED COMPLAINT

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Plaintiffs, 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 (collectively the "Murphy Practice"), submit this Memorandum of Law in Opposition to Defendants' Motion to Dismiss the Amended Complaint.

I. INTRODUCTION

In late March of 2020, America's worst pandemic in over 100 years, the COVID-19 outbreak, was ravaging the country. In response, the United States Congress and the President of the United States agreed that immediate and drastic action was necessary. Because the disease was easily spread by an infected person, even before symptoms developed, any effort to contain the disease required testing as many Americans as possible to identify the infected to provide prompt treatment. Further, rapid testing was needed so that infected people would quarantine themselves and not infect others with the highly communicable disease. In pursuit of this goal, the Government took the extraordinary step of enacting a pair of statutes to reduce the pandemic's harm by ensuring that any person who needed a test could get one.

Specifically, the Government needed to address two impediments to comprehensive COVID-19 testing. First, COVID-19 testing can be expensive. If patients could not be assured that their insurance would cover the full cost of testing, the cost and uncertainty would undoubtedly deter many from getting tested, particularly those most vulnerable to the disease. Second, testing needed to be made widely available. Most medical practices were closed as a result of lockdown orders, and few were seeing new patients. The Government needed to incentivize medical professionals and practices to open up and invest money in providing ready access to testing.

Congress addressed both of these concerns in the Families First Coronavirus Response Act ("FFCRA") and the CARES Act. Taken together, these statutes required all health insurance

plans to cover COVID-19 testing with no out of pocket expenses to patients. The acts sought to make certain that no person would have to consider the economic cost of getting tested, and so co-payments, deductibles, and co-insurance were prohibited. But removing barriers that might discourage patients from getting tested was only part of the goal – Congress also needed to persuade practitioners to participate and invest in establishing testing centers that would test anyone. This included making sure that providers would not turn away patients who had insurance coverage, but the coverage was through a plan in which the provider was not a contracted participant, *i.e.*, was "out-of-network." So Congress addressed both in-network and out-of-network providers directly, requiring plans to cover testing from out-of-network providers on the same terms as from in-network providers: no out of pocket expenses, no co-payments, no deductibles. Congress recognized, however, that plans often pay very little to out-of-network providers, something they do to incentivize their members to use in-network providers who have agreed by contract to accept discounted rates. In order to prevent providers from declining to provide testing services to patients who were out-of-network with respect to the providers, Congress set out a specific reimbursement protocol for out-of-network providers: plans were required to pay them their cash price, unless a lower negotiated price was agreed to.

The Government's strategy of removing financial deterrents to patients and providers by taking patients out of the business end of COVID-19 testing and assuring that providers would be fairly reimbursed for providing testing to all who needed it, regardless of insurance status, was remarkably successful. Within five months of the passage of the FFCRA and the CARES Act, nearly 80 million Americans were tested for COVID-19. This was due in no small part to the extraordinary efforts of the health care community, widely recognized as the heroes of the pandemic. Part of those heroic efforts were at testing centers. Thousands of health care

professionals and others worked to set up safe, effective, and accessible locations where patients could be tested. Healthcare workers interacted with hundreds of potentially infected patients daily, at significant personal risk, to fulfill the U.S. Government's testing goal: everybody who needs a test can get a test. Dr. Steven Murphy and the Murphy Practice were among the earliest pioneers in the effort, establishing numerous testing centers and providing around the clock opportunities for residents of southern Connecticut to protect themselves and their families by getting tested. Dr. Murphy's efforts, which included testing over 30,000 patients and providing no-cost testing to over 3,000 uninsured patients, were hailed by state and local leaders, including the Governor of Connecticut.

Cigna, a multi-billion dollar insurer that promises on their website that they are "more than a health insurance company," apparently didn't get the memo. In response to the national emergency, Cigna did not embrace the coordinated approach to testing developed by Congress. Rather, Cigna looked to protect their bottom line and engaged in a campaign to undermine and circumvent federal policy and federal law as reflected in the FFCRA and the CARES act, as well as the guidance issued by federal agencies. Cigna has routinely refused to honor its coverage obligations under the federal legislation and has instead pursued an improper and illegal strategy to punish those providers who were naïve enough to rely on the legislation and on Cigna's good faith when they made sacrifices to make Americans safer. Cigna has repeatedly refused to pay providers, like the Murphy Practice, for services federal law requires Cigna to reimburse.[1] Sometimes the refusal was outright, other times it was accomplished by endless and prohibited demands for medical records even after it had been established that Cigna patients received the COVID-19 tests to which they were entitled. On other occasions, Cigna simply ignored the requests for reimbursement.

[1] *See, e.g., Open MRI and Imaging v. Cigna Health and Life*, Dkt. # 20-10345 (DNJ).

Most shocking, however, is that when challenged, Cigna's response is essentially, "tough luck – there is nothing you can do about it." In this action, Cigna actually makes the argument that even if federal law requires them to reimburse the Murphy Practice for testing and related services (which it undoubtedly does), and even if Cigna wrongfully refused to reimburse the Murphy Practice for the testing services provided to Cigna members (which they undoubtedly did), there is nothing that can be done. In essence, Cigna contends that they are entitled to treat a binding federal statute as an option, something they can comply with or not as they see fit, but something that there is little or no consequence for disobeying. They insist that this is precisely what Congress wanted.

While Cigna's arguments sound in procedural niceties, such as the adequacy of assignment provisions or the detailed inpatient data provided by the Murphy Practice, the true thrust of Cigna's position is, in fact, far darker. According to Cigna, when Cigna blatantly violates federal law, and you are harmed, you are out of luck. Cigna is free to deny millions of dollars of reimbursement claims that federal law requires Cigna to pay, and all they risk is an insignificant fine from a federal agency.

The Murphy Practice brings this action to hold Cigna responsible for their not only illegal and irresponsible response to the pandemic and to federal efforts to combat it, but for the sheer arrogance of their assertion that Cigna is above the law.

II. CIGNA'S INTRODUCTION

In their introductory remarks Cigna goes to great lengths to defame the Murphy Practice by citing and relying on numerous unreliable sources, all outside the record. Pointing to and quoting from articles in newspapers and alleging "gross overcharging" based on non-record data regarding prices of other tests that are not at issue in this litigation. Rather than respond with

allegations about Cigna's many shameful episodes and the media coverage of them, we ask the Court to disregard and strike the first two paragraphs of Cigna's Memo of Law.

III. STATEMENT OF RELEVANT FACTS

A. The Parties

Plaintiff Murphy Medical Associates LLC is a limited liability company organized under Connecticut law. Amended Complaint ¶ 8. Plaintiff Diagnostic and Medical Specialists of Greenwich, LLC is a limited liability company organized under Connecticut law. Amended Complaint ¶ 9. Plaintiff North Stamford Medical Associates, LLC is a limited liability company organized under Connecticut law. Amended Complaint ¶ 10. Plaintiff Steven A.R. Murphy, M.D. is a physician licensed to practice medicine in Connecticut and New York. His principal place of practice is located at One East Putnam Avenue, Greenwich, Connecticut 06830. Amended Complaint ¶ 11.

The mission of the Murphy Practice is to provide high-quality preventive and general health services, as well as acute primary care, to men, women, and adolescents. The Murphy Practice accomplishes its mission by offering various preventive medical services, including diagnostic laboratory testing and imaging such as ultrasounds and echocardiograms. Amended Complaint ¶ 16.

Defendant Cigna Health and Life Insurance Company is a corporation organized under Connecticut law. Defendant Connecticut General Life Insurance Company is a corporation organized under Connecticut Law. Amended Complaint ¶ 13.

B. To Combat The National Pandemic, The Murphy Practice Creates Testing Sites At The Very Start Of The Pandemic

In early 2020 the COVID-19 pandemic quickly set upon the United States. With 26 confirmed cased of COVID-19, on March 15, 2020, Governor Lamont shut down the state of

Connecticut to all non-essential business.[2] Due to the hyperbolic onset of COVID-19, Connecticut, and the rest of the country, were unprepared in many critical aspects.

One glaring issue was the lack of COVID-19 testing. Dr. Murphy was one of the first to assist in the fight against COVID-19 and assist the populations of Fairfield and New Haven Counties, Connecticut, and Westchester County, New York, to address the desperate need for timely COVID-19 testing. Amended Complaint ¶ 14.

Not surprisingly, this drastic and immediate change required that the Murphy Practice invest hundreds of thousands of dollars to transform its traditional medical practice to set up COVID-19 testing sites. These sites – which were erected virtually overnight – were designed to provide efficient drive and/or walk-through COVID-19 testing to patients with symptoms or suspected exposure. This was the first line of defense against the pandemic. Amended Complaint ¶ 22. Ultimately, the Murphy Practice operated drive and/or walk-through COVID-19 testing sites in Greenwich, Stamford, New Canaan, Darien, Fairfield, Bridgeport, New Haven, West Haven, Stratford, and Ridgefield, Connecticut, and Bedford, Brooklyn, and Pound Ridge, New York. Amended Complaint ¶ 23.

