No.

In The

SUPREME COURT OF THE UNITED STATES

SALOOJAS, INC.,

Petitioner,

vs.

AETNA HEALTH OF CALIFORNIA, INC.,

Respondent.

On Petition for a Writ of Certiorari
To The United States Court of Appeals For the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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I. QUESTION PRESENTED

Does a private right of action exist to enforce a federal right when the federal law's primary goal is health and safety?

II. CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, the undersigned counsel of record for Petitioner SALOOJAS, INC., hereby certifies that SALOOJAS, INC., is incorporated and does not have any parent companies, subsidiaries, or affiliates that have issued shares to the public.

III. PARTIES TO THE PROCEEDINGS AND RELATED CASES

SALOOJAS, INC., Petitioner, v. AETNA HEALTH OF CALIFORNIA, INC., Respondent. Below are cases directly related to the case in this Court:

- *Saloojas, Inc vs. Aetna Health of California, Inc.*, No: 22-16034, No: 22-16035, No: 22-16036, No: 22-16037, No: 22-16038, United States Court Appeals for the Ninth Circuit.
- *Saloojas, Inc. vs. Aetna Health of California, Inc.,* No. 3:22-cv-01696-JSC. U.S. District Court for Northern District of California, Judgment entered August 17, 2022. Notice of Appeal July 15, 2022.
- *Saloojas, Inc. vs. Aetna Health of California, Inc.*, No. 3:22-cv-01702-JSC. U.S. District Court for Northern District of California, Judgment entered August 17, 2022. Notice of Appeal July 15, 2022.
- *Saloojas, Inc. vs. Aetna Health of California, Inc.*, No. 3:22-cv-01703-JSC. U.S. District Court for Northern District of California, Judgment entered August 17, 2022. Notice of Appeal July 15, 2022.
- *Saloojas, Inc. vs. Aetna Health of California, Inc.*, No. 3:22-cv-01704-JSC. U.S. District Court for Northern District of California, Judgment entered August 17, 2022. Notice of Appeal July 15, 2022.
- *Saloojas, Inc vs. Aetna Health of California, Inc.*, No. 3:22-cv-01706-JSC. U.S. District Court for Northern District of California, Judgment entered August 17, 2022. Notice of Appeal July 15, 2022.

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VI. PETITION FOR WRIT OF CERTIORARI

PETITIONER SALOOJAS, INC., by and through Michael L. Gabriel, Attorney for Petitioner, respectfully requests that this court issue a writ of certiorari to reverse the decision from the United States Court of Appeals for the Ninth Circuit issued on September 7, 2023 in *Saloojas, Inc. v. Aetna Health of California, Inc.*, Nos. 22-16034, 22-16035, 22-16036, 22-16037, 22-16038 (9th Cir. Sep. 7, 2023), which held there is no private cause of action under the CARES Act.

VII. OPINION BELOW

The United States Court of Appeals for the Ninth Circuit issued an Opinion on September 7, 2023, holding that there is no private cause of action and remedy under the CARES Act. [Opinion, September 7, 2023, Appendix A].

VIII. JURISDICTION

This Court has jurisdiction over this Petition For A Writ Of Certiorari from the Ninth Circuit's decision under 28 U.S.C. section 1254(1).

IX. CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS

The Coronavirus Aid, Relief, and Economic Security Act, Pub. L. 116-136 (2020) ("CARES Act"), which was passed by Congress. Appendix C, 28a.

Section 6001 of the Families First Coronavirus Response Act ("FFCRA"), as amended by Section 3201 of the CARES Act. Appendix C, 33a.

X. STATEMENT OF THE CASE

In late March of 2020, America's worst pandemic in over 100 years began ravaging the country. Persons infected with the COVID-19 virus easily spread the disease – even before symptoms developed. Thus, any effort to contain the pandemic

required rapid testing for as many Americans as possible to identify infected persons. Rapid testing would permit infected persons to receive prompt treatment and to quarantine themselves to slow and/or prevent the transmission of this highly communicable virus.

To address this public health emergency, Congress passed the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), Pub. L. No. 116-136, § 3202(a) 134 Stat. 281 (2020), and the Families First Coronavirus Response Act ("FFCRA"), Pub. L. No. 116-127, § 6001(a), 134 Stat. 178 (2020).

As is pertinent here, these statutes require group health insurance plans to cover COVID-19 diagnostic testing by qualified providers at no cost to their insureds. In the absence of a negotiated rate, insurers are required to pay for the testing administered to their insureds at the cash rate the provider publishes on its website (and the providers are required to post a public cash price).

To ensure that no person would have to consider the economic cost of getting tested, the FFCRA And the CARES Act prohibited co-payments, deductibles, and co-insurance. To incentivize medical providers to participate and invest in establishing testing centers that would test anyone – regardless of insurance coverage – the FFCRA and the CARES Act required insurers to cover the cost of COVID-19 testing from out-of-network providers (those who don't have a contractual relationship with the insurer) on the same terms as in-network providers – no out of pocket expenses, no co-payments, and no deductibles.

The CARES Act was specifically and intentionally created to assure adequate Covid testing services to all Americans during the pandemic where one out of every

300 Americans died. It was Congress' bipartisan intent to save lives by doing so. The mandating of the payment of out of network providers' posted prices was not the primary goal of the act but the method employed by which Congress intended to achieve the goal of savings lives. When insurers refused to reimburse providers at the posted prices, they intentionally thwarted the legislative goal of ensuring health and safety by providing Covid testing for all Americans.

A. STATEMENT OF FACTS

Dr. Parmjit Singh, the founder Saloojas, was among the earliest pioneers in establishing COVID-19 testing centers for Northern California residents. Dr. Singh's efforts resulted in over 35,000 COVID-19 tests, including no-cost testing to over 3,000 uninsured patients. Dr. Singh invested significant time and money in creating a COVID-19 testing program for people who wanted immediate testing, rather than waiting for an appointment.

Unfortunately, Respondent Aetna Health of California, Inc. failed to comply with the CARES Act and failed to pay Saloojas for COVID-19 testing services provided to Aetna's insureds. Accordingly, Saloojas filed suit against Aetna, seeking to obtain payments due from Aetna pursuant to the CARES Act.

The district court granted Aetna's motion to dismiss the complaint on the grounds that the CARES Act does not provide an implied private right of action. The appellate court affirmed.

In so ruling, the Ninth Circuit ran afoul of this Court's precedents regarding private right of actions. Most significantly, in *Health and Hospital Corporation of Marion County v. Talevski* ("*Talevski*"), 599 U.S. 166 (2023), this Court addressed

the same issue presented by this Petition – whether a private right of action exists to enforce a federal right when the federal law's primary goal is health and safety.

