UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

OPEN MRI AND IMAGING OF RP VESTIBULAR DIAGNOSTICS, P.A., Plaintiff, v. CIGNA LIFE AND HEALTH INSURANCE CO., Defendant.	Civil Action No. 2:20-cv-10345 (KM)(ESK) *Document electronically filed*

DEFENDANT CIGNA HEALTH AND LIFE INSURANCE COMPANY'S MEMORANDUM OF LAW IN SUPPORT OF ITS MOTION TO DISMISS PLAINTIFF'S AMENDED COMPLAINT

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Defendant Cigna Health and Life Insurance Company ("Cigna") respectfully submits this brief in support of its motion to dismiss Plaintiff Open MRI and Imaging of RP Vestibular Diagnostics, P.A.'s ("Plaintiff") Amended Complaint pursuant to Federal Rule of Civil Procedure 12(b)(6). For the reasons set forth below, Cigna respectfully requests that its motion be granted and that Plaintiff's claims be dismissed in their entirety.

PRELIMINARY STATEMENT

In this action, Plaintiff asserts this Court's jurisdiction to adjudicate a claim for benefits under ERISA pursuant to employee-based medical benefit plans for diagnostic COVIC-19 testing. Neither the plans nor their terms are identified and no theory emerges from the Amended Complaint why the plans require that Plaintiff receive payment. Plaintiff invokes federal statutes, the Families First Corona Response Act ("FFCRA"), Pub. L. 116-127, 134 Stat. 178 (2020), and the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), Pub. L. 116-136, 134 Stat. 281 (2020), which govern payment for COVID-19 testing. These statutes do not provide a private cause of action that would support this lawsuit, however. Plaintiff's invocation of ERISA in connection with these statutes does not alter that fundamental truth. The only detailed allegations appear as Explanations of Benefit forms attached to the Amended Complaint, but these documents actually undermine rather than support the causes of action set forth.

Plaintiff's ancillary claims for unjust enrichment and quantum meruit suffer from the same flaws of incomplete and conclusory pleading, and they are invalid as a matter of law in any event. The Amended Complaint fails to allege the core components of these quasi-contract claims, including that Plaintiff actually conferred a benefit upon Cigna. Even if these causes of action were adequately alleged, they would be preempted by ERISA, as Plaintiff seeks to recover the same unpaid medical benefits it claims it is entitled to by virtue of its patients' ERISA-governed

plans. For these reasons, the Amended Complaint as a whole fails to state a claim upon which relief can be granted and must be dismissed.

PROCEDURAL HISTORY

On August 12, 2020, Plaintiff filed a three-count Complaint alleging: (1) violation of Section 6001(A) of the FFCRA, and Section 3202(A) of the CARES Act; (2) unjust enrichment; and (3) quantum meruit. On December 11, 2020, Plaintiff filed an Amended Complaint, which couches its former claim for violation of Section 6001(A) of the FFCRA and Section 3202(A) of the CARES Act as a claim for reimbursement of benefits under Section 502 of ERISA. The Amended Complaint maintains claims for unjust enrichment and quantum meruit.

STATEMENT OF FACTS

Plaintiff alleges[1] it is a "medical office engaged in the practice, diagnosis, and treatment of Coronavirus, among other medical services that it provides," and is located in Rochelle Park, New Jersey. Am. Compl. ¶¶ 3, 4 (ECF No. 13). Plaintiff further alleges that Cigna is a "health insurer and employee benefit plan" pursuant to ERISA, *id.* ¶ 6, and "issues group health insurance coverage and individual health insurance coverage" as defined in 42 U.S.C. 300gg-91, 29 U.S.C. 1191b, and Section 9832 of the Internal Revenue Code of 1986 and within the terms of Section 6001(a) of the FFCRA and Section 3202(a) of the CARES Act, *id.* ¶¶ 7-8.

The Amended Complaint alleges that between February and July 2020, Cigna improperly declined to pay a very large number of individual claims totaling collectively $398,665 for "diagnostic services and treatment related to Coronavirus." *Id.* ¶¶ 9-11. Plaintiff further alleges that in denying these claims, Cigna provided the following explanations, as set forth in the

[1]Reference in this brief to facts alleged in the Amended Complaint is not a concession of their truth.

Explanations of Benefits attached as Exhibits B and C to the Amended Complaint: (1) the services were "not rendered as billed"; and/or (2) the submitted procedures were disallowed because they were incidental to a code billed on the same date of service. *See id.* ¶ 13.

In support of its ERISA claim, Plaintiff alleges that "[i]n arbitrarily refusing to make payment for diagnostic and treatment services rendered in connection with Coronavirus, Defendant violated the provisions of Section 6001(a) of the FFCRA as amended by Section 3201 of the CARES Act as well as Section 3202(a) of the CARES Act[,]" and, therefore, is "liable pursuant to ERISA (29 U.S.C. 1132(a)) for said payments." *Id.* ¶¶ 20, 21. No allegation appears in the Complaint as to why the dispositions of the claims set forth in the attached Explanations of Benefits—that the services were not actually provided as billed or billed incorrectly—are wrong.