In addition to creating the physical infrastructure for the testing sites, the Murphy Practice had to assemble the clinical and administrative staff needed to operate the sites. Similarly, it had to develop extensive protocols and procedures to ensure the sites were effectively and efficiently operating, and that all safety, infection control, OSHA, and CDC guidance were observed. Amended Complaint ¶ 24.

Dr. Murphy and his efforts to drastically increase testing in the area were a key and valuable part of the population's defenses against COVID-19.

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[2] https://portal.ct.gov/Office-of-the-Governor/News/Press-Releases/2020/03-2020/Governor-Lamont-Coronavirus-Update-March-15-2020-6PM

C. The Murphy Practice Uses Cutting Edge Effective Techniques In Its Testing To Identify Additional Respiratory Pathogens Related to COVID-19

The Murphy Practice went above the minimum of just providing COVID-19 testing. The Murphy Practice invested significant hours and resources researching peer-reviewed and other expert literature to determine the most effective and informative way to fulfill its COVID-19 testing mission. Amended Complaint ¶ 25. Plainly, just doing the bare minimum was not good enough for the Murphy Practice's standards and the requisite standard of care to treat a patient.

Through its research and based on personal experience, the Murphy Practice concluded that solely performing a COVID-19 test failed to adhere to the requisite standard of care. To properly treat a patient, other diagnostic testing was required. Patients who presented with symptoms of COVID-19 or who potentially have exposure to COVID-19 need to be tested for COVID-19 and other respiratory viruses and infections that could cause the same or similar symptoms as COVID-19. This information about other potential respiratory issues is vitally important to ensure that patients who present with symptoms or were possibly exposed to COVID-19 receive the most appropriate and effective treatment for a life-threatening condition.[3] Amended Complaint ¶ 26.

Initially, the Murphy Practice lacked the capacity to perform COVID-19 testing in its lab. Amended Complaint ¶ 30. Although the Practice had state-of-the art testing for most respiratory illnesses in the form of a BioFire Film Array machine, COVID-19 testing was not included.

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[3] *See, e.g., Bangshun He et al., Tumor Biomarkers Predict Clinical Outcome of COVID-19 Patients*, 81 J. OF INFECTION 452 (2020). Medical Studies have also concluded that a statically significant percentage of patients (20% in one study) who tested positive for COVID-19 also tested positive for one or more respiratory pathogens.[3] Amended Complaint ¶ 27. In particular, FAQs regarding the federal COVID-19 testing law that have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, "FAQs"), state that "the CDC strongly encourages clinicians to test for other causes of respiratory illnesses."[3] Amended Complaint ¶ 28. As a result, when testing for COVID-19 among symptomatic patients the Murphy Practice also tested for other respiratory pathogens. Amended Complaint ¶ 29.

Accordingly, the Murphy Practice retrieved samples at its testing centers and sent them to outside labs for analysis. In addition, where appropriate, the Murphy Practice split the sample and also ran it through the BioFire test, which was consistent with the research and guidance discussed above. Amended Complaint ¶ 30.

After extensive efforts to obtain COVID-19 testing technology, in May of 2020, the Murphy Practice purchased an advanced BioFire Film Array System with COVID-19 testing capability. Amended Complaint ¶ 32. According to the makers of BioFire, "[t]he inclusion of SARS-CoV-2 in the BIOFIRE® RP2.1 panel allows healthcare providers to quickly identify patients with common respiratory pathogens, as well as those with COVID-19, using one simple test. The BIOFIRE® RP2.1 panel takes approximately 45 minutes and tests nasopharyngeal swab samples in transport media." Amended Complaint ¶ 33. The advanced BioFire machine was an extraordinary advance, and it enabled the Murphy Practice to test far more efficiently for COVID-19 and other respiratory viruses. To be more specific, instead of waiting a week to ten days for results, BioFire can produce COVID-19 test results on the same day a sample was taken. Amended Complaint ¶ 35. Once the Murphy Practice had COVID-19 testing capacity through the BioFire machines, patients who were symptomatic or otherwise required expedited results had their samples run through BioFire, which often provided them with results in one day or less. For others, the samples were sent to an outside lab that did the COVID-19 testing. Amended Complaint ¶ 36. For some patients, the time difference was potentially life-saving. Amended Complaint ¶ 35.

In addition to the testing, the Murphy Practice also provided COVID-19 antibody blood testing in its lab for patients who knew or had reason to believe that they had recovered from COVID-19. Amended Complaint ¶ 37. This was essential for many reasons. For example, for

patients who tested positive for COVID-19 – or who had COVID-19 antibodies in their system – additional blood testing was necessary to determine the potentially life-threatening damage that the virus was doing or had done to the body's organs and systems. This blood testing includes checking for certain protein levels, vitamin levels, hormone levels, and other indicia that will provide key insights into the operation of various vital organs and systems.[4] Amended Complaint ¶ 38.

Furthermore, during the time period between the day the sample was taken and the results were available, the Murphy Practice's clinical personnel conducted telemedicine visits with the patients to check on their conditions and determine whether further medical intervention, such as hospitalization, was a need. Amended Complaint ¶ 40.

Finally, when the results of the tests were available, they were posted on the patient's registration portal. Obviously, for positive tests, a telemedicine visit was scheduled with the patient to review the results and discuss the next steps with a clinician.

From March 1, 2020, through December 31, 2020, the Murphy Practice engaged in over 75,000 encounters with patients and collectively tested and provided medical treatment and care to over 35,000 of those patients. To date, the Murphy Practice has provided COVID-19 testing to approximately 3,000 uninsured patients, without any cost to the patients. Amended Complaint ¶ 42. In fact, the Murphy Practice has received accolades for its public health efforts from federal and state elected representatives, local government officials, and the media. Indeed, the Murphy Practice's efforts in creating the first walk up and/or drive through testing sites in Connecticut

[4] *See, e.g.*, Thirumalaisamy P. Velavan & Christian G. Meyer, *Mild Versus Severe COVID-19: Laboratory Markers*, 90 INT'L J. OF INFECTIOUS DISEASE 304 (2020); Jean M. Connors & Jerrold H. Levy, *COVID-19 and Its Implications for Thrombosis and Anticoagulation*, 135 BLOOD 2033 (2020); David O. Meltzer et al., *Association of Vitamin D Status and other Clinical Characteristics with COVID-19 Test Results*, 3 JAMA NETWORK OPEN E2019722 (2020); Brody H. Foy, Jonathan C.T. Carlson & Erik Reinersten, *Association of Red Blood Cell Distribution Width with Mortality Risk in Hospitalized Adults with SARS-CoV-2 Infection*, 3 JAMA NETWORK OPEN E2022058 (2020).

played a significant part in the relative success that Connecticut enjoyed in combating the COVID-19 crisis. Amended Complaint ¶ 43.

D. Due To The Need For Immediate And Efficient Testing, The Federal Government Enacted The FFCRA And CARES Act So Patients Could Get Easily Get Tested And Providers Would Be Fairly Compensated During A National Crisis

On January 31, 2020, a public health emergency was declared. Unprepared to fight the COVID-19 pandemic, Congress enacted legislation to help the country fight the virus. Specifically, in March of 2020, Congress, in recognition of the public health emergency and the desperate need to address it by making COVID-19 testing readily available to anyone who needed it, enacted two statutes. Both statutes addressed the issue of payment for testing: the FFCRA and the CARES Act. Amended Complaint ¶ 44. Specifically, through the FFCRA, Congress mandated that health plans and managed care companies cover and reimburse providers for COVID-19 testing, COVID antibody testing, and related testing and services. Amended Complaint ¶ 45. Moreover, in recognition of the emergency conditions, Congress went much further than merely requiring insurers to cover testing. To ensure that no patient would be deterred from getting a COVID-19 test due to a concern for the cost, Congress required coverage for COVID-19 testing and related services to be provided without cost sharing, deductibles, copayments or coinsurance, or other medical management requirements. Amended Complaint ¶ 46. Plainly, Congress sought to ensure that any patient with health insurance could get a COVID-19 test without any out of pocket costs and without getting permission from their insurer. Amended Complaint ¶ 47. In other words, Congress simplified the payment process for COVID-19 testing, and greatly limited insurance companies' role in deciding who got tested and what tests were reimbursable at what rates.