The Ninth Circuit's ruling has prevented medical providers – who invested significant resources in creating testing centers – from collecting the fees due under the CARES Act. As a result, these providers have absorbed approximately two-thirds of the significant cost incurred for creating and providing the testing services (including employee salaries and supplies). Such providers have been unable to recoup their costs. Most significantly, the providers' inability to pursue reimbursement claims against insurers for providing critical COVID-19 testing services has caused providers, like Dr. Singh, to pay the costs out of their own pocket. Plainly, the CARES Act never contemplated such a result.

B. PROCEDURAL HISTORY

1. The Complaints

In December 2021, Saloojas filed five separate complaints against Aetna in the Small Claims Division of the Alameda County Superior Court of California.

Each Complaint generally alleged as follows:

Saloojas, an out of network provider, provided Covid-19 testing services to Aetna's insured under the Cares Act. Section 3202(a)(2) of the CARES Act obligated Aetna to pay Saloojas's entire bill at posted prices without any deductions. Aetna intentionally violated the CARES Act by failing to pay the amount due to Saloojas.

Saloojas appealed Aetna's refusal to pay the full amount owed. Aetna denied Saloojas's appeal.

Each Complaint sought compensatory and punitive damages.

2. The Removal

In February 2022, Saloojas served Aetna with the Complaints.

In March 2022, Aetna filed a Notice of Removal of each Complaint in the Northern District of California pursuant to 28 U.S.C. section 1441(a), on the grounds that the claim asserted in each Complaint arose under federal law – the CARES Act.

3. The Dismissals

In April 2022, the district court deemed all five actions related. Aetna then filed identical motions to dismiss each action. In June 2022, the district granted Aetna's motion to dismiss all five actions. On August 17, 2022, the district court filed a Judgment in all five actions.

4. The Appeal

On July 15, 2022, Saloojas timely filed a Notice of Appeal in all five actions.

On September 7, 2023, the Ninth Circuit issued an Opinion, affirming the district court's Judgment. *Saloojas, Inc. v. Aetna Health of California, Inc.*, 80 F.4th 1011, 1016 (9th Cir. 2023).

The Opinion ruled as follows:

"[P]rivate rights of action to enforce federal law must be created by Congress." *Id.* at 1015 (quoting *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001)). We must "interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy. Statutory intent on this latter point is determinative." *Ibid.* (quotation omitted). "Because the Supreme Court has elevated intent into a supreme factor, we start

there and .... presume that Congress expressed its intent through the statutory language it chose." *Ibid.* (quotation omitted). "Congress's use of mandatory language alone is not enough to create an implied private right of action. Rather, a statute must use rights-creating language that places an unmistakable focus on the individuals protected instead of the person regulated." *Ibid.* (cleaned up).

"Saloojas bases its claim on section 3202(a)(2)'s directive that an insurer 'shall reimburse' the provider at 'the cash price' of testing if the insurer 'does not have a negotiated rate' with the provider." *Ibid.* But "the focus of the provision is on the regulated party—the 'group health plan or ... health insurance issuer'—and the diagnostic test 'provider' is only the object of the obligation." *Ibid.* "Accordingly, § 3202(a)(2) of the CARES Act does not contain rights-creating language that would evince Congress's intent to create a private right of action for providers to sue insurers." *Ibid.*

The Opinion also relied on "other provisions of the CARES Act and FFRCA that lay out enforcement mechanisms." *Id.* at 1016. The Opinion explained:

> Section 3202(b) of the CARES Act authorizes the Secretary of Health and Human Services to impose a monetary penalty on any provider that fails to publicly post its cash price. That Congress chose to include an enforcement mechanism in the CARES Act that is limited to actions by the Secretary against a provider of testing services cuts strongly against a finding of intent to create a private remedy for those providers.

Ibid.

Similarly: "[S]ection 6001 of FFCRA contains enforcement and implementation provisions for the Secretary of various agencies—Health and

Human Services, Labor, and the Treasury." *Ibid.* citing FFCRA § 6001(b), (c). "Moreover, the CARES Act was passed soon after FFCRA, expands on the requirements in § 6001(a) of FFCRA." *Ibid.*

The Opinion concluded: "[T]he fact that these provisions provide an enforcement mechanism but only through the Secretaries suggests a lack of congressional intent to create a private right of action for providers." *Ibid.* Finally, the Opinion noted that although "nothing in the language of the statute shows an intent to deny a remedy, ... that statutory silence is not enough." *Ibid.* Rather, "[a] statute must also display an intent to create a private remedy in order to create an implied right of action." *Ibid.* (quotation omitted).

5. The Petition For Rehearing

On October 16, 2023, the Ninth Circuit denied Saloojas' Petition for panel rehearing en banc. The Mandate was issued Oct 24, 2023 by the Ninth Circuit.

C. APPLICABLE LAW

1. The Private Right of Action

2. Relevant Statutes

3. Applying The *Cort* Factors

a. *Cort* Factor 1: The CARES Act Intended To Benefit Providers

The CARES Act has ***mandatory reimbursement language*** in favor of testing providers. Section 3202(a) of the CARES Act expressly states that insurers "***shall reimburse the provider*** of the diagnostic testing ...." CARES Act, § 3202(a) (emphasis added). The CARES Act also states: "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*** ...." *Id.*, 3202(a)(2) (emphasis added). This mandatory reimbursement language reveals a legislative intent to create both a private right and a private remedy.

The legislative objective of the CARES Act was to ensure that COVID-19 testing was widely available. This required: (1) providers willing to supply and administer tests; and (2) a reliable payment method for the service. Payment of providers was ***essential*** as Congress: (1) used the term "shall" to specify the amount to be paid to providers; and (2) protected patients from any burden as to either cost or administrative requirements.

The legislative history reveals that the CARES Act was intended to benefit ***providers***. A Senator addressing the CARES Act stated:

> In the end, the only way to end this crisis—and the only way to get the American economy moving again—is to contain the disease. This will require, as soon as possible, adopting a new goal. That goal should be to test every American who needs it for COVID-19 as soon as possible .... [T]he sooner we make more tests available ... the better....
>
> Expanding tests ... will do more to get the economy moving again than spending trillions stabilizing businesses and supporting employees.
>
> More instances of expansion of tests ... is what we need.
>
> Finally, containing the disease is the third goal. It makes all COVID-19 tests free. There is nearly $100 billion for the public health and social services emergency fund. That is at least $75 billion for hospitals and ***$10.5 billion for accelerating diagnostics***, treatments, and vaccines.