In connection with its unjust enrichment claim, Plaintiff claims that by retaining insurance premiums paid by the patient treated and diagnosed by Plaintiff, but not providing reimbursement for such treatment, Defendant was unjustly enriched. *Id.* ¶ 24. Finally, in support of its quantum meruit claim, Plaintiff contends that it is entitled to compensation for the diagnostic and treatment services it provided but was not paid for. *Id.* ¶ 26.

LEGAL ARGUMENT

I. THE STANDARD FOR MOTION TO DISMISS.

To avoid dismissal under Rule 12(b)(6), the allegations of the complaint must "raise a right to relief above the speculative level," *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007), and furnish "more than an unadorned, the-defendant-unlawfully-harmed-me accusation." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). A pleading, in other words, must contain "enough facts to state a claim to relief that is plausible on its face." *Twombly*, 550 U.S. at 570. "'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.'" *Lopez v. Beard*, 333 F. App'x 685, 687 (3d Cir. 2009) (quoting *Iqbal*, 556 U.S. at 678).

Courts deciding motions to dismiss thus should not accept bald assertions, untenable inferences, or unsupported legal conclusions disguised as factual allegations. *See Twombly*, 550 U.S. at 555. Moreover, "a court need not accept allegations as true that are contradicted by the documents upon which a party's claims are based." *Pai v. DRX Urgent Care, LLC*, No. 13-3558, 2014 WL 837158, at *6 (D.N.J. Mar. 4, 2014), *aff'd sub nom. Fabbro v. DRX Urgent Care, LLC*, 616 F. App'x 485 (3d Cir. 2015); *see also Pharmaceuticals, Inc. v. Chiron Corp.*, 27 F. App'x 94, 99-100 (3d Cir. 2002).

Finally, "Rule 12(b)(6) . . . 'authorizes a court to dismiss a claim on the basis of a dispositive issue of law.'" *DeGrazia v. FBI*, 316 F. App'x 172, 173 (3d Cir. 2009) (quoting *Neitzke v. Williams*, 490 U.S. 319, 326-27 (1989)); *Bishop v. GNC Franchising LLC*, 248 F. App'x. 298, 299 (3d Cir. 2007) (same); *Twp. of W. Orange v. Whitman*, 8 F. Supp. 2d 408, 413 (D.N.J. 1998) (same). Here, the Amended Complaint is insufficiently pled under *Twombly*'s basic pleading standard. However, even if alleged with more detail, Plaintiff's claims fail as a matter of law for the reasons detailed below. Accordingly, these claims against Cigna should be dismissed.

II. PLAINTIFF'S ERISA CLAIM FAILS AS A MATTER OF LAW

Quite apart from its legal problems, the Amended Complaint falls well short of stating a legally cognizable claim for reimbursement of benefits under ERISA. The ERISA claim lacks basic information that a long line of authority in this area requires, such as the identity of the patients whose claims are at issue, whether Plaintiff has been assigned its patients' rights under the terms of their benefit plans, the identity of the plans at issue, and, most critically, identifying the particular provisions of the plans that were allegedly violated. Plaintiff's allusions to the FFCRA and CARES Act do not remedy these omissions. In any event, neither of these statutes

contain a private right of action, and, as set forth in detail below, ERISA may not be used as an "end-run" around the statutory limitations of the FFCRA and CARES Act. For these reasons, Plaintiff's ERISA claim fails as a matter of law and cannot be cured by further amendment.

A. Plaintiff's ERISA Claim Is Insufficiently Pled Under *Twombly*.

The Amended Complaint lacks the core information necessary to state a claim for benefits under ERISA. First, it is unclear on whose behalf the claims are made, whether Plaintiff has standing to sue by virtue of assignments of benefits, or even how many claims are at issue. Moreover, Plaintiff does not identify what plans are at issue nor the terms of the plans Plaintiff contends Cigna violated. In total, the Amended Complaint fails to provide Cigna with proper notice of an alleged ERISA violation, *see Twombly*, 550 U.S. at 555 (the complaint must "give the defendant fair notice of what the . . . claim is and the grounds upon which it rests").

The latter deficiencies – regarding the plans and plan terms – are particularly problematic. It is well-settled in this District that a plaintiff cannot state an ERISA benefits claim without identifying the plan provision that was breached. *See, e.g., Univ. Spine Ctr. v. Cigna Health & Life Ins. Co.*, No. 17-13596 (KM), 2018 WL 4144684, at *3 (D.N.J. Aug. 29, 2018) (McNulty, J.) ("join[ing] recent holdings of other judges of this district" in "emphasiz[ing] that an ERISA claim requires plaintiff to allege and prove an entitlement to 'benefits due to him *under the terms of his plan*'") (emphasis in original). ERISA's plain language unequivocally requires a plaintiff to demonstrate that he is entitled to "benefits due to him ***under the terms of his plan***." 29 U.S.C. § 1132(a)(1)(B)(emphasis added); *see also US Airways, Inc. v. McCutchen*, 569 U.S. 88, 100-01 (2013) ("ERISA's principal function" is "to protect contractually defined benefits"—that is, benefits set forth ***in the plan***—and ERISA's "statutory scheme, we have often noted, 'is built around reliance ***on the face of written plan documents***.'" (emphases added)). "The plan, in short, is at the center of ERISA." *McCutchen*, 569 U.S. at 101. And, because plan terms are "at the