Congress also allowed patients to have access to a COVID-19 test that was provided by practice that was not in the patient's insurance network. Amended Complaint ¶ 48. The FFCRA and the CARES Act apply to COVID-19 testing, antibody testing, and related services rendered by both "in-network" and "out-of-network" providers (those who don't have a contractual relationship with the insurer). [5] Amended Complaint ¶ 51. This was done despite the usual practice that insurers seek to dissuade their members from using "out-of-network" providers, as a cost saving measure. For example, some healthcare plans provide zero or very little "out-of-network" benefits at all, meaning that any services obtained from an "out-of-network provider" must be paid for by the patient. Amended Complaint ¶ 52

Despite these standard insurance company actions, the FFCRA and the CARES Act addressed how insurers were required to reimburse both "in-network" and "out-of-network providers." In a section titled "ACCESS TO HEALTH CARE FOR COVID-19 PATIENTS," the CARES Act added a requirement that health plans covered by the FFCRA "**shall reimburse the provider of the diagnostic testing as follows . . .**" for covered tests and services. The Act then set forth alternative methods to calculate the actual payment amounts health plans were required to pay providers for testing and other services. Importantly, the Act addressed payment for services provided by "out-of-network" providers and "in-network" providers. Amended Complaint ¶ 53

To be more precise, under the legislation, if the patient's plan already had a negotiated rate with the provider, *i.e.*, the provider was "in-network," the plan had to pay that negotiated rate. Amended Complaint ¶ 54. Furthermore, the Act also addressed the payment requirements for providers who did not have a negotiated rate, *i.e.*, "out-of-network providers." Insurers must

[5] FAQs dated April 11, 2020, at Q.7 and Q.4, available at https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf

pay "out of network" providers their full cash price for the test unless the insurer can negotiate a lower rate with the provider. Amended Complaint ¶ 56. In addition to reimbursing providers for the COVID tests, insurers must reimburse providers for other related tests, items, and services furnished during a visit that results in an order for a COVID-19 or COVID-19 antibody test. Amended Complaint ¶ 57. Finally, more recently, the CDC has specifically expressed its approval of tests that, like the BioFire Array, screen patients for influenza variants, along with COVID-19.[6] Amended Complaint ¶ 58

E. Cigna Violates The FFCRA And CARES Act

Despite this clear legislation to fight a national pandemic, Cigna has not honored their obligation to reimburse the Murphy Practice for this vitally needed public health service. Amended Complaint ¶ 59. Cigna has instead engaged the Murphy Practice in a paperwork war of attrition. Specifically, Cigna has made and continues to make voluminous frivolous and bad faith medical records and audit requests in response to every claim submitted by the Murphy Practice. This is a clear effort by Cigna to overwhelm the Murphy Practice and to delay or avoid their payment obligations indefinitely. Amended Complaint ¶ 60. Indeed, Cigna's requests would require the Murphy Practice to provide hundreds of thousands of pages of documents, and cause the entire practice, and the COVID-19 testing operation that is so vital to the ongoing public health emergency, to grind to a halt. Amended Complaint ¶ 61

Cigna's practices are expressly prohibited. According to FAQs released on February 26, 2021, "The FFCRA prohibits plans and issuers from imposing medical management, including

[6] "Why the CDC Flu SC2 Multiplex Assay Is Important: Serves as a single test to diagnose infection caused by one of three viruses: SARS-CoV-2, influenza A, and influenza B," available at https://www.cdc.gov/coronavirus/2019-ncov/lab/multiplex.html .

specific medical screening criteria, on coverage of COVID-19 diagnostic testing."[7] Amended Complaint ¶ 62

Rather,

> "When an individual seeks and receives a COVID-19 diagnostic test from a licensed or authorized health care provider, or when a licensed or authorized health care provider refers an individual for a COVID-19 diagnostic test, plans and issuers generally must assume that the receipt of the test reflects an 'individualized clinical assessment' and the test should be covered without cost sharing, prior authorization, or other medical management requirements."[8]

Cigna has ignored this direction. Although a few payments have been made, as of now, the amount owed to the Murphy Practice for this testing totals more than $4 million dollars. Cigna has denied reimbursement for COVID-19 testing and testing-related services for thousands of Cigna members or beneficiaries. Amended Complaint ¶ 64. Cigna has, however, issued hundreds if not thousands of bad faith demands for patients' entire medical records, doing in virtually every case where the Murphy Practice has sought reimbursement for statutorily covered COVID-19 testing.

Notably, the Murphy Practice often initially submitted a claim for reimbursement only for the BioFire COVID-19 test array, even if many of the medically necessary ancillary services described above were also provided. Those tests and services were billed separately. Amended Complaint ¶ 65. Yet despite the CARES Act guidance discussed above advising that "plans and issuers generally must assume that the receipt of the test reflects an 'individualized clinical assessment' and the test should be covered without cost sharing, prior authorization, or other

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7 https://www.cms.gov/files/document/faqs-part-44.pdf at page 2.

8 *Id.*

medical management requirements," CIGNA either requested medical records or denied the claim. Amended Complaint ¶ 66.

Despite the impropriety of the record requests, the Murphy Practice responded, providing Cigna with the test order form, signed by a physician, and the test results. These documents demonstrated conclusively that "an individual [sought] and receive[d] a COVID-19 diagnostic test from a licensed or authorized health care provider." As the above guidance makes clear, Cigna "generally must assume that the receipt of the test reflects an 'individualized clinical assessment' and the test should be covered without cost sharing, prior authorization, or other medical management requirements." Amended Complaint ¶ 67. Cigna has either denied these claims, or requested additional records. Cigna has even engaged in the practice of denying testing claims *before* the Murphy Practice has responded with requested records or reasonably could respond to those claim appeals. Amended Complaint ¶ 68.

IV. LEGAL STANDARD

A motion to dismiss under Rule 12(b)(6) must be decided on "facts stated on the face of the complaint, in documents appended to the complaint or incorporated in the complaint by reference, and matters of which judicial notice may be taken." *Leonard F. v. Israel Disc.* Bank of N.Y., 199 F.3d 99, 107 (2d Cir. 1999). In deciding a motion to dismiss, well-pleaded facts must be accepted as true and considered in the light most favorable to the Plaintiff. *Patane v. Clark*, 508 F.3d 106, 111 (2d Cir. 2007). The issue in deciding a motion to dismiss is "not whether the plaintiff will ultimately prevail but whether the plaintiff is entitled to offer evidence to support the claims." *Villager Pond, Inc. v. Town of Darien*, 56 F.3d 375, 378 (2d Cir. 1995).

V. ARGUMENT

A. The Murphy Group Has Properly Identified Relevant Patients

Cigna argues that the Amended Complaint should be dismissed because the Murphy Practice has failed to identify all the patients and claims relevant to this action, including what benefit plan they were enrolled in, and what decision Cigna made on each claim. Cigna at p. 9-10. This is incorrect. As Cigna concedes, on April 9, 2021, the Murphy Practice produced a spreadsheet that identified all the claims at issue as of March 24, 2021.[9] Among other things, for each claim in the spreadsheet, the Murphy Practice has provided Cigna the patient name, service date, CPT code, CPT descriptions, amount billed, payment, and balance. This is more than enough information for Cigna to identify the relevant claims.

Cigna seems to complain that the list is deficient for a number of reasons. One is that it was not "attached to the Complaint." As Cigna well knows, the list consists of an Excel spreadsheet with 13,000 lines of data that would total well over 1,000 pages if printed on standard paper. Given the extraordinary volume of the list, and the HIPAA concerns, attaching such a document to the Amended Complaint was not practical.

Cigna also bemoans the absence of information on the list that would make it easier for them to locate and analyze the relevant claims. For example, Cigna complains that the initial estimate in the Complaint, that there were over 4,000 patients at issue turns out to be incorrect – the list produced contains approximately 2,600 people (although over 4,000 tests were performed). Plaintiff's initial estimate was indeed mistaken. Given that the Murphy Practice saw an unprecedented 75,000 patients during the relevant period and was tasked by Cigna with producing medical records for all 2,600 Cigna patients seen, the Practice's inability to estimate

[9] The Murphy Practice reserves the right and will be supplementing the spreadsheet throughout the course of the litigation.

precisely is hardly grounds to dismiss the action. Cigna does not explain how this error prejudiced them or what the legal significance of it is.

Cigna oddly complains that there is nothing in the list indicating that the people listed are Cigna members. That is because we are only suing Cigna for failing to pay for services provided to Cigna members, so all of the people on the list are Cigna members. If it turns out there are persons incorrectly included because they are not Cigna members, we will certainly remove them. Cigna further suggests the Amended Complaint should be dismissed because the list does not include Cigna member numbers, dates of birth, or social security numbers. According to Cigna, this information would make it easier for Cigna to locate them in their "systems."

These nitpicks are absurd. Cigna is a multi-billion dollar corporation with data and technological capabilities that undoubtedly enable it to do more than just read the list provided. In fact, what makes these complaints all the more pointless is the fact that Cigna has received and processed claims for every one of the patients on the list. Indeed, Cigna has reviewed the claims and sent one or more demands for medical records in connection with virtually every patient on the list. Cigna already knows full well which patients the Murphy Practice is suing them over, and if not, given the detail in the list provided, they undoubtedly have the ability to figure it out. Placing a burden on the Murphy Practice to make that job easier for Cigna, while the Practice continues to devote hundreds of hours to responding to Cigna's bad faith demands for the very same patients' medical records, is just another prong of Cigna's strategy to overwhelm the Murphy staff and bury them in nonsensical paper chases.

