

Covid Testing
Fee Disputes

By Patrick W. Begos

Can coronavirus legislation give health care providers a private right of action to enforce payment obligations placed on health plans and health insurers?

Emergency Laws and Private Rights of Action

The impact of the COVID pandemic on all aspects of life and society is virtually impossible to overstate. This article focuses on a very small aspect of the pandemic, but one that is highly significant to healthcare plans and employee benefit litigators.

Early in the pandemic, Congress passed two laws – the Families First Coronavirus Relief Act (“FFCRA”), and the Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”). Among the many provisions of these two laws (“Coronavirus legislation”) are requirements that health insurers and health plans cover COVID testing services, and that they pay testing providers either a negotiated rate or a posted “cash price.” It should come as no surprise that some providers sought to use the pandemic, and these laws, for their own enrichment – pandemic profiteering, in other words. This has led to a number of cases, and just-now developing case law, regarding exactly what rights, and what obligations, were established by the FFCRA and the CARES Act.

A central question, to which two courts have so far provided contradictory answers, is whether the Coronavirus legislation gives health care providers a private right of action to enforce payment obligations placed on health plans and health insurers. As discussed below, the author’s view, supported by one federal judge, is that the Coronavirus legislation does not grant providers a private right of action, and providers’ claims for reimbursement must proceed under the law governing the health plan at issue (typically ERISA).

Pandemic Profiteering?

Early in the pandemic, the Departments of Health and Human Services, Treasury, and Labor issued guidance recognizing

that some providers of COVID testing were putting profit above public health:

Although it is the Departments’ understanding that most providers have been pricing COVID-19 tests at reasonable levels, generally consistent with reimbursement rates set by the Medicare program, the Departments are aware that some providers have not done so and are using the public health emergency as an opportunity to impose extraordinarily high charges.

<https://www.cms.gov/files/document/faqs-part-44.pdf>

In February 2021, the U.S. Treasury noted the detection of numerous instances of potential COVID fraud by providers, identifying red flag indicators such as “ordering or submitting claims for expensive tests that do not test for COVID, oftentimes in conjunction with COVID testing, such as medically unnecessary and expensive respiratory testing” and overbilling for testing. *Advisory on COVID-19 Health Insurance- and Health Care-Related Fraud*, FinCEN Advisory (FIN-2021-A001) (Feb. 2, 2021).

In May 2021, the Department of Justice announced criminal charges against multiple defendants for “various health care fraud schemes that exploited the COVID-19 pandemic” including submitting claims for “medically unnecessary, and far more expensive ... respiratory pathogen panel tests.” Press Release, Department of Justice, *DOJ Announces Coordinated Law Enforcement Action to Combat Health Care Fraud Related to COVID-19* (May 26, 2021).

One provider, based in Connecticut, typically demands that health plans pay \$1,500



Patrick W. Begos is a partner in Robinson & Cole LLP’S Managed Care + Employee Benefits Litigation Group. His practice focuses on representing employers, insurers, and plans in ERISA and employee welfare plan litigation. He has litigated hundreds of ERISA cases involving disability, health, life and retirement benefits. This article owes much to the assistance of Kate Katchen, Ted Tucci, Jean Tomasco, and Milanna Datlow.



for each COVID test he administers. To put that charge in perspective, a study by The Johns Hopkins University determined that the average price nationwide for a COVID test is less than \$150. Meiselbach, Mark et al., *Charges of COVID-19 diagnostic testing and antibody testing across facility types and states*, J. GEN. INTERN. MED., 1-4 (Sept. 15, 2020). Other surveys have confirmed that a majority of COVID test providers charge under \$200 per test. See <https://www.healthsystemtracker.org/brief/covid-19-test-prices-and-payment-policy/>; and <https://www.ahip.org/wp-content/uploads/AHIP-COVID-Price-Gouging.pdf>.

The Coronavirus Legislation

The FFCRA, Pub. L. 116-127, 134 Stat. 178 (3/18/20), addressed multiple aspects of the COVID pandemic, including COVID testing. As pertinent here, it provides:

SEC. 6001. COVERAGE OF TESTING FOR COVID-19.