166 Cong. Rec. S1895-03 (Sen. Alexander, R-Tenn. (emphasis added).

The CARES Act's mandatory reimbursement requirement provides an "unmistakable focus on the benefited class" – diagnostic testing providers." *Cannon v. University of Chicago*, 441 U.S. 677, 691 (1979); *see also Maine Community Health Options v. United States* ("*Maine*"), 590 U.S. ---, 140 S.Ct. 1308, 1320-21 (2020) (finding insurers had right to payment from federal Government based on mandatory statutory term "shall"). Thus, providers are the persons to be protected and the CARES Act's mandatory language is neither a general ban on conduct nor or expression of public policy.[1]

Two examples illustrate the point. Title VI provides: "***No person*** in the United States ***shall*** ... be subjected to discrimination under any program or activity receiving Federal financial assistance" on the basis of race, color, or national origin. 42 U.S.C. § 2000d (emphasis added). Similarly, Title IX provides: "***No person*** in the United States ***shall***, on the basis of sex, ... be subjected to discrimination under any education program or activity receiving Federal financial assistance." 20 U.S.C. § 1681(a) (emphasis added). In both instances, Congress identified rights and obligations by mandating that no person shall be subjected to discrimination by programs or activities receiving federal financial assistance. The statutes speak to the parties who have rights ***and*** the parties who have responsibilities. The statutes

[1] *Maine* demonstrates that "Congress can ... create an obligation directly by statute, without also providing details about how it must be satisfied." *Maine*, 140 S.Ct. at 1320-21. There, health insurers sued the federal government under the Tucker Act, claiming an obligation created by the Affordable Care Act. This Court held that the mandatory "shall pay" requirement entitled the insurers to payment. *Ibid.* Thus, *Maine* supports the conclusion that the CARES Act's mandatory reimbursement language supports an implied private right of action here.

do not focus solely on the party whose conduct is to be regulated (or the regulating agency). Section 3202(a) is similar to these statutes in that the mandatory language identifies the specific parties who have rights and responsibilities, without identifying or even focusing on a regulating federal agency. *See Texas & P. Ry. Co. v. Rigsby*, 241 U.S. 33, 39 (1916) ("[I]n every case, where a statute enacts or prohibits a thing for the benefit of a person, he shall have a remedy upon the same statute for the thing enacted for his advantage, or for the recompense of a wrong done to him contrary to the said law.") (quotation omitted).

This Court "has never refused to imply a cause of action where the language of the statute explicitly conferred a right directly on a class of persons that included the plaintiff in the case." *Cannon*, 441 U.S. at 693 n.13 (emphasis added). Here, CARES Act section 3203(a) explicitly confers testing providers with a reimbursement right. Thus, providers are the CARES Act's intended beneficiaries and this factor supports an implied a private right of action.

For these reasons, the CARES Act is intended to benefit providers and this factor supports an implied private right of action.[2]

b. *Cort* Factor 2A: The CARES Act Reflects a Legislative Intent to *Create* a Private Right of Action

The text and structure of the CARES Act demonstrate an intent to create a private remedy. The CARES Act has ***mandatory reimbursement language*** in favor of testing providers. *See* CARES Act, § 3202(a) (insurers "***shall reimburse the provider*** of the diagnostic testing") (emphasis added). The CARES Act also sets

[2] The CARES Act *incidentally* benefit patients. Under FFCRA and the CARES Act patients are spared any cost or administrative burden in obtaining COVID-19 testing. Nevertheless, the FFCRA and CARES Act intend to benefit ***providers***.

the mandatory reimbursement rate. *Id.*, § 3202(a)(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*** ....") (emphasis added). This mandatory reimbursement language reveals a legislative intent to create a private right ***and*** a private remedy. *See Maine*, 140 S.Ct. at 1320 ("The first sign that the statute imposed an obligation is its mandatory language: 'shall.' Unlike the word 'may,' which implies discretion, the word 'shall' usually connotes a requirement.").[3]

The CARES Act has rights-creating language which states that insurers "shall reimburse" providers. Such language creates a mandatory reimbursement right and focuses on the persons protected -- providers. That conclusion is not altered merely because the CARES Act also refers to insurers.

As noted above, Title VI and Title IX both contain "rights-creating language" and give rise to an implied private right of action. *See Alexander*, 532 U.S. at 279-80. Both statutes identify the protected group – all persons – and the right created – to be free from discrimination. Both statutes also identify the regulated party – any program receiving Federal financial assistance. That these statutes also identify the regulated party did not eviscerate the private right of action. Here, the CARES Act identifies the protected group – testing providers – and the right created –

[3] When Congress enacts statutory provisions "stated in the form of commands," but for which "there is no mode of enforcement other than resort to the courts," courts have the "jurisdiction and duty to afford a remedy for a breach of statutory duty." *Steele v. Louisville & N.R. Co.*, 323 U.S. 192, 207 (1944). Otherwise, the "right would be sacrificed or obliterated if it were without the remedy which courts can give for breach of such a duty or obligation." *Ibid.*

reimbursement. That the CARES Act also identifies insurers does not eviscerate the private right of action.

The CARES Act's mandatory reimbursement requirement provides an unmistakable focus on the benefited class – the testing provider. Such providers are the persons protected by the CARES Act and section 3202(a)'s mandatory language explicitly confers providers with a reimbursement right. As such, the providers are the intended beneficiary of the CARES Act. Moreover, the CARES Act specifies the specific rate which the insurer must pay. *See* CARES Act, § 3202(a)(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.") (emphasis added). This additional mandatory language is further evidence of a legislative intent to create a private right of action. The CARES Act identifies a discrete group of people – testing providers – and used language creating a mandatory reimbursement right.

The CARES Act contains rights-creating language in favor of providers and unmistakably focuses on the providers as the class of persons protected. In passing the CARES Act, Congress provided mandatory reimbursement for diagnostic testing providers to incentivize them to quickly increase access to testing to help stop COVID-19 from spreading. Moreover, the CARES Act does not provide for any administrative remedies if an insurer fails to comply with the mandatory reimbursement requirement, and no agency has asserted authority to provide such

a remedy. Accordingly, an implied cause of action was contemplated (and is necessary) for COVID-19 testing providers to enforce the CARES Act's mandatory reimbursement requirement.