Finally, Cigna engages in a deceptive and dishonest attack on counsel, alleging that the pleading defects it cites to are similar to others that have been criticized as "artful" by other courts. In fact, in the case cited by Cigna, the issue was whether the Complaint had properly

pleaded the exhaustion of administrative remedies. The Court criticized the practice of pleading exhaustion of remedies "by simply arguing '[Plaintiff] administratively appealed each of the 200 claims at issue . . .'" *Neurological Surgery, P.C. v. Aetna Health Inc*., No. 19-cv-4817, 2021 WL 26097, at *18 (E.D.N.Y. Jan. 4, 2021). Of course, such a pleading generality does not exist in the Amended Complaint in this case and Cigna does not suggest otherwise.[10] Rather, as with their opening salvo, Cigna raises the issue because they apparently recognize that their legal position - they have a right to thumb their nose at Congressional commands - is so repugnant that their best hope for success is to distract with scurrilous allegations against the opponent. These arguments have no place in Cigna's motion and no relevance to any issue before the Court.

Finally, to the extent that the claim chart is not attached to the Amended Complaint, this is to protect the patients' identity and to comply with HIPAA. If the Court agrees that the chart must be attached to the Amended Complaint, the Murphy Practice requests permission to amend the Amended Complaint and have the chart filed under seal.

B. The Murphy Practice Has An Implied Private Right Of Action Under The FFCRA And The CARES Act

In their Motion, Cigna attempts to circumvent federal law by arguing that there is no private right of action under the FFCRA or the CARES Act, requiring dismissal of Plaintiff's First Cause of Action. Cigna Brief at p. 11-14. In fact, a private right of action can readily be inferred from the language and context of the FFCRA and the CARES Act establishing the Murphy Practices' right to reimbursement for the COVID testing services it provided.[11]

The question of whether a federal statute contains an implied private right of action is "basically a matter of statutory construction." *Transamerica Mortg. Advisors, Inc. (TAMA) v.*

[10] Plaintiff's Cause of Action under FFCRA and CARES requires no exhaustion, and in the ERISA counts Plaintiffs have alleged that exhaustion of remedies is excused in this case due to Cigna's multiple ERISA violations, and the exhaustion would be futile. Amended Complaint ¶ 148-148.

[11] The Murphy Practice does not contend that the statutes contain an express private right of action.

Lewis, 444 U.S. 11, 15 (1979). The Supreme Court has enumerated several factors that are relevant to this analysis, including: (1) whether the plaintiff is "one of the class for whose especial benefit the statute was enacted"; (2) whether there is "any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one"; (3) whether a private right of action is "consistent with the underlying purposes of the legislative scheme"; and (4) whether "the cause of action [is] one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law." *Cort v. Ash*, 422 U.S. 66, 78 (1975); *Republic of Iraq v. ABB AG*, 768 F.3d 145, 170 (2d Cir. 2014) ("To 'illuminate' this analysis, we also consider factors enumerated in *Cort v. Ash*") (internal citation omitted)); *see also M.F. v. State of New York Exec. Dep't Div. of Parole*, 640 F.3d 491, 495 (2d Cir. 2011) (courts in the Second Circuit continue to apply the factors set forth in *Cort* in order to discern congressional intent to provide a private right of action); *Lindsay v. Ass'n of Prof'l Flight Attendants*, 581 F.3d 47, 52 n.3 (2d Cir. 2009) (same).

The FFCRA and the CARES Act plainly create a benefit for the class of persons of which the Murphy Practice is a member: out-of-network providers who furnish COVID testing. The statute straightforwardly directs insurers like Cigna to pay out-of-network providers who furnish COVID-19 testing. Importantly, the statutes go further, describing how the amount such providers must be paid will be calculated. It states that "such plan or issuer shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website . . ." This provision "grant[s] private rights to members of an identifiable class." *Transamerica Mortg. Advisors, Inc. (TAMA) v. Lewis*, 444 U.S. at 24. Unlike the provision found insufficient to create a private right of action in *Transamerica*, this one "create[s] or alter[s] any civil liabilities." *Id* at 19.

With respect to the second factor to be considered, there appears to be limited extrinsic evidence of legislative intent one way or the other on the issue of a private cause of action with respect to the particular provisions at issue here, other than the language used. But the language used reflects a legislative intent that is in fact consistent with providing a private right of action because Congress specifically identified a discrete group and then used language giving that group a right to reimbursement. It is only logical to assume that if the group is denied the right granted to it by Congress, they will have a remedy. The lack of more specificity is not surprising, given the emergency Congress faced, the need for immediate decisive action, and the overall complexity of the entire statutory schemes, which primarily focused on economic relief, of which the specific provision we focus on in this case is but a tiny part.

In fact, one example of the difficulties caused by the rushed adoption of the FFCRA and the CARES Act will be discussed below – the failure of Congress to provide a reimbursement calculation method for any period where the provider did not publish their cash price on the website. This was the case at the Murphy Practice for a period of time, and it was undoubtedly the case elsewhere as providers scrambled to line up staff, equipment, and supplies sufficient to safely and effectively address the pandemic. But the relevant CARES Act provisions are silent about what happens when no cash price is listed on the website. The 300+ page statute, and the testing provisions, in particular, were simply not subject to extensive debate, analysis, and revision before it was enacted – people were dying, and time was of the essence. [12]

[12] As Forbes wrote in April of 2020, "The Coronavirus Aid, Relief, and Economic Security Act, commonly known as the CARES Act, was a remarkable legislative feat when passed into law at the end of March. The economic crisis stemming from COVID-19 made speed and size the order of the day." https://www.forbes.com/sites/kathrynjudge/2020/04/20/the-design-flaw-at-the-heart-of-the-cares-act/?sh=55c45cb56bed

Nor can there be any question that a private right of action is "consistent with the underlying purposes of the legislative scheme." As described above, Congress wanted providers to be confident that if they participated in the national effort to combat the pandemic through widespread testing and diagnosis, they would be reimbursed appropriately. Such assurance was essential given the extensive costs (not to mention the personal risk) providers faced in setting up broad testing capability. Congress was well aware that, if left to their own devices, insurance companies would protect their economic interests and do what they could to avoid paying for the massive testing required to defeat the disease. Accordingly, Congress specifically removed nearly all discretion and back doors that insurers might use to avoid coverage. Congress wanted widespread testing, and they wanted insurers to pay for it.

Had the law been written as Cigna now urges this Court to interpret it – insurers should pay providers for COVID-19 testing, but if they don't, the providers have absolutely no recourse beyond asking the Department of Labor to fine the insurers – it is inconceivable that sufficient resources would have been invested to reach the level of testing Congress hoped for. It is simply beyond cavil that allowing providers to sue to enforce the right to payment granted them by the CARES Act is consistent with the act's purposes.

Nor is this lawsuit an action of the type "traditionally relegated to state law." Actions by healthcare providers to enforce federal rights to payment for healthcare services flood the federal courts, in the context of government funded plans, ERISA plans and related healthcare legislation. Not surprisingly, Cigna does not argue to the contrary.

Moreover, if there were no private right of action, patients and medical providers would be left remediless. The statute intended to prevent medical providers from directly billing the patients here, but that is apparently what Cigna wants. This is inappropriate. *Franklin v.*

Gwinnett County Pub. Schs., 503 U.S. 60, 76 (1992) (finding private right of action for money damages under Title IX because administrative process would leave complainant "remediless").

In the face of the compelling arguments in favor of interpreting Part II, Subpart A, Section 3201 of the CARES Act as creating a private cause of action for out-of-network providers of COVID-19 related testing and services, Cigna advances three arguments. First, Cigna contends that the Act contains "no statutory language focused on protecting private rights." But this is simply inaccurate. As described above, the statutory provision at issue, 3201, specifically protects the rights of out-of-network providers to reimbursement for COVID-19 testing.

Next, Cigna points to the provisions of the FFCRA and the CARES Act that authorize federal agencies to enforce their rules, and argues that this demonstrates that there can be no private right of action. But the law is clear that the existence of an alternative method of enforcement is not fatal to the existence of a private right of action. As the Second Circuit has explained, when concluding that an implied private right of action exists despite the presence of alternative enforcement avenues, "the provision of other (private or public) enforcement mechanisms (Bellikoff factors (i) and (ii)) merely "suggests" "that Congress intended to preclude" implied private rights of action." *Oxford Univ. Bank v. Lansuppe Feeder, LLC*, 933 F.3d 99, 106 (2d Cir. 2019) (citing *Alexander v. Sandoval*, 532 U.S. 275, 290).