center of ERISA," 569 U.S. at 101, to state a benefits claim, a plaintiff must first "demonstrate that the benefits ***are actually 'due'***" under the plan—"that is, [the ERISA plaintiff] must have a right to benefits that are legally enforceable against the plan." *Hooven v. Exxon Mobil Corp.*, 465 F.3d 566, 574 (3d Cir. 2006); *Hein v. F.D.I.C.*, 88 F.3d 210, 215 (3d Cir. 1996) ("Only the words of the Plan itself can create an entitlement to benefits.").

Courts in this District have repeatedly recognized that, without identifying plan language that was actually breached, a claim for benefits under an ERISA plan cannot withstand a Rule 12(b)(6) motion. *See, e.g.*, *Atl. Plastic & Hand Surgery, PA v. Anthem Blue Cross Life & Health Ins. Co.*, No. 17-4599-BRM-LHG, 2018 WL 5630030, at *7-8 (D.N.J. Oct. 31, 2018) (dismissing ERISA claim where plaintiff alleged that Anthem "improperly refused 'to pay the usual and customary charge'" of the provider but "fail[ed] to identify any specific Plan provision entitling payment of benefit based on the 'usual and customary charge'"; citing "several courts in this circuit [that] have dismissed denial of benefits claims for failure to allege the specific provision violated in an ERISA-governed plan."); *Robinson v. Anthem Blue Cross Life & Health Ins. Co.*, No. 17-4600 (FLW), 2018 WL 6258881, at *4 (D.N.J. Nov. 30, 2018) (no "viable claim under § 502(a)(1)(B)" where the complaint "points to relevant provisions in the Plan but fails to allege what amount Plaintiff should be entitled to under those provisions."); *see also Somerset Ortho. Assocs., P.A. v. Horizon Healthcare Servs., Inc.*, No. 19-8783, 2020 WL 1983693, at *9 (D.N.J. Apr. 27, 2020) (dismissing where plaintiffs failed to "identify a plan term that indicates that Plaintiffs were in fact underpaid"); *K.S. v. Thales USA, Inc.*, 2019 WL 1895064, at *1 (D.N.J. Apr. 29, 2019) (collecting D.N.J. cases that "granted motions to dismiss in instances where a plaintiff has failed to tie his or her allegations of ERISA violations to specific provisions of an applicable plan").

There is, of course, no reference whatsoever in the Amended Complaint to an ERISA plan or plans that would support Plaintiff's cause of action. There is no articulation of a plan term that, if properly applied, would lead to Plaintiff gaining the relief it seeks. And, if any of this information did appear, there is no allegation as to how this medical provider would have standing to assert the rights of its patients under their respective employee benefit plans. The Amended Complaint relies purely on bald assumptions that Plaintiff is entitled to relief under ERISA and leaves the matter there. As the Court is well aware, conclusory assertions of liability are not entitled to a presumption of truth on a Rule 12 motion. *See Twombly*, 550 U.S. at 555 (court need not accept bald assertions, untenable inferences, or unsupported legal conclusions). The Amended Complaint here amounts to no more than the "defendants harmed me" statement specifically disapproved by the Supreme Court in *Iqbal*. 556 U.S. at 678.

Even the information Plaintiff does provide in the Amended Complaint undermines the coherence of its pleading. To detail what claims are actually at stake here, the Complaint relies on Exhibit A to the Amended Complaint, purporting to be a collection of "invoices totaling $398,665 for diagnostic services and treatment related to Coronavirus." However, it is impossible to glean from this exhibit the identities of the patients or claims at issue, or even how many claims in total their might be.

Indeed, it appears that many of the services listed in Exhibit A relate to treatment that preceded the COVID-19 Pandemic. *See, e.g.*, Am. Compl., Ex. A at 12 of 43 (referencing services provided in March, April and October 2019), 15-16 of 43 (referencing services provided in December 2018 and February 2019), 18 of 43 (referencing services provided in 2015, 2016, 2017 and 2019), 42 of 43 (same). Moreover, it is not clear whether the amounts charged for these

services, which are clearly unrelated to "diagnostic services and treatment related to Coronavirus", comprise portions of the $398,665 demanded in the Amended Complaint

Plaintiff invokes the FFCRA and CARES Act apparently believing in their talismanic power to make Cigna "liable pursuant to ERISA" for unreimbursed medical benefits. *See* Am. Compl. ¶¶ 20-21. This does not fix the failure to plead a plausible claim, however.