Congress wanted providers to be confident that if they participated in the national effort to combat the pandemic through widespread testing, 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 knew that, if left to their own devices, insurers would serve their own economic interests and attempt to avoid paying for the massive testing required to combat the pandemic. Accordingly, Congress removed nearly all discretion because Congress wanted widespread testing, and Congress wanted insurers to pay for it.

Congress did not give insurers any discretion in determining whether they can cover Covid-19 testing services and how much to pay providers for such services. To address the public health emergency, the federal government sought to encourage extensive and swift Covid-19 testing and to incentivize providers to accept the inherent risks in providing these tests by ensuring they would be paid promptly at a rate set by law. The FFCRA and the CARES Act mandate that insurers cover these tests at specific rates. Thus, an implied private right of action is entirely consistent with the text, structure, context, and policy of the FFCRA and the CARES Act.

c. *Cort* Factor 2B: The CARES Act Does Not Reflect A Legislative Intent to *Deny* a Private Remedy

The mandatory reimbursement language is evidence of a legislative intent to create both a private right ***and a private remedy***. There is nothing in the text or structure of the FFCRA or the CARES Act which indicates an intent to ***deny*** a private remedy.

Section 3202 does ***not*** provide an alternative enforcement mechanism. The FFCRA obligates insurers to provide ***coverage*** for COVID-19 testing. FFCRA, § 6001(a). The FFCRA has an "implementation" provision which permits the Secretaries of Health and Human Services, Labor, and Treasury to implement the FFCRA's *coverage* requirement. *Id.*, § 6001(c). The FFCRA also has an "enforcement" provision which permits the Secretaries to enforce the *coverage* requirement. *Id.*, § 6001(b). Thus, the FFCRA's enforcement scheme is designed for the purpose of ensuring ***coverage*** for insureds.

The FFCRA does not, however, provide any ***enforcement mechanism*** pertaining to the mandatory reimbursement requirement. Thus, the FFCRA does ***not*** indicate an intent to deny a remedy for COVID-19 testing providers.

Similarly, section 3202(a) of the CARES Act creates a mandatory reimbursement requirement for testing providers. The only enforcement provision related to that requirement is a civil fine ***against providers*** who do not publish their cash price (required to calculate payments). CARES Act, § 3202(b). Thus, the CARES Act, like the FFCRA, has no express enforcement provision relating to the mandatory reimbursement requirement. In short, the CARES Act created clear rights to reimbursement with no other enforcement mechanism. As such, neither the CARES Act, nor FFCRA, indicates an intent to ***deny*** a remedy for those

providing COVID-19 testing services.

d. *Cort* Factor 3: A Private Right Of Action Is Consistent With The Legislative Scheme

A private right of action pertaining to the reimbursement requirement is consistent with the legislative scheme.

FFCRA Section 6601(a) obligates insurers to ***provide coverage*** for COVID-19 diagnostic testing. Section 6601(b), in turn, provides an enforcement mechanism solely related to the insurance coverage requirement set forth in section 6601(a). In contrast, the CARES Act section 3202(a) obligates insurers to reimbursement providers performing diagnostic testing. The CARES Act has no enforcement mechanism related to the reimbursement requirement. Section 3202(b) merely states that providers "shall make public the cash price for such [diagnostic] test on a public internet website of such provider." CARES Act, § 3202(b)(1). Section 3202(b)(2) states that 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) [the publication requirement] and has not completed a corrective action plan to comply with the requirements of such paragraph ...." *Id.*, § 3202(b)(2). Thus, the CARES Act's enforcement mechanism merely provides for a penalty against the provider for failing to publish the diagnostic test price. There is no enforcement mechanism related to the reimbursement requirement.

Absent a private right of action, providers had no incentive to invest millions of dollars in creating testing centers to rapidly provide widespread testing. Had the

CARES Act stated that providers would not be able to recover testing costs, they would not have invested in testing facilities, permitting the virus to spread undetected and leaving Americans vulnerable to the deadly virus.

Rather, Congress wanted rapid, widespread COVID-19 testing, which could only be accomplished if private entities incurred the cost of establishing testing sites and procuring the necessary supplies to administer tests. The CARES Act dispensed with details regarding the relationship between providers and insurers by including a mandatory methodology for determining the rate to be paid in the absence of negotiated rates. Thus, a private right of action to recover the mandated reimbursement is fully consistent with the legislative scheme.

e. *Cort* Factor 4: A Private Right Of Action Would Not Interfere With Any State Concerns

The national response to the COVID-19 pandemic is consistent with state interests. Moreover, a claim seeking reimbursement for testing provided in response to the global pandemic is neither a matter neither traditionally relegated to state law nor an area which is primarily a state concern.

Because a private right of action interferes with no state concerns, this factor also supports the conclusion that Congress intended to create a private right of action.

4. This Court's Recent *Health and Hospital Corporation* Decision

In *Health and Hospital Corporation of Marion County v. Talevski* ("*Talevski*"), 599 U.S. 166 (2023), this Court addressed the same issue presented by this Petition – whether a private right of action exists to enforce a federal right

when the federal law's primary goal is health and safety.

Talevski considered the Federal Nursing Home Reform Act ("FNHRA") which ensures that nursing homes that receive Medicaid funding respect and protect their residents' health, safety, and dignity. The FNHRA provides nursing-home residents with: (1) the right to be free from unnecessary physical or chemical restraints; and (2) the right to be discharged or transferred only when certain preconditions are satisfied. The Court held that these two FNHRA provisions unambiguously create rights enforceable under 42 U.S.C. § 1983. *Id.* at 172.

This Court first noted: "The FNHRA provisions at issue in this case, like the rest of [FNHRA], stem from a longstanding national commitment to provide safe and dignified care for the elderly." *Id.* at 180-81. This Court also noted that the two provisions at issue fall within a section concerning the requirements relating to ***residents' rights***. *Id.* at 184. This Court explained: "This framing is indicative of an individual 'rights-creating' focus." *Ibid.* (quotation omitted).) This Court also examined the text of the two provisions and concluded that they "unambiguously confer[] rights upon the residents of nursing-home facilities." *Ibid. Talevski* specifically noted that the two provisions expressly focus on the health, welfare, medical needs, and safety of nursing home residents. *Id.* at 184-85. *Talevski* also acknowledged that the two provisions establish that Medicaid-participant nursing homes must respect and honor these statutory rights. Regardless, this Court noted that this did not present "a material diversion from the necessary focus on the nursing-home residents ...." *Id.* at 185. In short, *Talevski* concluded that the two provisions at issue created rights enforceable under § 1983 because they use "rights-

creating language, speak in terms of the persons benefited, and have an 'unmistakable focus on the benefited class." *Id.* at 186 (cleaned up).