(a) IN GENERAL. — 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 the following items and services furnished during any portion of the emergency period ... beginning on or after the date of the enactment of this Act:

1. In vitro diagnostic products ... for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized ... and the administration of such in vitro diagnostic products....

2. Items and services furnished to an individual during ... [medical] visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), 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.

(b) ENFORCEMENT. — The provisions of subsection (a) shall be applied by the Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury to group health plans and health insurance issuers [...] ...

(c) IMPLEMENTATION. — The Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury may implement the

provisions of this section through sub-regulatory guidance, program instruction or otherwise.

The CARES Act, Pub. L. 116-136, 134 Stat. 281 (3/27/20), authorized \$2 trillion in pandemic-related programs. It also included a provision pertinent here:

SEC. 3202. PRICING OF DIAGNOSTIC TESTING.

(a) REIMBURSEMENT RATES. —

A group health plan or a health insurance issuer providing coverage of items and services described in section 6001(a) of division F of the Families First Coronavirus Response Act (Public Law 116-127) with respect to an enrollee shall reimburse the provider of the diagnostic testing as follows:

1. If the health plan or issuer has a negotiated rate with such provider ... 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.

(b) REQUIREMENT TO PUBLICIZE CASH PRICE FOR DIAGNOSTIC TESTING FOR COVID-19. —

1. IN GENERAL. — During the emergency period [,] ... each provider of a diagnostic test for COVID-19 shall make public the cash price for such test on a public internet website of such provider.
2. CIVIL MONETARY PENALTIES. — The Secretary of Health and Human Services may 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 Secretaries of HHS, Labor, and Treasury have defined “Cash price” as “the charge that applies to an individual who pays cash (or a cash equivalent) for a COVID-19 diagnostic test.” 45 C.F.R. § 182.20. In issuing that regulation, they stated their “expectation that the ‘cash price’ established by the provider will be generally similar to, or lower than, rates negotiated with in-network plans and insurers.” 85 Fed. Reg. 71152.

Private Rights of Action

When Congress passes a law regulating an area of the economy, or creating rights for a person or group, the question arises who has the ability to enforce the law. More particularly, does a private individual allegedly injured by an alleged violation of the law have the ability to sue for that violation. In other words, do they have a private right of action.

“[P]rivate rights of action to enforce federal law must be created by Congress.” *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). Sandoval explained that the jurisprudence regarding private rights of action had changed dramatically in 1975, when the Court decided *Cort v. Ash*, 422 U.S. 66 (1975). Prior to *Cort*, the Supreme Court had instructed that courts should “be alert to provide such remedies as are necessary to make effective the congressional purpose[.]” *Sandoval*, 532 U.S. at 286. In other words, if a federal statute appeared to create a right for some group, courts should create a private remedy for that group if Congress did not. However, the Court “abandoned that understanding in *Cort* ... and we have not returned to it since.” *Id.* See also *Lopez v. Jet Blue Airways*, 662 F.3d 593, 296 (2d Cir. 2011) (In *Sandoval*, the Supreme Court strictly curtailed the authority of the courts to recognize implied rights of action[.]”). After *Cort*, evaluation whether a private right of action existed centered on whether the text of the legislation “manifests an unambiguous intent to confer individual rights[.]” *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002) (quotation marks omitted)

A private right of action is created either expressly “or, more rarely, by implication.” *Rep. of Iraq v. ABB AG*, 768 F.3d 145, 170 (2d Cir. 2014). ERISA provides an example of an express right of action, because 29