Plaintiff does not allege that particular provisions of the FFCRA and CARES Act are incorporated or recited as explicit terms in the plans at issue. In fact, the Amended Complaint is completely silent as to how an alleged violation of the FFCRA or CARES Act, if committed, is also a violation of the plans at issue. As a result, there is no plausible basis to conclude that Cigna wrongly denied benefits in violation of ERISA § 502(a)(1)(B). Any tacit suggestion that the FFCRA or CARES Act are incorporated by implication or as a matter of law--and no such allegation actually appears in the Amended Complaint--is simply wrong for the reasons set forth in Point II.B.1, *infra.*

Here, Plaintiff has failed to identify a single plan provision that Cigna allegedly violated, explain why proper application of that provision would require a different benefit determination than what Cigna made, nor even claim that it has standing to assert rights under a relevant ERISA plan. The only factual detail in the Amended Complaint appears in the invoices and Explanations of Benefits appended to it, which actually negate any plausibility the body of the pleading might have had. Even assuming these Explanations of Benefits concern charges for COVID-19 testing, and many do not, the Amended Complaint makes no attempt to address the grounds for the denials stated in those very documents. If, as these documents state, the services were never actually performed or were improperly billed, then presumably the claims for reimbursement were properly denied. Certainly, no plausible allegations of fact appears why those grounds stated were wrong.

In sum, Count I of the Amended Complaint is not adequately pled and should be dismissed. No plausible articulation of a claim for benefits under an ERISA plan is alleged in the Amended Complaint. On the contrary, the Amended Complaint epitomizes the conclusory style of pleading the Supreme Court rejected in the *Twombly/Iqbal* line of cases.

B. No Claim is Stated under the FFCRA or CARES Act.

As set forth above, Plaintiff has not alleged with sufficient detail facts to support a cause of action under ERISA. Raising the FFCRA and CARES Act adds nothing to the legal weight of the Amended Complaint. Neither statute provides a private right of action. A breach of the FFCRA or CARES Act is not one of the very specific causes of action enumerated in ERISA. Plaintiff does not and cannot argue that the various, unnamed and unidentified benefit plans at issue in this case impliedly incorporate the terms of the FFCRA or CARES Act. We remain in the dark what those plans might say and the settled law discussed below bars such an end run around the omission of a private right of action in the statutes themselves. Finally, the invoices and Explanations of Benefits provided with the Amended Complaint show that the claims were denied either because Plaintiff never actually provided the services billed or Plaintiff improperly billed for them. Neither the FFCRA the CARES Act nor any other law requires payments to a medical provider for services it never performed or improperly submitted.

Section 6001(a) of the FFCRA provides, in relevant part, that a "group health plan and a health insurance issuer offering group or individual health insurance coverage … shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements," for services related to COVID-19 diagnostic testing or "items and services furnished to an individual during health care provider office visits (which term in this paragraph includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for"

administration of COVID-19 diagnostic testing, "but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product." FFCRA, Pub. L. 116-127.

Section 3202(a) of the CARES Act provides that a "group health plan or a health insurance issuer providing coverage of items and services" described in section 6001(a) of the FFCRA shall reimburse the provider of the diagnostic testing as follows:

> (1) If the health plan or issuer has a negotiated rate with such provider in effect before the public health emergency declared under section 319 of the Public Health Service Act (42 U.S.C. 247d), such negotiated rate shall apply throughout the period of such declaration.
>
> (2) If the health plan or issuer does not have a negotiated rate with such provider, 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, or such plan or issuer may negotiate a rate with such provider for less than such cash price.

CARES Act, Pub. L. 116-136.[2]

1. There is No Private Right of Action under the FFCRA or the CARES Act.

No explicit private right of action appears in the text of either the FFCRA or the CARES Act. No authority has directly addressed whether an implied right of action exists under that portion of these statutes addressing coverage or reimbursement for COVID-19 testing. Settled law on when and whether a private right of action may be implied under a federal statute, and case law addressing other portions of these sprawling statutes, make it crystal clear that no such private right of action may be implied to support Plaintiff's claims here.

[2]Plaintiff has not alleged it negotiated a rate with Cigna regarding the COVID-19-related services it provided, or posted prices for such services on a publicly available website. This furnishes yet another ground for dismissal of this Count, for failure to articulate the elements of a plausible cause of action under the statute, if one existed, which of course it does not.

As the Court is well aware, the federal courts are not quick to perceive an implied private right to bring a civil lawsuit to enforce the terms of a federal statute. The correct analysis has two steps: "(1) Did Congress intend to create a personal right?; and (2) Did Congress intend to create a private remedy? Only if the answer to both of these questions is 'yes' may a court hold that an implied private right of action exists under a federal statute." *Wisniewski v. Rodale, Inc.*, 510 F.3d 294, 301 (3d Cir. 2007) (citing *Alexander v. Sandoval*, 532 U.S. 275 (2001)); *Three Rivers Ctr. v. Hous. Auth. of the City of Pittsburgh*, 382 F.3d 412, 421 (3d Cir. 2004) ("Put succinctly, for an implied right of action to exist, a statute must manifest Congress's intent to create (1) a personal right, and (2) a private remedy.").