Regarding enforcement, *Talevski* noted that FNHRA "establishes a detailed administrative scheme for government inspections of nursing facilities" *Id.* at 182. "In addition, the statute authorizes government actors to sanction and correct noncompliant facilities, or, if appropriate, exclude them from the Medicaid program entirely." *Ibid.* Notwithstanding the administrative enforcement scheme, this Court held that FNHRA did not create a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983. *Ibid.* The Court concluded: "We discern no incompatibility between the FNHRA's remedial scheme and § 1983 enforcement of the rights that the unnecessary-restraint and predischarge-notice provisions unambiguously secure." *Id.* at 188. *Talevski* reasoned: "[T]he FNHRA details administrative processes concerning inspection of covered nursing facilities and accountability for noncompliant facilities. But the statute lacks any indicia of congressional intent to preclude § 1983 enforcement ...." *Ibid.* Despite the administrative enforcement provisions, the import of the two FNHRA provisions reflects an "unambiguous conferral of rights." *Ibid.* "The attendant presumption is that § 1983 can play its textually prescribed role as a vehicle for enforcing those rights, even alongside a detailed enforcement regime that also protects those interests, so long as § 1983 enforcement is not 'incompatible' with Congress's handiwork." *Id.* at 188-89 (quotation omitted). In sum, "the FNHRA secures the particular rights that Talevski invokes, without otherwise signaling that enforcement of those rights via § 1983 is precluded as incompatible with the

FNHRA's remedial scheme." *Id.* at 192.

Talevski unequivocally supports the conclusion that an implied private right of exists to enforce the Cares Act. It addressed the same issue presented by this Petition – whether a private right of action exists to enforce a federal right when the federal law's primary goal is health and safety.

Here, as in *Talevski*, Congress enacted a federal statute primarily enacted for public safety. Here, as in *Talevski*, the CARES Act identified a discrete group of people – providers of COVID-19 testing services – and then used language giving that group rights (to mandatory reimbursement). Moreover, the *administrative* enforcement mechanisms in FFCRA and CARES do ***not*** provide any mechanism for COVID-19 testing providers to recover the reimbursements required by the statutes. The FFCRA does ***not*** indicate an intent to deny a remedy for those providing COVID-19 testing services. Similarly, the CARES Act section 3202(a) has no express enforcement provision – administrative or otherwise – that permits providers to enforce the mandatory reimbursement right created by the CARES Act. Thus, absent any enforcement provision, the Cares Act necessarily created an *implied* private right of action.

XI. REASON FOR GRANTING THE PETITION

This writ presents a question of ***exceptional national importance*** and an issue of first impression – whether an implied private right of exists to enforce a federal statute primarily enacted for public safety and to save lives by ensuring adequate Covid testing services to all Americans. The nonenforcement of the Cares Act will likely result in preventable deaths due to COVID-19 which remains a

significant health threat and has now become endemic.

This is an action seeking congressionally-mandated reimbursement for the full price of lifesaving COVID-19 diagnostic testing services that Petitioner Saloojas, Inc., provided to insureds of Respondent Aetna Health of California, Inc.

Congress took the extra ordinary step of enacting the CARES Act and the FFCRA to mitigate the harm caused by the pandemic by ensuring that any person who needed a test could get one. Congress addressed such concern by requiring 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. In doing so, Congress mandated that insurers like Aetna "shall reimburse the provider of the diagnostic testing." Despite such mandate, Aetna has refused to do so, and such refusal jeopardizes public safety and violates the intent of Congress.

It was the need to get tested for COVID which gave cause for Congress to enact the CARES Act (and such reason still exists today).

In *Talevski*, this Court held that a private right of action exist to enforce a federal right when the federal law's primary goal is health and safety. That ruling applies with equal force to the CARES Act.

In short, review is required so that this Court may interpret the CARES Act and the FFCRA and conclusively determine whether a private right of action exist to enforce the federal rights created by these acts. Review by this Court is warranted because, as previously detailed: (1) the Ninth Circuit has decided an

important federal question in a way that conflicts with *Talevski*; and (2) the Petition presents an important question of federal law that has not been, but should be, settled by this Court.

XII. CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

January 16, 2023

/s/Michael L. Gabriel
MICHAEL LYNN GABRIEL
Attorney for Petitioner

APPENDIX A – OPINION OF THE UNITED STATES NINTH CIRCUIT OF APPEALS FILED, SEPTEMBER 7, 2023

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

Case Nos.

22-16034, 22-16035,
22-16036, 22-16037,
22-16038

D.C. Nos. 3:22-cv-01696-JSC
3:22-cv-01702-JSC
3:22-cv-01703-JSC
3:22-cv-01704-JSC
3:22-cv-01706-JSC OPINION

SALOOOJAS, INC,

Plaintiff-Appellant

v.

AETNA HEALTH OF CALIFORNIA, INC

Defendant-Appellee

Appeal from the United States District Court for the Northern District of California

Jacqueline Scott Corley,Magistrate Judge, Presiding

Argued and Submitted February 14, 2023
San Francisco, California
Filed September 7, 2023

Before: Kim McLane Wardlaw, Jacqueline H. Nguyen, and Lucy H. Koh, Circuit Judges.

Opinion by Judge Nguyen

APPENDIX TO THE PETITION FOR A WRIT OF CERTIORARI

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Appendix A

SUMMARY*

Coronavirus Aid, Relief, and Economic Security Act

The panel affirmed the district court's dismissal of five actions filed by Saloojas, Inc., against Aetna Health of California, Inc., seeking under the Coronavirus Aid, Relief, and Economic Security Act ("CARES" Act) to recover the difference in cost between Saloojas's posted cash price for COVID-19 testing and the amount of reimbursement it received from Aetna.

Saloojas argued that § 3202 of the CARES Act required Aetna to reimburse out-of-network providers like itself for the cash price of diagnostic tests listed on the providers' websites.

Agreeing with the district court, the panel held that the CARES Act does not provide a private right of action to enforce violations of § 3202. Saloojas correctly conceded that the CARES Act did not create an express private right of action. The panel held that there is not an implied private right of action for providers to sue insurers. The use of mandatory language requiring reimbursement at the cash price does not demonstrate Congress's intent to create such a right. The statute does not use "rights-creating language" that places "an unmistakable focus" on the individuals protected as opposed to the party regulated.

* This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

Appendix A

COUNSEL

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Emily S. Costin (argued), Alston & Bird LLP, Washington, D.C.; David B. Carpenter, Alston & Bird LLP, Atlanta, Georgia; for Defendant-Appellee.