U.S.C. § 1132 identifies who can sue, who they can sue, and what relief they can seek. To determine if Congress intended to imply a private right of action, a court’s “interpretative inquiry begins with the text and structure of the statute and ends once it has become clear that Congress did not provide a cause of action.” *Sandoval*, 532 U.S. at 288 n.7 (citations omitted). “[U]nless Congress speak[s] with a clear voice, and manifests an unambiguous intent to confer individual rights,” a court may not infer a private right of action. *Gonzaga Univ. v. Doe*, 536 U.S. at 280 (quotation marks omitted). See also *Lopez*, 662 F.3d at 596 (requiring “a clear manifestation of congressional intent to create” a private remedy.). Significantly, after *Cort* and *Sandoval*, courts cannot create an implied private right of action simply because it would be useful or desirable in carrying out congressional goals. Specifically, “a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute.” *Sandoval*, 532 U.S. at 286-87. Thus, it is not enough that a statute creates a right benefiting the potential plaintiff; rather the language of the statute must reveal Congress’ intent to create a remedy for that person: “[t]he judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy.” *Id.*, at 286; see also *Universities Rsch. Ass’n, Inc. v. Coutu*, 450 U.S. 754, 771 (1981) (requiring a court to consider “whether the language of the statute indicates that Congress intended that [a right it granted] be enforced through private litigation”); *Wisniewski v. Rodale, Inc.*, 510 F.3d 294, 301 (3d Cir. 2007), cert. denied, 555 U.S. 814 (2008) (Test whether to imply a private right focuses on the questions: “(1) Did Congress intend to create a personal right? and (2) Did Congress intend to create a private remedy?”).

This test is very restrictive. It is therefore not surprising that federal courts have rarely found implied





private rights of action in federal statutes after *Sandoval*.

Does a Provider Have a Private Right of Action Under the Coronavirus Legislation?

Neither the FFCRA nor the CARES Act creates an express private right of action for providers to sue to collect COVID-19 test payments. The only discussion of enforcement in section 6001 of the FFCRA delegates enforcement to the Secretaries of HHS, Labor, and Treasury. Similarly, the only enforcement provision in section 3202 of the CARES Act authorizes HHS to penalize providers who fail to post a cash price for COVID-19 testing.

As of the writing of this article, there are only two cases addressing the question whether a COVID test provider can assert a private right of action under the Coronavirus legislation. The first, *Diagnostic Affiliates of NE. Hous., LLC v. United Healthcare Servs. Inc.*, No. 2:21-cv-121, 2022 WL 214101 (S.D. Tex. Jan. 18, 2022), held that an implied private right of action existed. The second, *Murphy Med. Assocs., LLC v. Cigna Health and Life Ins. Co.*, No. 3:20-cv-01675, 2022 WL 743088 (D. Conn. Mar. 11, 2022), a case in which the author represented defendants, rejected the reasoning of the first case and held that there was no implied private right of action. Not surprisingly, it is the author's view that the *Murphy* court has the correct analysis.

Diagnostic Affiliates began by noting that *Cort v. Ash* had identified four factors that are "relevant" in "determining whether a private remedy is implicit in a statute not expressly providing one":

First, is the plaintiff 'one of the class for whose especial benefit the statute was enacted,'—that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? And finally, is the cause of action 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. at 78. But, *Diagnostic Affiliates* continued, "[t]he central inquiry remains whether Congress intended to create, either expressly or by implication, a private cause of action. Indeed, the first three factors discussed in *Cort*—the language and focus of the statute, its legislative history, and its purpose—are ones traditionally relied upon in determining legislative intent." *Diagnostic Affiliates*, at *5 (quoting *Touche Ross & Co. v. Redington*, 442 U.S. 560, 575-76 (1979) (citations omitted)).

The court then considered, and rejected, numerous cases that had found no implied private right of action under other parts of the Coronavirus legislation, such as the Payroll Protection Program, because these "cases fail to address whether the FFCRA or CARES Act contains an implied right of action in favor of a COVID-19 testing provider seeking statutorily-mandated reimbursements." *Diagnostic Affiliates*, at *6.

Turning to the *Cort* factors, the court held that *Diagnostic Affiliates* was "among the class of providers for whose benefit the payment provisions were included," that implying a private right of action was consistent with the legislative scheme, and that state concerns did not preclude implying a right of action. *Id.*

The key to the decision, however, was the court's conclusion that the Coronavirus legislation evidenced Congress' intent to create a private right of action. It began by stating that "[t]he mandatory nature of the reimbursement right" — *i.e.*, providing that plans "shall reimburse the provider" — "supports recognition of an implied right of action." *Id.* at *7. The court stated that the delegation of enforcement authority to the Secretaries of HHS, Labor, and Treasury "fall[s] short of providing any avenue for a COVID-19 testing provider to recover the reimbursements required by the statutes." *Id.* And then it held that "clear rights to reimbursement were created and no other enforcement mechanism exists. An implied private right of action is a more appropriate construction of the statute than the creation of a right without any remedy." *Id.* at *8. This reasoning, however, is exactly what *Sandoval* held to be improper: "a cause of action does not exist and courts may not

create one, no matter how desirable that might be as a policy matter[.]" *Sandoval*, 532 U.S. at 286-87.