a. The CARES Act

The CARES Act addresses a wide range of areas impacted by the COVID-19 pandemic beyond payment for diagnostic testing. Since its enactment in March 2020, courts applying the *Sandoval* test have concluded that the statute does not grant a private right of action in these other contexts. *See, e.g.*, *Profiles, Inc. v. Bank of Am. Corp.*, 453 F. Supp. 3d 742 (D. Md. 2020) (concluding that "language of the CARES Act" did not evidence "requisite congressional intent to create a private right of action" to apply for paycheck protection program ("PPP") loan from lender of one's choosing, nor a private remedy against participating lenders), *appeal dismissed*, No. 20-1438, 2020 WL 6042036 (4th Cir. May 28, 2020); *Johnson v. JPMorgan Chase Bank, N.A.*, No. 20-CV-4100 (JSR), 2020 WL 5608683, at *8 (S.D.N.Y. Sept. 21, 2020) (finding that the CARES Act does not contain an express cause of action to enforce PPP and that there is "no language in the CARES Act" suggesting that Congress intended for plaintiffs to have a private remedy); *Prof'l Staff Cong./CUNY v. Rodriguez*, No. 20 CIV. 5060, 2020 WL 4668164 (S.D.N.Y. Aug. 12, 2020) (finding Congress did not intend to create private remedy for enforcement of section of CARES

Act providing that institution which received funding under Act was required to continue to pay its employees and contractors during period of any disruptions or closures related to coronavirus).

This very month, the Southern District of Ohio addressed the issue head on. "This Court concludes that the CARES Act creates no implied private right of action. The text of the CARES Act indicates no intent on the part of Congress to create such a private right of action; it included no clear and unambiguous rights-creating language. Absent congressional intent to create a private remedy, this Court may not imply one." *Autumn Court Operating Co. LLC v. Healthcare Ventures of Ohio*, No. 2:20-CV-4901, 2021 WL 325887, at *6 (S.D. Ohio Feb. 1, 2021); *see also Matava v. CTPPS, LLC*, No. 3:20-CV-01709 (KAD), 2020 WL 6784263, at *1 (D. Conn. Nov. 18, 2020) (noting that, for purposes of establishing federal question jurisdiction, CARES Act does not expressly provide a private right of action and concluding that the Complaint does not set forth "sufficient (or any) analysis as to why … the Court should find an implied right of action."); *Shehan v. U.S. Dep't of Justice*, No. 1:20-CV-00500, 2020 WL 7711635, at *11 (S.D. Ohio Dec. 29, 2020) (concluding that there is no express or implied right of action created by CARES Act sufficient to establish federal question jurisdiction).

The courts require that any Congressional intent to create a private right and a private remedy to enforce must be expressed through a "clear manifestation," and only exists "where the statute's text and structure show an intention to create a federal right through rights-creating language, an intention to create a private remedy, and consistency of a private remedy with the statutory scheme." *Johnson*, 2020 WL 5608683, at *8. Section 3202(a) of the CARES Act merely provides that a health insurer must reimburse a provider at (1) a previously-agreed upon rate; or (2) if there is no negotiated rate, at a rate equivalent to the cash price for such service listed on a

public website or at a lower rate, negotiated between the health insurer and the provider. It neither states nor implies anything about private rights or remedies.

A key factor in divining Congressional intent regarding private remedies for statutory violations is whether Congress delegated enforcement to a public regulator rather than to private litigation. Where Congress has specifically provided for agency enforcement, there is "a strong presumption against implied private rights of action that must be overcome." *Wisniewski v. Rodale, Inc.*, 510 F.3d 294, 305 (3d Cir. 2007); *In re Pennsylvania*, No. 13-CV-1871, 2013 WL 4193960, at *13 (E.D. Pa. Aug. 15, 2013) ("[W]hen a statute explicitly delegates authority to a federal agency to enforce its law, there is a 'strong presumption against implied private rights of action.'" (internal citation omitted)); *Malecki v. Christopher*, No. 4:CV-07-1829, 2008 WL 11496499, at *9 (M.D. Pa. Mar. 20, 2008) ("The sole reference to enforcement of [statutory provision] by the United States Attorney General, along with the absence of other enforcement provisions, creates a presumption that Attorney General's enforcement of this statute is exclusive."); *In re Commonwealth's Motion to Appoint New Counsel Against or Directed to Def. Ass'n of Philadelphia*, No. MISC.A. 13-62, 2013 WL 4501056, at *7 (E.D. Pa. Aug. 22, 2013) ("Where, as here, a statute provides for 'agency enforcement' (that is, delegation to a federal agency to enforce the law), it 'creates a strong presumption against implied private rights of action.'"); *cf. Bakos v. Am. Airlines, Inc.*, 748 F. App'x 468, 474 (3d Cir. 2018) (finding private right of action existed where amendment did not task agency with enforcement).

In the CARES Act, Congress did not leave enforcement of its terms to private litigants. On the contrary, Section 3202(b)(2) expressly bestows upon the Secretary of Health and Human Services (the "Secretary") the exclusive right to:

> impose a civil monetary penalty on any provider of a diagnostic test for COVID–19 that is not in compliance with paragraph (1) and has not completed a corrective

> action plan to comply with the requirements of such paragraph, in an amount not to exceed $300 per day that the violation is ongoing.