Here, as in *Oxford Univ*. that "suggestion" is not particularly persuasive. The federal agencies are only empowered to fine Cigna for non-compliance. They are not empowered to protect the very specific right that the Murphy Practice seeks to vindicate – their right to payment for services provided. Notably, Cigna does not make any suggestion that agency enforcement would alleviate the situation where a provider such as the Murphy Practice stands to lose millions of

dollars because they trusted the promise of the CARES Act that insurers "shall reimburse the provider" of COVID-19 testing services. As a result, closing the courthouse door to the Murphy Practice, because a federal agency might take some undescribed enforcement action, would leave the Practice uncompensated and in severe financial distress, and is utterly inconsistent with the clear legislative intent of the statute.[13]

Finally, Cigna cites cases rejecting attempts to privately enforce "various provisions" of the 300+ page CARES Act. Cigna Brief at 14. However, these cases are all inapposite because not one of them addresses the specific provision of the CARES Act that the Murphy Practice seeks to enforce in this case. As noted, the CARES Act is over 300 pages of legislation of which two pages are devoted to COVID-19 testing. The bulk of the Act addresses economic relief and stimulus programs. We do not contend that the CARES Act authorizes private actions to enforce all or even most of its provisions. None of the cases cited by Cigna remotely addresses the issue before the Court – whether Part II, Subpart A, Section 3201 of the CARES Act permits out-of-network providers to sue insurers to collect payments the Act entitles them to. Instead, the cases cited by Cigna concern payroll protection loans and other legislation to assist small businesses. *Am. Video Duplicating, Inc. v. City Nat'l Bank*, No. 20-cv-04036, 2020 WL 6882735, at *1 (C.D. Cal. Nov. 20, 2020) (concerns Paycheck Protection Program and the right of an agent to collect fees); *Autumn Ct. Operating Co. LLC v. Healthcare Ventures of Ohio*, No. 20-cv-4901, 2021 WL 325887, at *1 (S.D. Ohio Feb. 1, 2021) (concerns the distribution of federal funds between different entities); *Healthcare Ventures of Ohio, LLC v. HVO Operations Windup LLC*, No. 20-cv-04991, 2020 WL 6688994, at *1 (S.D. Ohio Nov. 13, 2020) (concerns the distribution of federal funds between different entities); *Juan Antonio Sanchez, PC v. Bank of S. Texas*, No. 20-

[13] Despite diligent searching, we could find no evidence of a single case of DOL enforcement of the testing provisions in the CARES Act.

cv-00139, 2020 WL 6060868 (S.D. Tex. Oct. 14, 2020) (concerns Paycheck Protection Program). None of the barriers these courts cited to recognition of a private right of action have any impact on the issues in this case.

Notably, one of the more recent of the many cases rejecting a private right of action for unrelated provisions of the CARES Act, *M&M Consulting Grp., LLC v. JP Morgan Bank, N.A.*, No. 10-cb-01318, 2021 WL 71436 (C.D. Cal. Jan 6, 2021), involved an effort by agents to collect fees for arranging loans pursuant to the Paycheck Protection Program ("PPP"), a claim similar to the one rejected in *Am. Video Duplicating, Inc. v. City Nat'l Bank*, a case cited by Cigna. But the PPP's only mention of agent fees provided that "[a]n agent that assists an eligible recipient to prepare an application for a covered loan may not collect a fee in excess of the limits established by the Administrator." *Id. at* *5; 15 U.S.C. § 636(a)(36)(P)(ii). The Court rejected the agents' arguments that this created a private right of action because "the choice of language – using may as opposed to shall or must – indicates that payment is not compulsory." *Id. at* *6. Accordingly, the Court found "that the statutory text and implementing regulations clearly do not guarantee payment or establish a right to payment" on behalf of the agents. Here the opposite is true. *Id.* The provisions of the CARES Act the Murphy Practice relies upon in Section 3201 do contain the compulsory language that insurers "shall reimburse the provider," and thus they do "guarantee payment and establish a right to payment" on behalf of the Practice.

C. Issues Related To The Posting Of Cash Prices Are Not Grounds For Dismissal

Cigna contends that because the Murphy Practice has not alleged in the Amended Complaint that its cash price for COVID-19 testing and related services was posted on its public website, the action should be dismissed. Cigna cites no support for this argument, and not surprisingly, we could find none. In fact, in the publication from Department of Labor (DOL),

the Department of Health and Human Services (HHS), and the Department of the Treasury, FAQS ABOUT FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT IMPLEMENTATION PART 43, issued June 23, 2020, it was acknowledged that a situation could arise where an out-of-network provider did not publish cash prices. The suggestion by Cigna that this means the provider is not entitled to reimbursement was decidedly not the answer. Rather, "[i]f the provider has not complied with this requirement, and the plan or issuer does not have a negotiated rate with the provider, the plan or issuer may seek to negotiate a rate with the provider for the test. However, Section 3202(a) is silent with respect to the amount to be reimbursed for COVID-19 testing in circumstances where the provider has not made public the cash price for a test and the plan or issuer and the provider cannot agree upon a rate that the provider will accept as payment in full for the test."[14] The amount due for such situations is simply an issue that will have to be addressed in this litigation

In addition, the CARES Act clearly spells out the potential consequences for a provider who bills a cash price that is not posted on their website: a civil monetary penalty not to exceed $300 per day that the price is not posted. *See* CARES Act, Section 3302(b)(2). There is no authority whatsoever for the proposition that the consequences are that the provider is not entitled to any reimbursement.

The Murphy Practice currently posts its cash prices and has done so for some time, as Cigna is well aware since they reference this fact in their Introduction. Cigna Brief at p. 1, 6, and fn 9. In response to Cigna's discovery demands on this issue the Murphy Practice will provide information about the date when the prices were first posted.

[14] https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf, at p. 9.

D. The Murphy Practice Does Have Standing To Challenge Cigna's Violations Of The FFCRA And CARES Act Under ERISA

Whether or not the Murphy Practice has a private right of action directly under the FFCRA and CARES Act, Plaintiffs are nonetheless entitled to challenge Cigna's indirect payment scheme through the private rights of action provided under ERISA. Specifically, ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) permits a plan participant or beneficiary to bring a civil action to recover plan benefits, enforce his or her rights under the plan, or clarify the right to future benefits. ERISA § 502(3), 29 U.S.C. § 1132(a)(3) further permits a plan participant or beneficiary to seek to "enjoin any act or practice which violates any provision" of ERISA or the terms of the plan, or "to obtain other appropriate equitable relief" to "redress such violations or . . . enforce any provisions" of ERISA.

1. The Murphy Practice Has Standing Through Patient Assignments

In Cigna's motion, they incorrectly claim that the Murphy Practice has not sufficiently established its standing to sue under either of their ERISA claims. However, the Second Circuit has held that health care providers, such as the Murphy Practice, have standing to bring claims under ERISA § 502(a) where their patients assign their plan rights in exchange for health care services. *See Simon v. Gen. Elec. Co.*, 263 F.3d 176, 178 (2d Cir. 2001); *see I.V. Servs. of Am., Inc. v. Trustees of Am. Consulting Engineers Council Ins. Tr. Fund*, 136 F.3d 114, 117 (2d Cir. 1998). The Murphy Practice has standing because it routinely receives broad assignments of benefits from its patients in exchange for emergency health care services. Amended Complaint ¶¶ 78-79.

Cigna argues that the Murphy Practice has not adequately alleged the existence of patient assignments to assert ERISA claims. Cigna Brief at p. 16. The Amended Complaint clearly states that the patients either signed an assignment of benefit or executed an assignment acknowledging that federal law requires the insured to cover the cost of testing. Amended Complaint ¶¶ 78 ("The assignment documents stated that 'each patient assign[s] to [the Murphy Practice] … all of your rights and claims . . . for medical benefits'") and ¶ 79 (patients who enrolled electronically agreed that the Murphy practice would bill and collect for testing services from their insurer). Thus, the Murphy Practice has done more than required to allege patient assignments, clearly meeting their pleading burden. *See Premier Health Ctr., P.C. v. UnitedHealth Grp.*, No. 11-cv-425, 2012 WL 1135608, at *7 (D.N.J. Apr. 4, 2012) ("Plaintiffs have clearly alleged that assignments exist and have pleaded that they are relying on them to support their right to recovery. Nothing more is required.") (citations omitted). Pleading the assignment language or attaching the actual assignment is more than sufficient to confer ERISA standing. *Id.*; *see also North Jersey Brain & Spine Cyr. v. Conn. Gen. Life*, No. 10-cv-4260, 2011 WL 4737067 at *5-6, (D.N.J. June 30, 2011) (allegation reciting an assignment of "all payments for medical services rendered" was adequate).