Charles C. Gokey, Engstrom Lee, Minneapolis, Minnesota; Jeffrey S. Gleason, Robins Kaplan LLP, Minneapolis, Minnesota; for Amicus Curiae Premera Blue Cross.

OPINION

NGUYEN, Circuit Judge:

Saloojas, Inc. ("Saloojas") filed five actions against Aetna Health of California, Inc. ("Aetna"), seeking to recover the difference in cost between its posted cash price for COVID-19 testing and the amount of reimbursement it received from Aetna. Saloojas argues that § 3202 of the CARES Act requires Aetna to reimburse out-of-network providers like Saloojas for the cash price of diagnostic tests listed on their websites. The district court dismissed this action on the ground that the CARES Act does not provide a private right of action to enforce violations of § 3202. We agree and therefore affirm the dismissal.

Appendix A

I.

On March 18, 2020, in response to the outbreak of the COVID-19 pandemic in the United States, Congress enacted the Families First Coronavirus Response Act ("FFCRA").Pub. L. No. 116-127, 134 Stat. 178. Section 6001 of FFCRA, titled "Coverage of Testing for COVID-19," requires health insurers to cover, at no additional expense to insureds, diagnostic products for detection of COVID-19. *Id.* § 6001(a). It contains an enforcement provision: the statute "shall be applied by the Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury" to insurers "as if included in" certain provisions of the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986. *Id.* § 6001(b).

Soon after, on March 27, 2020, Congress enacted the Coronavirus Aid, Relief, and Economic Security Act ("CARES" Act). CARES Act, Pub. L. No. 116-136, 134 Stat. 281, 367. Section 3202 of the CARES Act, titled "Pricing of Diagnostic Testing," states that insurers providing coverage of COVID-19 diagnostic products as described in § 6001(a) of FFCRA "shall reimburse the provider of the diagnostic testing" at either a negotiated rate or "in an amount that equals the cash price for such service as listed by the provider on a public internet website." *Id.*

§ 3202(a). The provision mandates that "each provider of a diagnostic test" publish its cash price on a public website. *Id.* § 3202(b)(1). Finally, the statute provides that the "Secretary of Health and Human Services may impose a civil monetary penalty on any provider of a diagnostic test for COVID-19 that" does not comply with posting a cash price. *Id.* § 3202(b)(2).

II.

Saloojas is a provider of COVID-19 diagnostic testing. Saloojas is outside of Aetna's provider network and therefore does not have a negotiated rate for COVID-19 tests. Saloojas alleges that Aetna paid less than Saloojas's posted cash price for COVID-19 tests provided to Aetna's insureds between November 20 and 23, 2020. Saloojas filed five actions against Aetna in Alameda County Superior Court. In each case, Saloojas alleged identical claims under § 3202(a)(2) of the CARES Act, seeking reimbursement for the cost of COVID-19 testing and services provided to patients insured by Aetna. Saloojas sought the difference between what Aetna already paid and Saloojas's entire bill, as well as "punitive damages . . . for the intentional violation of the Federal CARES Act."

Aetna removed the cases to federal court and moved to dismiss for failure to state a claim on the ground that the CARES Act does not provide a private right of action to Saloojas. On June 23, 2022, the district court determined that the CARES Act does not contain any private right of action for providers to bring claims against insurers for violations of § 3202, and granted the motions to dismiss. The district court gave Saloojas leave to amend its complaints, but Saloojas instead filed notices of appeal. The district court then entered orders of dismissal and judgment in favor of Aetna. The parties jointly moved to consolidate the appeals, which this court granted on September 12, 2022.

III.

We review dismissals for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6) de novo and may affirm on any ground supported by the record. *Hooks v. Kitsap Tenant Support Servs., Inc.*, 816 F.3d 550, 554 (9th Cir. 2016). We review questions of statutory interpretation de novo. *Id.* "Dismissal is appropriate when the complaint lacks a 'cognizable legal theory' or sufficient factual allegations to 'support a cognizable legal theory.'" *Beckington v. Am. Airlines, Inc.*, 926 F.3d 595, 604 (9th Cir. 2019) (quoting *Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 652 (9th Cir. 2019)).

IV.

Saloojas concedes that the CARES Act did not create an express private right of action for a provider to seek reimbursement for COVID-19 testing at the provider's publicly posted cash price, but argues that there is an implied private right of action.

"Like substantive federal law itself, private rights of action to enforce federal law must be created by Congress." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). We must "interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy. Statutory intent on this latter point is determinative." *Id.* (citation omitted).

The Supreme Court initially identified four factors for courts to examine in determining whether Congress intended to imply a private right of action:

> 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?

ACort v. Ash, 422 U.S. 66, 78 (1975) (internal citations and quotations omitted). "In later cases, the Supreme Court essentially collapsed the *Cort* test into a single focus: '[t]he central inquiry remains whether Congress intended to create, either expressly or by implication, a private cause of action.'" *Logan v. U.S. Bank Nat'l Ass'n*, 722 F.3d 1163, 1170 (9th Cir. 2013) (quoting *Touche Ross & Co. v. Redington*, 442 U.S. 560, 575 (1979)); *see also Lil' Man in the Boat, Inc. v. City & Cnty. of San Francisco* ("*Lil' Man*"), 5 F.4th 952, 958 (9th Cir. 2021) ("Since announcing this test, 'the Supreme Court has elevated intent into a supreme factor,' and *Cort*'s other three factors are used to decipher congressional intent." (quoting *Logan*, 722 F.3d at 1171)).

"Because the Supreme Court has elevated intent into a supreme factor, we start there and . . . . presume that Congress expressed its intent through the statutory language it chose." *Logan*, 722 F.3d at 1171. Saloojas argues that the statute shows Congress's intent to create an implied private right of action because it uses mandatory language requiring reimbursement at the cash price.[1] According to Saloojas, the

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[1] Saloojas's argument is based on the following statutory text of the CARES Act:

> (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

use of such mandatory language "grant[s] private rights to the members of an[] identifiable class." *Transamerica Mortg. Advisors, Inc. (TAMA) v. Lewis*, 444 U.S. 11, 24 (1979). However, Congress's use of mandatory language alone is not enough to create an implied private right of action. Rather, a statute must use "rights-creating language" that places "an *unmistakable focus*" on the individuals protected instead of the person regulated. *UFCW Loc. 1500 Pension Fund v. Mayer*, 895 F.3d 695, 699 (9th Cir. 2018) (internal quotations and citation omitted).