Murphy Medical properly applied *Sandoval* and its progeny, and reached the opposite conclusion.

Murphy Medical noted that, under *Sandoval*, a court could not create a private right of action without clear Congressional intent, "no matter how desirable that might be as a policy matter, or how compatible with the statute." 2022 WL 743088, at *4 (quoting *Sandoval*, 532 U.S. at 286-87).

In that vein, the court rejected the argument that "mandatory payment language" in the legislation made it "logical to assume" that providers should have a remedy to vindicate a violation of the right to payment. *Id.*, at *5. The payment language could not support an implied right of action, because the question is whether the statute "displays an intent to create not just a private right but also a private remedy." *Id.* (citing *Coutu, supra*). The court continued: "Plaintiff has not identified anything in the text or structure of the CARES Act which suggests that Congress intended to afford them with a privately enforceable remedy." *Id.*

Next, the court rejected the argument that "Congress' silence was merely a product of its rush to create legislation in the midst of the pandemic[.]" *Id.*, at *5. The court held that "[t]his argument ... ignores the principle that '[i]f Congress has manifested no intent to provide a private right of action, [the Court] cannot create one.'" *Id.* (quoting *Lindsay v. Ass'n of Pro. Flight Attendants*, 581 F.3d 47, 52 (2d Cir. 2009) (brackets by the *Murphy* Court)). In this regard, it is noteworthy that courts around the country have consistently held that other provisions in the Coronavirus legislation did not create implied private rights of action. *See e.g., Arroyo v. Yelen*, No. 21-CV-1250-GLS, 2022 WL 195042, at *2 (N.D.N.Y. Jan. 21, 2022) ("courts considering claims brought under the Cares Act have repeatedly found that it provides no private right of action, express or implied, that would permit Plaintiff to maintain this action."); *Am. Video Duplicating, Inc. v. City Nat'l Bank*, No. 2:20-CV-04036, 2020 WL 6882735, at *5 (C.D. Cal. Nov. 20, 2020) ("every court to address whether the

CARES Act created an implied private right of action has held that it does not.”).

The court also rejected the argument that a provider “is left remediless without a private right of action[.]” *Murphy Medical*, 2022 WL 743088, at *5. First, “it is not clear that Plaintiff is left remediless [.]” citing a statement by the Secretaries of HSS, Labor, and Treasury that “the Departments would ‘enforce the applicable provisions of the FFCRA (and the related provisions of the CARES Act), in conjunction with states, where applicable.’” *Id.*, at *5, n. 5. The court also observed: “while Plaintiff asserts that it will be left without a remedy because state law and ERISA will not compensate its claims, it has nonetheless asserted claims under both.” *Id.*

The court held that, at bottom, it was irrelevant whether a provider had a remedy under the Coronavirus legislation, because: “[w]hile this argument may provide a good policy reason to create a private right of action, it does not provide an indication that Congress intended to create such a right.” *Id.* (citing *Sandoval*). Based on this analysis, the Court concluded:

Mindful that the Supreme Court “has increasingly discouraged the recognition of implied rights of actions without a clear indication of congressional intent,” *Duplan v. City of N.Y.*, 888 F.3d 612, 621 (2d Cir. 2018), the Court concludes that neither § 6001 of the FFCRA nor §

3202 of the CARES Act contains a private right of action. *Id.* at *6.

Conclusion

Though the pandemic has changed many aspects of our lives, it has not changed the way that courts must interpret laws and evaluate the rights and obligations of health care providers and health care plans. Parties faced with claims asserting violation of the Coronavirus legislation have strong arguments that Congress did not create new remedies to enforce the rights that providers may argue exist in the legislation.



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