2. FFCRA and the CARES Act Confer Standing to Sue Under ERISA

Additionally, under the unique circumstances of this case, the relevant federal legislation makes clear the medical providers have standing to sue for an insurer's violation of the law. As described in detail above, the goal of the FFCRA and the CARES Act's approach to COVID testing was to remove any financial burden from the patients. In the ordinary situation, a patient who sees an out-of-network provider is likely to be required to make a significant financial

outlay. Many ERISA plans prohibit assignment.[15] *See, e.g., Neurological Surgery, P.C. v. Aetna Health Inc.,* 2021 WL 26097, at *8 (E.D.N.Y. Jan. 4, 2021) ("There are 46 claims that implicate 39 ERISA plans with this anti-assignment provision or a nearly identical one. 'Coverage may be assigned only with the written consent of Aetna. To the extent allowed by law, Aetna will not accept an assignment to an out-of-network provider, including ...'"); *Sasson Plastic Surgery, LLC v. Unitedhealthcare of New York, Inc*., 17-cv-1674, 2021 WL 1224883, at *5 (E.D.N.Y. Mar. 31, 2021) ("United seeks dismissal of the claims relating to the treatment of one hundred eighty (180) patients because the ERISA Plans at issue contain anti-assignment provisions"). When an ERISA plan prohibits assignment, the patient is required to pay the cash price directly to the out-of-network provider for the services and then seek reimbursement from the plan. Similarly, some providers do not accept assignments from out-of-network plans. Again, patients who see these providers must pay the cash price and seek reimbursement from the plan.

Such scenarios - out of pocket expenses that could deter patients from getting tested - are precisely what the FFCRA and the CARES Act sought to prevent. Thus the language of the CARES Act says that "such plan or issuer shall reimburse the provider in an amount that equals the cash price for such service . . ." It does <u>not</u> say "such plan or issuer shall reimburse the provider <u>if the provider obtains a valid assignment of benefits from the patient</u>" and it does <u>not</u> say "such plan or issuer shall reimburse the provider, <u>unless the plan is an ERISA plan and prohibits assignment</u>."

[15] "In response to this increase in litigation, many plan sponsors have included the anti-assignment language in their plan documents in order to prevent participants and beneficiaries from assigning their rights under the plan to a health care provider or any other third party." <u>New England InHouse</u>, June 27, 2018. Available at https://newenglandinhouse.com/2018/06/27/near-unity-among-the-circuits-anti-assignment-provisions-are-enforceable/

This decision by Congress, to remove the patient from the reimbursement chain in out-of-network situations, obviates the ordinary requirement that for an out-of-network provider to have standing to sue under ERISA, there must be a valid assignment.

Cigna argues that *Rojas v. Cigna Health & Life Ins. Co.*, 793 F.3d 253, 259 (2d Cir. 2015), forecloses this argument. It does not. Rojas was an in-network provider who was removed from the network and sought to bring an ERISA anti-retaliation claim against Cigna and require Cigna to reinstate him. The anti-retaliation provisions of ERISA only protect "a participant or beneficiary" in the ERISA plan from discrimination. Rojas argued that he was a "beneficiary" because the plan permitted Cigna to pay him directly, and/or because he had valid assignments of benefits. The Court rejected these arguments.

This case is nothing like *Rojas*. The Murphy Practice does not seek "beneficiary" status under ERISA. Rather, the case here is a standard action by an out-of-network provider for payment for services rendered to ERISA beneficiaries. Courts have routinely recognized that out-of-network providers who receive assignments can sue ERISA plans for reimbursement. This is not because they are "beneficiaries" or "participants" in the plan, but because, with respect to the right to reimbursement, they stand in the shoes of a beneficiary or participant. As discussed above, plans will often require a beneficiary to pay the out-of-network provider for services and then seek reimbursement from the plan. An assignment allows the provider to instead seek reimbursement directly from the plan.

The wrinkle here, should the Court find that the assignments described in the Amended Complaint are not sufficient, or should the plans at issue validly prohibit assignment, is that Congress has assigned the right to reimbursement to the Murphy Practice. If Congress had not directed plans to pay providers directly for COVID-19 testing, but only directed them to cover it,

the plans would indeed be free to require an assignment before they pay providers for COVID-19 testing, or to prohibit assignment completely and require the beneficiary to pay the provider first and then request reimbursement. But this would have been inconsistent with Congress's goal of encouraging patients to get tested by removing any financial barriers and guaranteeing them access to any provider rendering testing services, including out-of-network providers, with no out of pocket costs. Thus, Congress effectively assigned the right to payment for the covered COVID-19 testing to any out-of-network provider who renders the services.

None of the facts here bear any resemblance to *Rojas*, who, the Court concluded, "sued under the wrong agreement." Rojas's case should have been a contract claim against Cigna, since he was essentially alleging that they breached his contract with them. *Rojas* simply did not involve a Congressional act requiring Cigna to pay Rojas directly for services rendered to Cigna beneficiaries. Put simply, by virtue of either the assignments described in the Amended Complaint or by virtue of the CARES Act's assignment to providers of the right to payment from a plan for COVID-19 testing services, the Murphy Practice has standing to assert ERISA claims for reimbursement.

3. The Murphy Practice Has Properly Plead Its ERISA Claims

a. Since the FFCRA Directs Insurance Companies "To Reimburse The Provider Of The Diagnostic Testing" The Plan Terms Are Irrelevant

Cigna argues that the Murphy Practice has failed to allege sufficient facts about the relevant patient plans. Cigna Brief at p. 20. This argument misses the point. As explained above, the CARES Act added a requirement that health plans, including ERISA plans, covered by the FFCRA "shall reimburse the provider of the diagnostic testing as follows . . ." for covered tests and services. Thus, regardless of what plan is involved or what its provisions are, the reimbursement obligation is identical, and it arises from federal law, not from plan language.

Plainly, since Cigna was required under federal law to reimburse providers for COVID-19 testing it is irrelevant what the actual plans state.

Similarly, for this same reason, the Murphy Practice has properly plead the Second Cause of Action seeking reformation of Cigna's non-compliant plans. Cigna Brief at p. 22. In addition, while Cigna posits that ERISA plans are free to structure benefits as they see fit, this freedom has been circumscribed by federal legislation. Finally, Cigna's complains that Plaintiffs have not provided enough information about which plans need to be reformed or how they need to be reformed is of no moment. Either the plan mirrors the CARES Act language, or it does not. Any plan that does not contain language entitling providers to reimbursement as established in the CARES Act should be reformed to do so.

b. Exhaustion of Administrative Remedies Is Not an Appropriate Basis for the Dismissal of the Murphy Practice's Claim

Cigna argues that the Third Cause of Action should be dismissed because the Murphy Practice fails to plead that it exhausted administrative remedies. Cigna Brief at p. 23. In fact, in the Amended Complaint, the Murphy Practice alleges that exhaustion of administrative remedies is not required as a result of Cigna's multitude of ERISA violations and that exhaustion of administrative remedies would be futile. Amended Complaint ¶ 120.

The Second Circuit has ruled that "a failure to exhaust ERISA administrative remedies is not jurisdictional, but is an affirmative defense." *Paese v. Hartford Life Accident Ins. Co.*, 449 F.3d 435, 446 (2d Cir. 2006) (emphasis added); *see Neurological Surgery, P.C. v. Siemens Corp.*, 17-cv- 3477, 2017 WL 6397737, at *8 (E.D.N.Y. Dec. 12, 2017). Because it is an affirmative defense – and not part of a *prima facie* claim for plan benefits – courts within this Circuit have repeatedly held that "it is the Defendant's burden to prove that the Plaintiffs failed to exhaust their administrative remedies." *Siemens*, 2017 WL 6397737, at *8 (emphasis added);

see Levi v. RSM McGladrey, Inc., 12-cv-8787, 2014 WL 4809942, at *10 (S.D.N.Y. Sept. 24, 2014); *C.M. v. Fletcher Allen Health Care, Inc.*, 12-cv-108, 2013 WL 4453754, at *9 (D. Vt. Apr. 30, 2013). Indeed, because the burden of proving the failure to exhaust rests with the defendant, an ERISA plaintiff is not even required to plead that it exhausted its administrative remedies. *See Rozek v. New York Blood Ctr.*, 925 F. Supp. 2d 315, 342 (E.D.N.Y. 2013); *White v. Univ. of Rochester, Strong Mem'l Hosp.*, 12-cv-6288, 2012 WL 3598210, at *3 (W.D.N.Y. Aug. 20, 2012). Cigna's attempt to turn this well-established standard on its head must be rejected. Because it is Cigna's burden to prove the failure to exhaust administrative remedies, the Court must deny its motion to dismiss the Murphy Practice's ERISA claims on this basis.

Although "an affirmative defense may be raised by a pre-answer motion to dismiss under Rule 12(b)(6) ... if the defense appears on the face of the complaint." *Pani v. Empire Blue Cross Blue Shield,* 152 F. 3d. 67, 74 (2d Cir. 1998), that is not the case here. Rather, as discussed below, the Amended Complaint pleads valid grounds to excuse the failure to exhaust administrative remedies.

To the extent, if any, that the Court finds that the Murphy Practice did not exhaust its administrative remedies, the Court should find that (1) exhaustion is excused; and/or (2) the pursuit of those remedies would have been futile.