For example, we held that statutory language in the Protecting Tenants at Foreclosure Act that "any immediate successor in interest . . . shall assume such interest subject to" certain rights of "bona fide tenant[s]" did not provide a private right of action to the bona fide tenants. *Logan*, 722 F.3d at 1171. The bona fide tenants had no implied private right of action because the statutory language was framed in terms of imposing obligations on the "successor in interest," while the "bona fide tenant[s]" were "referenced only as an object" of the obligation. *Id.* Similarly, we held that statutory language in the Rivers and Harbors Act prohibiting non-federal entities from imposing fees or other charges on

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shall reimburse the provider of the diagnostic testing as follows:

. . .

(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 § 3202(a)(2) (emphasis added).

vessels, which only referred to vessels as an object of the obligation not to impose fees, did not provide a private right of action to the vessels. *Lil' Man*, 5 F.4th at 960 (quoting 33 U.S.C. § 5(b) ("No . . . fees . . . shall be levied upon or collected from any vessel or other water craft, or from its passengers or crew, by any non-Federal interest ")).

Here, Saloojas bases its claim on § 3202(a)(2)'s directive that an insurer "shall reimburse" the provider at "the cash price" of testing if the insurer "does not have a negotiated rate" with the provider. Like in *Logan* and *Lil' Man*, the focus of the provision is on the regulated party —the "group health plan or . . . health insurance issuer"— and the diagnostic test "provider" is only the object of the obligation. Accordingly, § 3202(a)(2) of the CARES Act does not contain rights-creating language that would evince Congress's intent to create a private right of action for providers to sue insurers.

Saloojas relies heavily on a single district court's decision from the Southern District of Texas which initially relied on § 3202(a)'s mandatory reimbursement language to find an implied private right of action under the CARES Act, *Diagnostic Affiliates of Northeast Hou, LLC v. United Healthcare Services, Inc.*, No. 2:21-CV-00131, 2022 WL 214101 (S.D. Tex. Jan. 18, 2022); however, that court ultimately reversed course. *Diagnostic Affiliates of Ne. Hou, LLC v. Aetna, Inc.*, No. 2:22-CV-00127, 2023 WL 1772197 (S.D. Tex. Feb. 1, 2023). Although no circuit court has addressed this question, we note that every district court that

has ruled on this issue has concluded that there is no private right of action under § 3202 of the CARES Act.[2] We agree.

Our conclusion is reinforced by other provisions of the CARES Act and FFRCA that lay out enforcement mechanisms. *See Logan*, 722 F.3d at 1172 ("Where a statutory scheme contains a particular express remedy or remedies, 'a court must be chary of reading others into it.'" (quoting *TAMA*, 444 U.S. at 19)). Section 3202(b) of the CARES Act authorizes the Secretary of Health and Human Services to impose a monetary penalty on any provider that fails to publicly post its cash price. That Congress chose to include an enforcement mechanism in the CARES Act that is limited to actions by the Secretary against a provider of testing services cuts strongly against a finding of intent to create a private remedy for those providers. *See Sandoval*, 532 U.S. at 289 ("Nor do the methods that § 602 goes on to provide for enforcing its authorized regulations manifest an intent to create a private remedy; if anything, they suggest the opposite."). Moreover, the CARES Act was passed soon after FFCRA and expands on the requirements in § 6001(a) of FFCRA. Section 6001 of FFCRA contains enforcement and implementation provisions for the Secretary of various agencies—Health and Human Services, Labor, and the Treasury. FFCRA § 6001(b), (c). Again, the fact that these provisions provide an enforcement mechanism but only through the Secretaries suggests a lack of congressional

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[2] *See, e.g.*, *Murphy Med. Assocs., LLC v. Cigna Health & Life Ins. Co.*, No. 3:20-CV-1675, 2022 WL 743088 (D. Conn. Mar. 11, 2022); *GS Labs, Inc. v. Medica Ins. Co.*, No. 21-CV-2400, 2022 WL 4357542 (D. Minn. Sept. 20, 2022); *BCBSM, Inc. v. GS Labs, LLC*, No. 0:22-CV-00513, 2023 WL 2044329, at *2–4 (D. Minn. Jan. 30, 2023); *Carr v. Kabbage, Inc.*, No. 1:22-CV-01249, 2023 WL 3150084, at *4 (N.D. Ga. Mar. 31, 2023) (collecting cases).

intent to create a private right of action for providers. *See Sandoval*, 532 U.S. at 289. Saloojas correctly points out that nothing in the language of the statute shows an intent to deny a remedy, but that statutory silence is not enough. As we explained in *Lil' Man*, "[a] statute must also display an intent to create a private remedy in order to create an implied right of action." 5 F.4th at 959. We therefore hold that the CARES Act does not grant a private right of actn to a provider of COVID-19 diagnostic testing to enforce § 3202.

V.

"Without [statutory intent], 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. Because the district court properly dismissed Saloojas's claims, we affirm.

AFFIRMED.

Appendix A

APPENDIX B - ORDER OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA, FILED JUNE 23, 2022

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

Case Nos.
22-cv-01696-JSC
22-cv-01702-JSC
22-cv-01703-JSC
22-cv-01704-JSC
22-cv-01706-JSC

SALOOJAS, INC.,

Plaintiff,

v.

AETNA HEALTH OF CALIFORNIA, INC.,

Defendant.

June 23, 2022, Decided
June 23, 2022, Filed

ORDER RE: MOTIONS TO DISMISS

Plaintiff, a healthcare provider, brings five related cases against an insurer for underpaying for COVID

testing of five patients. Before the Court are Defendant's identical motions to dismiss each of the five cases. (Case No. 22-cv-01696-JSC, Dkt. Nos. 5, 7, 14, 17, 19, 20; Case No. 22-cv-01702-JSC, Dkt. Nos. 7, 14, 18, 20, 21; Case No. 22-cv-01703-JSC, Dkt. Nos. 5, 11, 15, 17, 18; Case No. 22-cv-01704-JSC, Dkt. Nos. 6, 12, 16, 18, 19; Case No. 22-cv-01706-JSC, Dkt. Nos. 7, 14, 18, 20, 21.)[2] After carefully considering the parties' initial and supplemental briefing, *(see* Dkt. No. 18), the Court concludes that oral argument is unnecessary, *see* N.D. Cal. Civ. L.R. 7-l(b), and GRANTS the motions as explained below.