The foregoing defeats any remaining notion that there is a private right of action under the CARES Act to recover the cost of COVID-19 testing. Congress decided that the Secretary, not private litigants, was the proper enforcer of the CARES Act. Courts dealing with other portions of the CARES Act have uniformly rejected the notion of a private right of action. Recognizing a private right of action on the facts of this case would irretrievably be at odds with the overall statutory scheme. *See Johnson*, 2020 WL 5608683, at *8. There is no basis for a suggestion that Congress intended to create a private right of action for medical providers (like Plaintiff here) to seek reimbursement from health insurers, nor a private remedy in Plaintiff's favor under the CARES Act. *See Profiles, Inc.*, 453 F. Supp. 3d at 751-52.

b. The FFCRA

As set forth *supra*, Section 6001(a) of the FFCRA requires health insurers to provide coverage for COVID-19 diagnostic testing and related treatment. Like the CARES Act, the FFCRA does not expressly create a private right of action for medical providers to seek reimbursement for allegedly unpaid medical benefits arising from COVID-19 testing. No court has examined whether the FFCRA gives rise to an implied private right of action for COVID-19 testing either. The statute does, however, expressly grant a private right of action against improperly denied leave under the Family Labor Standards Act. FFCRA § 5105; 29 C.F.R. § 826.150; *Kofler v. Sayde Steeves Cleaning Serv., Inc.*, No. 8:20-CV-1460-T-33AEP, 2020 WL 5016902, at *2 (M.D. Fla. Aug. 25, 2020). This weighs strongly against finding an implied private right of action with respect to diagnostic testing for COVID-19. Where Congress explicitly granted a private right of action elsewhere in the statute, the only fair inference to be drawn from the absence of an express right of action with respect to COVID-19 testing is that Congress was

aware of the implications of granting such a right and intentionally withheld it. *See Nat'l R. R. Passenger Corp. v. Nat'l Ass'n of R. R. Passengers*, 414 U.S. 453, 461 (1974) (in refusing to recognize a private right of action under the Rail Passenger Service Act of 1970, the Supreme Court invoked the restrictive maxim of statutory construction, *expressio unius est exclusio alterius*, and interpreted a section of the Act providing for administrative remedy as an indication Congress intended to preclude all other remedies); *see also Transamerica Mortgage Advisors, Inc. v. Lewis*, 444 U.S. 11 (1979) (invoking *expressio unius* doctrine to deny implied private action under section 206 of the Investment Advisors Act of 1940, and noting that "when Congress wished to provide a private damages remedy, it knew how to do so and did so expressly." (internal citations omitted)).

Further parallel to the CARES Act, the Congress also delegated enforcement of the FFCRA to the Secretary. The Secretary is empowered to enforce the provisions of subsection 6001(a), "as if included in the provisions of part A of title XXVII of the Public Health Service Act, part 7 of the Employee Retirement Income Security Act of 1974 ("ERISA Part 7"), and subchapter B of chapter 100 of the Internal Revenue Code of 1986, as applicable." FFCRA, § 6001(b). CARES Act Section 3202(a) amends Section 6001(a) of the FFCRA, to provide that the Secretary possesses authority under Section 3202(b) to enforce any failure by health insurer to provide coverage for COVID-19 diagnostic testing and related treatment as set forth in Section 6001(a). *See* FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42, Dep't of Labor (April 11, 2020), *available at* https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf.

The fact that FFRCA borrows from ERISA Part 7 and provides that the Secretary shall enforce its terms "as if included in" Part 7 does not incorporate the FFCRA into ERISA, nor does

it graft onto the FFCRA ERISA's carefully delineated cause of action for plan benefits under ERISA Section 502(a)(1)(b).[3] The FFCRA is not the only statute to borrow from ERISA Part 7's enforcement regime. The Mental Health Parity Act and the Affordable Care Act are examples. The courts have been clear that these other statutes do not magically gain a private cause of action via reference to ERISA Part 7 – even where those other statutes are explicitly incorporated into ERISA Part 7 – which, of course, the FFCRA is not.[4] *See N.R. by & through S.R. v. Raytheon Co.*, No. CV 20-10153-RGS, 2020 WL 3065415, at *7 (D. Mass. June 9, 2020) (holding that the Mental Health Parity Act ("Parity Act") is not impliedly incorporated into terms of ERISA plan, and therefore, plaintiff could not bring claim under ERISA Section 502(a)(1)(B) based on alleged violation of same, despite requirement for coverage under Parity Act set forth in 29 U.S.C. 1185a).

The courts have explicitly based these decisions on the danger of frustrating Congress's intention omission of a private right of action by permitting an end-run around it through ERISA. *Smith v. United Healthcare Ins. Co.*, No. 18-CV-06336-HSG, 2019 WL 3238918, at *7 (N.D. Cal. July 18, 2019) (rejecting plaintiff's argument that she has a private right of action under Section 2706 of Affordable Care Act ("ACA") through ERISA Section 29 U.S.C. 1132(a)(1)(B) because ACA is "incorporated" into ERISA under 29 U.S.C. 1185d as an "attempted end-run" around ACA's statutory limitation); *Apollo MD Bus. Servs., L.L.C. v. Amerigroup Corp. (Delaware)*, No. 1:16-CV-4814-RWS, 2017 WL 10185527, at *11 (N.D. Ga. Nov. 27, 2017) (rejecting claim under ACA because it does not provide private right of action and plaintiff does not have standing to bring claim under Section 502(a)(3) of ERISA).