"Under the ERISA regulations, if a plan fails to "follow claims procedures consistent with the requirements of [29 C.F.R. § 2560.503-1], a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a)." 29 C.F.R. § 2560.503-1(l)(1*)." Montefiore Med. Ctr. v. Loc. 272 Welfare Fund, No.* 09-cv-3096, 2018 WL 1665645, at *9 (S.D.N.Y. Feb. 20, 2018). In the Amended Complaint at paragraphs 87 through 94, the Murphy Practice details Cigna's utter

disregard of ERISA's claims procedures. Cigna inexplicably overlooks this section of the Amended Complaint in its entirety, even though these allegations are repeated in the ERISA causes of action, and one of the causes of action, the Fourth, specifically demands injunctive relief for these shortcomings.

Alternatively, "[t]he exhaustion doctrine . . . does not require plaintiffs to 'engage in meaningless acts or to needlessly squander resources as a prerequisite to commencing litigation.'" *Sibley-Schreiber v. Oxford Health Plans (N.Y.), Inc.*, 62 F. Supp. 2d 979, 986 (E.D.N.Y. 1999. As such, "a court will release the claimant from the requirement" where the claimant "make[s] a 'clear and positive showing' that pursuing available administrative remedies would be futile." *Kennedy v. Empire Blue Cross and Blue Shield*, 989 F.2d 588, 594 (2d Cir. 1993). A plaintiff makes a clear and positive showing of futility where, as here, the defendant ignores plaintiff's appeals. *See Siemens*, 2017 WL 6397737, at *9 (citing *Sibley-Schreiber*, 62 F. Supp. 2d at 987).

Here, the Murphy Practice sufficiently alleges that the pursuit of any further appeals would have been futile. The Amended Complaint states that "Cigna has reflexively denied thousands of claims for the exact same clearly reimbursable services, without providing any legitimate justification, appeal of these decisions would be futile." Amended Complaint ¶ 120. Indeed, Cigna concedes that it has gone further and demanded repayment of every dollar that it has previously paid the Murphy Practice for COVID-19 testing services. Given this pattern of conduct, the Murphy Practice should not be required to pursue any meaningless administrative remedies before bringing this action.

Accordingly, the Court should deny Cigna's motion to dismiss the Murphy Practice's ERISA claims based on the Practice's alleged failure to exhaust its administrative remedies.

E. The Murphy Practice Has Properly Plead Its State Court Claims

1. The State Law Claims Are Not Preempted

In *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004), the Supreme Court set out the standard for ERISA preemption of state laws. "[I]f an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA § 502(a)(1)(B). In conclusory fashion, Cigna argues that ERISA preempts the Fifth through Eighth Causes of Action in the Amended Complaint because they relate to ERISA plans. However, Cigna contends that the Murphy Practice has no standing to assert ERISA claims. If Cigna is correct, under *Aetna* the Murphy Practice could not have brought the claims under ERISA and they are not preempted because the first prong of the *Davila* test has not been met.

In addition, each of the state law claims asserted in the Amended Complaint rest on an "independent legal duty," namely, Cigna's duty to obey federal law: the FFCRA and the CARES Act. For example, the CUTPA claims arise out of Cigna's failure to reimburse the Murphy Practice for "medically necessary COVID-19 testing services" as required by "federal and state law," (Amended Complaint ¶¶ 154, 155), *.i.e.*, FFCRA and the CARES Act, as the rest of the complaint makes clear. Similarly, Cigna's unjust enrichment arises not from their failure to pay reimbursement as required by ERISA, but as required by FFCRA and the CARES Act. Likewise, the Seventh cause of action specifically notes that Cigna has failed to obey federal law, not any ERISA provisions.

In sum, 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. That some of the plans at issue may be ERISA plans is irrelevant. Nothing about the claims implicates ERISA rules or regulations, and the language of the ERISA plans have no bearing on the claims.

As the Second Circuit observed in *Geller v. County Line Auto Sales, Inc.*, 86 F.3d 18, 22 (2d Cir. 1996), "the intent of Congress was not to foreclose every state action with a conceivable effect upon ERISA plans." In *Geller*, ERISA plan fiduciaries sought to recover monies paid by the plan as a result of a wrongful claim for benefits. The District Court found that the plaintiffs state-law fraud claim "related to" an ERISA plan and was therefore preempted because the claim had "a connection with or reference to" the plan. *Id.* The Second Circuit reversed, holding that the fraud claim, "which seeks to advance the rights and expectations created by ERISA, is not preempted simply because it may have a tangential impact on employee benefit plans." *Id.* at 23. Allowing the fraud claim to proceed "would in no way compromise the purpose of Congress;" "[t]o the contrary, 'insuring the honest administration of financially sound plans' is critical to the accomplishment of ERISA's mission." *Id. Accord Gerosa v. Savasta & Co.*, 329 F.3d 317, 325 (2d Cir. 2003) (preemption depends on whether state remedies are consistent with ERISA's core purposes).

The Murphy Practice's state-law claims are entirely consistent with and would not frustrate ERISA's core purposes. *Geller*, 86 F.3d at 23; *Gerosa*, 329 F.3d at 325. For example, the CUTPA claim would help to ensure that Cigna does not profit from their deceptive business practices. Accordingly, courts in this Circuit have routinely held that ERISA does not preempt state-law claims such as the Murphy Practice's here. *See, e.g., Stevenson v. Bank of N.Y. Co.*, 609 F.3d 56, 62 (2d Cir. 2010) (holding that unjust enrichment, negligent misrepresentation, fraud, and tortious interference with contract claims were not preempted by ERISA); *DaPonte v.*

Manfredi Motors, Inc., 157 F. App'x 328, 331 (2d Cir. 2005) ("ERISA plan may provide contextual background for a garden variety fraud without triggering preemption where … [the] fraud claim does not rely on the [ERISA] plan's operation or management."); *Conn. Gen. Life Ins. Co. v. Adv. Chiropractic Healthcare*, 54 F. Supp. 3d 260, 267 (E.D.N.Y. 2014) (acknowledging "the trend towards a narrowing application of preemption" and declining to find ERISA preemption of insurer's fraud and unjust enrichment claims "that [providers] … defrauded the Plaintiff insurance company by billing and getting paid for medical services that were fraudulently provided"); *DiPietro-Kay Corp. v. Interactive Benefits Corp.*, 825 F. Supp. 459, 462 (D. Conn. 1993) (holding that CUTPA and CUIPA claims were not preempted by ERISA).

2. The Quantum Meruit Cause of Action is Properly Pled

Cigna misinterprets the Seventh Cause of action as a claim "under federal law." In reality, it is a state law claim for quantum meruit reimbursement, relying on the FFCRA and CARES Acts to support the reasonableness of the Murphy Practice's expectation of payment. Although Cigna suggests, without any support, that this is an effort to "back door" a cause of action based on Cigna's violation of these acts, that is not the case. If Cigna is correct in their challenge to the First Cause of Action, and there is no federal private right of action for Cigna's FFCRA and CARES Act violations, that does not mean that those violations are not relevant on the state law issue of whether the Murphy Practice is entitled to recover under a quasi-contract theory.

Quantum meruit is a theory of contract recovery that does not depend upon the existence of a contract, either express or implied in fact. *Gustave Fischer Co. v. Morrison*, 137 Conn. 399, 403, 78 A.2d 242 (1951). Rather, quantum meruit arises out of the need to avoid unjust enrichment to a party, even in the absence of an actual agreement. *Fischer v. Kennedy*, 106

Conn. 484, 492, 138 A. 503 (1927); *see also Sidney v. DeVries*, 215 Conn. 350, 351–52 n. 1, 575 A.2d 228 (1990) (quantum meruit and unjust enrichment are common-law principles of restitution; both are noncontractual means of recovery without valid contract). Quantum meruit literally means "'as much as he has deserved'...." Black's Law Dictionary (7th Ed.1999). Quantum meruit strikes the appropriate balance by evaluating the equities and guaranteeing that the party who has rendered services receives a reasonable sum for those services. *Gagne v. Vaccaro,* 255 Conn. 390, 401, 766 A.2d 416, 423–24 (2001).

3. The Murphy Practice Has Properly Plead a CUTPA Claim

Cigna argues that the Murphy Practice has not adequately alleged that unfair or deceptive acts caused them to suffer an ascertainable loss. Cigna Brief at p. 27. But the CUTPA Cause of Action itself is painstakingly pleaded, alleging violations of both CUTPA's "unfair trade practices" and "deceptive trade practices" prongs, and making *specific* the "unfairness" allegations Plaintiffs are relying on to support their "unfairness" claim.

Moreover, the CUTPA cause of action repeats and realleges all of the previous allegations in the Amended Complaint. Those allegations detail Cigna's persistent bad faith avoidance of their obligations under federal law, and the improper tactics they have employed.