[3]Section 502 is within Part 5 of the ERISA statute.

[4]The FFCRA does not technically amend ERISA. *See* COVID-19 Compliance for Health and Welfare Plans, Practical Law Practice Note w-025-1497. Reference to ERISA Part 7 in FFCRA does not, therefore, mean that the FFCRA is part of ERISA.

It may be that Plaintiff is attempting the same type of end-run rejected in the *Smith* decision quoted *supra.* 2019 WL 3238918, at *7. The Amended Complaint is silent as to that, simply citing the statute and leaving the analysis to Cigna and the Court. There is no justification, however, for Plaintiff to attempt such an "end-run" around the statutory limitations of the FFCRA or the CARES Act. Until such time that Congress explicitly determines parties such as Plaintiff should have a private right of action for violations of either the FFCRA or CARES Act through ERISA (or otherwise), this Court should decline to infer such a right. For the reasons set forth above, Plaintiff's ERISA claim, based solely on alleged violations of the FFCRA and CARES Act, fails as a matter of law and must be dismissed.

III. PLAINTIFF'S QUASI-CONTRACT CLAIMS FAIL AS A MATTER OF LAW.

A. Plaintiff's Quasi-Contract Claims Do Not State A Claim Upon Which Relief Can Be Granted.

To state a viable claim for unjust enrichment or quantum meruit, a plaintiff must have conferred a benefit on the defendant. *See Montich v. Miele USA, Inc.*, 849 F. Supp. 2d 439, 459 (D.N.J. 2012) ("New Jersey law requires that a plaintiff have conferred a direct benefit on the defendant."); *Knox v. Samsung Elecs. Am.*, No. 08-4308, 2009 WL 1810728, at *4 (D.N.J. June 25, 2009) (dismissing claim for unjust enrichment because "New Jersey law require[s] that a plaintiff confer a benefit on the defendant"); *see also Burton Imaging Grp. v. Toys "R'" Us, Inc.*, 502 F. Supp. 2d 434, 440 (E.D. Pa. 2007) ("A plaintiff must prove the same elements for quantum meruit and unjust enrichment. (citing *Allegheny Gen. Hosp. v. Philip Morris, Inc.*, 228 F.3d 429, 447 (3d Cir. 2000)).

Plaintiff alleges it conferred benefits on its patients in the form of medical treatment. *See* Amended Compl., ¶ 9. But there is no allegation that Plaintiff conferred a benefit on Cigna – or that Cigna benefited in any way from the plan members' receipt of medical treatment. Federal

courts have repeatedly rejected the notion that a benefit conferred on an insured constitutes a benefit to the payor. *See Plastic Surgery Ctr., P.A. v. Cigna Health & Life Ins. Co.*, No. CV 17-2055 (FLW), 2019 WL 1916205, at *8 (D.N.J. Apr. 30, 2019) ("Here, TPSC cannot adequately plead that Cigna or Multiplan received a benefit, or that it would be unjust for them to retain the alleged benefit without payment, ***as a result of the health care services which were rendered to K.D.*** Indeed, district courts have consistently dismissed unjust enrichment claims under substantially similar circumstances, reasoning that, if anything, the benefit is derived solely by the insured party." (emphasis in original)); *see also New Jersey Carpenters Health Fund v. Philip Morris, Inc.*, 17 F. Supp. 2d 324, 344 (D.N.J. 1998) ("The argument that the [plaintiffs] conferred a benefit on defendants because the defendants may ultimately be found liable for the medical costs that the [plaintiffs] have already paid is simply too remote and speculative to constitute a recoverable benefit."); *Broad St. Surgical Ctr., LLC v. UnitedHealth Group, Inc.*, No. 11-2775, 2012 WL 762498, at *8 (D.N.J. March 6, 2012) ("In this case, the Plaintiff provided services to [medical patients] and any benefit conferred was conferred on [the medical patients] not [the medical insurer]. [The Plaintiff], as the insurance company, 'derives no benefit from those services; indeed, what the insurer gets is a ripened obligation to pay money to the insured—which hardly can be called a benefit.'") (quoting *Travelers Indem. Co. v. Losco Group, Inc.*, 150 F. Supp. 2d 556, 562 (S.D.N.Y. 2001)).

Those treatments at most may have triggered obligations under each patient's plan, but as the foregoing authorities have recognized, this is patently not a benefit accruing to Cigna nor to the plans it administers and the case law has recognized as much. Thus, the claim that Cigna was unjustly enriched by virtue of its members' payment of insurance premiums suffers from an obvious disconnect: (1) Plaintiff did not confer the benefit of insurance premiums upon Cigna;

and (2) Plaintiff's treatment of Cigna's members did not trigger the members' payment of insurance premiums to Cigna.[5] Thus, Plaintiff's treatment of Cigna's members neither directly ***nor*** indirectly benefit Cigna. Because the Amended Complaint is devoid of any allegations plausibly suggesting that Cigna received some benefit from Plaintiff, Plaintiff's claims for unjust enrichment and quantum meruit fail as a matter of law.

B. Plaintiff's Quasi-Contract Claims Are Preempted By ERISA.

As detailed above, Plaintiff's state law claims fail on the merits. However, the Amended Complaint as a whole appears to seek reimbursement for allegedly unpaid medical benefits which, if due, could only be due under each patient's employee benefit plan. *See, e.g.*, claims for relief for Counts II and IV[6] of the Amended Complaint, seeking payment of $398,665 in allegedly unpaid benefits. The plans and any claims for benefits under same are regulated by ERISA and are thus preempted "no matter how couched." *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 273 (3d Cir. 2001).

1. ERISA Preempts State Law Causes of Action.

ERISA contains two statutory provisions that preempt state law causes of action. The first is Section 502(a), 29 U.S.C. § 1132(a), which sets forth a comprehensive civil enforcement scheme and forecloses any state law claim that falls within its zone of influence. In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), *overruled in part on other grounds, Ky. Ass'n of Health Plans v.*

[5]For the Court's information, Cigna is almost certainly a third-party administrator for the vast majority of the plans whose members allegedly were treated by plaintiff. For these, no premium was paid to Cigna. The point has no bearing on the analysis above, however.

[6]Count IV of the Amended Complaint, setting forth a cause of action for quantum meruit, is the third and final count of the pleading.

Miller, 538 U.S. 329 (2003), the Supreme Court described the broad preemptive effect of Section 502(a):

> [T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Id. at 54. As such, this first preemption provision is known as "complete preemption."

ERISA's second preemption provision, which effectuates what is known as "express preemption" or "conflict preemption," is set out in Section 514(a), 29 U.S.C. § 1144(a). Section 514 preempts "any and all state laws" that "relate to any employee benefit plan." The Supreme Court has recognized that express or conflict preemption under Section 514(a) is "deliberately expansive." *Pilot Life*, 481 U.S. at 46. Indeed, a state law "relates to" an ERISA benefit plan when "it has a connection with or reference to such a plan," *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 739 (1985), *overruled in part on other grounds, Ky. Ass'n of Health Plans*, 538 U.S. 329, or when "the existence of [an ERISA] plan is a critical factor in establishing liability," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139-40 (1990).

Taken together, these two sections give ERISA a preemptive effect with few parallels in this country's laws. "[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). ERISA's preemption regime "establishes as an area of federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (citation omitted) (alteration in original).

2. Plaintiffs' State Law Claims Challenge Benefit Determinations Made as to Claims Under ERISA Plans, and Thus are Preempted.

Here, Plaintiff alleges state-law causes of action for unjust enrichment and quantum meruit, both of which are purportedly based on the failure to pay for COVID-19 diagnostic testing and treatment, as allegedly required under the FFCRA, CARES Act and in violation of ERISA. As explained *supra*, these state law claims are substantively invalid. However, even if these causes of action were viable, they seek entitlement to benefits under ERISA-governed plans, and are therefore preempted. *See Sleep Tight Diagnostic Ctr., LLC v. Aetna, Inc.*, 399 F. Supp. 3d 241, 250-51 (D.N.J. 2019) (dismissing out-of-network provider's state-law claims as preempted; noting that "disputes of this nature fall 'squarely within ERISA's ambit'" and that "courts within this district have consistently dismissed [state-law] claims … when they arise from an ERISA-governed plan on the basis of preemption") (collecting cases); *Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, No. 17-13467 (FLW) (LHG), 2018 WL 10229920, at *6-7 (D.N.J. Sept. 26, 2018) (finding various state-law claims, including quasi-contract claims, preempted because "by disputing its right to reimbursement for a medical procedure performed on a patient insured by an ERISA plan, Plaintiff's common law causes of action are quintessential ERISA claims."); *See Scheibler v. Highmark Blue Shield*, 243 Fed. App'x 691 (3d Cir. Jun. 5, 2007) (affirming district court's dismissal of state law claims, including unjust enrichment, as preempted by ERISA); *Stanley v. IBEW*, 207 F. App'x 185, 189-90 (3d Cir. 2006) (same).

As demonstrated *supra*, Plaintiff makes no bones that its claims are claims for plan benefits. The proposition that Plaintiff conferred a benefit directly on Cigna by treating a Cigna plan beneficiary only makes sense if there is a plan-based obligation to pay for that treatment. As noted above, of course, even that theory does not hold water—a ripened obligation to pay for an insured's treatment is not a benefit to the payor. The quasi-contract cause of action is a loser on

its merits and, if it had any legs, is preempted under main stream ERISA precedent. Plaintiff's state law quasi-contract claims cannot escape their "connection with or reference to" ERISA plans necessitating their dismissal on preemption grounds. *See Metropolitan Life Ins. Co.*, 471 U.S. at 739.

CONCLUSION

For the foregoing reasons, Cigna respectfully requests that Plaintiff's Amended Complaint be dismissed, with prejudice, in its entirety.

Respectfully submitted,

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Newark, New Jersey

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