CUTPA expressly states that "[n]o person shall engage in unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce." *See Laura Laaman & Assocs. LLC v. Davis*, 16-cv-0594, 2017 WL 5711393 at *9 (D. Conn Nov. 27, 2017) (*citing* Conn. Gen. Stat. § 42-110b(a)). In order to successfully state a claim under CUTPA, a plaintiff must plead that 1) they suffered an ascertainable loss of money or property, 2) that was caused by 3) an unfair method of competition or an unfair or deceptive act in the conduct of any trade or commerce. *See Richards v. Direct Energy Servs. LLC*, 120 F. Supp. 3d 148, 156 (D. Conn. 2015) (denying defendant's motion to dismiss CUTPA claim). "The purpose of CUTPA is

to protect the public from unfair practices in the conduct of any trade or commerce." *See id.* at *157 (*citing Willow Springs Condominium Ass'n, Inc. v. Seventh BRT Dev. Corp.*, 245 Conn. 1, 42, 717 A.2d 77 (1998).). Accordingly, "CUTPA applies to a broad spectrum of commercial activity...and must be liberally construed in favor of those whom the legislature intended to benefit." *See Larsen Chesley Realty Co. v. Larsen*, 232 Conn. 480, 492, 656 A.2d 1009 (1995); *see also Richard v. Direct Energy Servs.*, 246 F. Supp. 3d 538, 550 (D. Conn. March 31, 2017).

In determining whether a practice violates CUTPA, courts are to consider the following criteria: "1) whether the practice, without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the common law, or otherwise - in other words, it is within at least the penumbra of some common law, statutory, or other established concept of unfairness; (2) whether it is immoral, unethical, oppressive, or unscrupulous; (3) whether it causes substantial injury to consumers, [competitors or other businesspersons]..." *See Richards v. Direct Energy Servs. LLC*, 120 F. Supp. 3d. at 158 (*citing Naples v. Keystone Bldg. & Dev. Corp.*, 295 Conn. 214, 227-28, 990 A.2d 326 (2010)). Cigna's conduct, as alleged through the Amended Complaint, meets all of these standards. Cigna violated federal statutes, their conduct is immoral, unethical, and oppressive, and it causes substantial injury.

*"*A practice may violate CUTPA without meeting all three criteria - *i.e.*, a practice 'may be unfair because of the degree to which it meets one of the criteria or because to a lesser extent it meets all three*..."* *Laura Laaman & Assocs., LLC v. Davis*, No. 3:16-cv-00594 (MPS), 2017 WL 5711393, at *9 (D. Conn. Nov. 27, 2017). Whether a practice is unfair and thus violates CUTPA is an issue of fact not readily susceptible to resolution on a motion to

dismiss. *See Richards v. Direct Energy Servs. LLC*, 120 F. Supp. 3d at 158 (*citing Langan v. Johnson & Johnson Consumer Cos.*, 95 F. Supp. 3d 284, 2015 WL 1476400, at *3 (D. Conn. 2015).). A violation of CUTPA "may be established by showing either an actual deceptive practice...or a practice amounting to a violation of public policy." *See Walker v. Deutsche Bank Nat'l Trust Co.*, at *3.

Here, as discussed above, the Murphy Practice has shown that Cigna clearly violated public policy when it intentionally violated federal law. *See* Amended Complaint, *passim.*

4. The Murphy Practice Has Properly Plead An Unjust Enrichment Claim

The Court should also deny Cigna's motion to dismiss the Murphy Practice's unjust enrichment claim (the Sixth Cause of Action). Cigna Brief at p. 29. Under Connecticut law, a claimant need plead only three elements to establish an unjust enrichment claim: (1) that the party against whom the claim is asserted received a benefit; (2) that the party against whom the claim is asserted unjustly did not pay for the benefit; and (3) that the failure of payment was to the claimant's detriment. *Hartford Whalers Hockey Club v. Uniroyal Goodrich Tire Co.*, 231 Conn. 276, 283 (1994). The Connecticut Supreme Court recently provided that unjust enrichment claims are "an equitable means of recovery in restitution" which is "consistent with the principles of equity, a broad and flexible remedy." *Reclaimant Corp. v. Deutsch*, 332 Conn. 590, 599-600, 211 A. 3d 976 (Conn. 2019) (citations omitted).

Here, Cigna had a legal obligation under the FFCRA and CARES Act to reimburse the Murphy Practice for the medically necessary, covered health care services provided to Cigna's members. Despite this obligation, Cigna unjustly enriched itself by failing to provide appropriate reimbursement to the Murphy Practice and by maintaining such funds for Cigna's own benefit. Under the principles of equity, Cigna should be obligated to remit these funds to

the Murphy Practice. *See Josephson v Oxford Health Ins., Inc.*, 2012 WL 3449413 (Sup. Ct., Nassau County July 31, 2012) ("[T]o prevent injustice, an out-of-network provider who has not been paid at reasonable and customary rates may maintain an action for unjust enrichment."). Furthermore, since the Murphy Practice provides testing services to Cigna members, which Cigna is legally obligated to reimburse for, the Murphy Practice should be reasonably compensated for its services.

The Court should reject Cigna's absurd contention that it derived no benefit from services rendered to Cigna's members. As stated above, Cigna had an obligation to pay for those services, and it was unjustly enriched by retaining monies that should have been paid to the Murphy Practice or to other health care providers who would otherwise have rendered the necessary treatment to Cigna's members.

F. The Murphy Practice Has Properly Plead A Claim for Tortious Interference

Finally, the Court should reject Cigna's attempt to dismiss the Murphy Practice's Eighth Cause of Action. Under Connecticut law, a plaintiff states a claim for tortious interference by alleging (1) a contract or beneficial relationship exists; (2) the defendants have knowledge of that relationship; (3) the defendants intended to interfere with that relationship; and (4) plaintiffs suffered an actual loss as a result. *Bergman v. Town of Hamden*, 10-cv-1315, 2011 WL 337347, at *3 (D. Conn. Jan. 31, 2011). Such interference is tortious when the defendant has an "improper motive or [uses] improper means," *Blake v. Levy*, 191 Conn. 257, 262 (Conn. 1983); *see Daley v. Aetna Life & Casualty Co.*, 249 Conn. 766, 806 (1999) ("The plaintiff in a tortious interference claim must demonstrate malice on the part of the defendant, not in the sense of ill will, but intentional interference without justification." (quotation marks and citation omitted)). The Amended Complaint alleges facts sufficient to satisfy these elements.

Initially, this is a claim for tortious interference, not one for defamation so Cigna's reliance on defamation pleading standard is inapplicable. The Murphy Practice properly alleged that Cigna was telling patients and testing location sponsors that Cigna was a fraudulent enterprise. Amended Complaint ¶ 96. There is no requirement under Connecticut law that the Plaintiffs must disclose the specific, personal identity of the third parties with whom they had/have existing contractual or business relationships to state a claim for tortious interference. On the contrary, a contractual relationship between a plaintiff and third parties is sufficiently identified where the third parties are collectively described as a group or class. *See Raymond Road Associates, LLC V. Taubman Centers, Inc.*, 2009 WL 939848 at *5, (Conn. Super. Ct. Mar. 5, 2009) (allegation that "the defendants interfered with plaintiffs' business relationships with intended tenants of Blue Back Square" sufficient to plead the existence of contractual or beneficial relationships); *Deutsch v. Backus Corp.*, 2012 WL 1871398, 54 Conn. L. Rptr. 30 (Conn. Super. Ct. May *2*, 2012) (claim for tortious interference with contractual relationships sufficiently stated where plaintiff doctor alleged that defendants interfered with plaintiff's contracts with his patients).

G. In The Alternative, The Court Should Grant The Murphy Practice Leave To Amend The Complaint

The Murphy Practice respectfully submits that it has met its burden, at this early stage of the lawsuit, to assert plausible causes of action with respect to each and every medical claim at issue. However, if the Court is inclined to dismiss action, or any claim or cause of action therein, then Murphy Practice respectfully requests leave to amend its Amended Complaint to cure any pleading deficiencies. *See, e.g., Cortec Indus., Inc. v. Sum Holding L.P.*, 949 F.2d 42, 48 (2d Cir. 1991) ("It is the usual practice upon granting a motion to dismiss to allow leave to replead."); *Ronzani v. Sanofi S.A.*, 899 F.2d 195, 198 (2d Cir. 1990).

VI. CONCLUSION

For the foregoing reasons, the Murphy Practice respectfully request that this Court deny Cigna's Motion to Dismiss the Amended Complaint.

Dated: Stamford, Connecticut
May 7, 2021

PLAINTIFFS 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

By: */s/ Michael J. Keane*
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CERTIFICATION

I hereby certify that on May 7, 2021, a copy of the foregoing Memorandum of Law in Opposition 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. Parties may access this filing through the Court's CM/ECF System.

:

/s/ Michael J. Keane, Jr.
Michael J. Keane, Jr.