BACKGROUND

Plaintiff alleges Defendant underpaid for COVID tests that Plaintiff provided to Defendant's insureds between November 20 and 23, 2020. Plaintiff is outside of Defendant's provider network. It alleges that under Section 3202(a)(2) of the Coronavirus Aid, Relief, and Economic Security ("CARES") Act, Defendant must "pay the entire bill at posted prices without any deductions

1. *(See* Case No. 22-cv-01696-JSC, Dkt. No. 1 at 6 ("Patient ID no: 2069047"); Case No. 22-cv-01702-JSC, Dkt. No.1 at 6 ("Patient ID no: 2068896"); Case No. 22-cv-01703-JSC, Dkt. No. 1 at 6 ("Patient ID no: 2068125"); Case No. 22-cv-01704-JSC, Dkt. No.1-1 at 3 ("Patient ID no: 2068239"); Case No. 22-cv-01706-JSC, Dkt. No. 1 at 6 ("Patient ID no: 2069003").) A sixth related case does not have a pending motion to dismiss. (Case No. 22-cv-02887-JSC.)

2. Record citations are to material in the Electronic Case File ("ECF") for Case No. 22-cv-01696-JSC, unless otherwise indicated; pinpoint citations are to the ECF-generated page numbers at the top of the documents.

for cop[a]y or deductibles." (Dkt. No. 1 at 7.) For the five patients at issue, Plaintiff contends Defendant owes $922, $1,090, $1,090, $924, and $922, each rounded up to $2,500 to account for a "balance" of "punitive damages ... for intentional violation" of the CARES Act. *(Id.* at 6.)[3]

Plaintiff filed in small claims court in Alameda County. It attached as an exhibit an undated letter from Plaintiff to Defendant, on letterhead of AFC Urgent Care of Newark, appealing Defendant's payment decision and asserting that the CARES Act requires Defendant to pay Plaintiff's posted cash prices. *(Id.* at 12-15.) For two cases, Plaintiff attached October 2021 letters from Defendant to Plaintiff, each denying an appeal request because it was filed after the 60-day deadline. *(Id.* at 16-17; Case No. 22-cv-01703-JSC, Dkt. No. 1 at 16.) For the other three cases, Plaintiff attached an acknowledgement of appeal request, an acknowledgement of dispute, and an appeal denial, respectively.[4] (Case No. 22-cv-01702-JSC, Dkt. No. 1 at 17; Case No. 22-cv-01704-JSC, Dkt. No.1-1 at 13; Case No. 22-cv-01706-JSC, Dkt. No. 1 at 12.)

Thereafter, Defendant removed to federal court. Defendant moves to dismiss for failure to state a claim, *see* Fed. R. Civ. P. 12(b)(6), on the grounds that the CARES

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3. *(See* Case No. 22-cv-01702-JSC, Dkt. No. 1 at 6; Case No. 22-cv-01703-JSC, Dkt. No. 1 at 6; Case No. 22-cv-01704-JSC, Dkt.
No. 1-1 at 3; Case No. 22-cv-01706-JSC, Dkt. No. 1 at 6.)

4. The Court takes judicial notice of these documents attached to the complaints. *See Parks Sch. of Bus., Inc. v. Symington,* 51 F.3d 1480, 1484 (9th Cir. 1995).

Appendix B

Act does not provide a private right of action to Plaintiff.

DISCUSSION

Section 3202 of the CARES Act provides:

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 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.

Appendix B

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

(1) IN GENERAL.- During the emergency period declared under section 319 of the Public Health Service Act (42 U.S.C. 247d), 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.

Pub. L.116-136, § 3202 (Mar. 27, 2020), 134 Stat. 367. Thus, Section 3202 referenced and amended Section 6001(a) of the Families First Coronavirus Response Act ("FFCRA"). *See id.* § 3201; Pub. L. 116-127, § 6001(a) (Mar. 18, 2020), 134 Stat. 178. Section 6001, in turn, provides:

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 defined in paragraph (l)(B) of section 1135(g) of the Social Security Act (42
U.S.C. 1320b-5(g)) beginning on or after the date of the enactment of this Act:

(1) In vitro diagnostic products (as defined in section 809.3(a) of title 21, Code of Federal Regulations) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized under section 510(k), 513, 515 or 564 of the Federal Food, Drug, and Cosmetic Act, and the administration of such in vitro diagnostic products.

(2) 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 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 offering group or individual health insurance coverage 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, and subchapter B of chapter 100 of the Internal Revenue Code of 1986, as applicable.

(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.

(d) TERMS.-The terms "group health plan"; "health insurance issuer"; "group health insurance coverage", and "individual health insurance coverage" have the meanings given such terms in section **2791** of the Public Health Service Act (42 U.S.C. 300gg-91), section 733 of the Employee Retirement Income Security Act of 1974 (29 U.S.C.1191b), and section 9832 of the Internal Revenue Code of 1986, as applicable.

Pub. L.116-127, § 6001. Plaintiff bases its claim on CARES Act Section 3202(a)(2)'s directive that an insurer "shall reimburse" the provider at "the cash price" of testing if the insurer "does not have a negotiated rate" with the provider. Pub. L. 116-136, § 3202(a). Plaintiff concedes that the CARES Act provides no express right of action for its testing reimbursement claim, but argues there is an implied right of action.

"Like substantive federal law itself, private rights of action to enforce federal law must be created by Congress." *Alexanderv. Sandoval,* 532 U.S. 275,286,121 S. Ct.1511, 149 L. Ed. 2d 517 (2001). The Supreme Court's opinions in *Cort* and *Alexander* govern whether a statute implies a private right of action. *Id.; Cort v. Ash,* 422 U.S. 66, 95 S. Ct. 2080, 45 L. Ed. 2d 26 (1975); *see McGreevey v. PHH Mortg. Corp.,* 897 F.3d 1037, 1043-44 (9th Cir. 2018). *Cort* lays out four factors:

> 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?

422 U.S. at 78 (cleaned up). The Ninth Circuit has explained that the *Cort* factors "remain relevant," but "the focus now is on" *Alexander. McGreevey,* 897 F.3d at 1043. *Alexander* asks "whether Congress displays through the statute an intent to create not just a private right but also a private remedy. Statutory intent ... is determinative; without Congress's intent to create a remedy, no right of action can be implied." *Id.* at 1043-44 (cleaned up); *see also Touche Ross & Co. v. Redington,* 442 U.S. 560, 575, 99 S. Ct. 2479, 61 L. Ed. 2d 82 (1979) *("[Cort]* did not decide that each of these factors is entitled to equal weight. The central inquiry remains whether Congress intended to create, either expressly or by implication, a private cause of action."). Courts "begin ... [the] search for Congress's intent with the text and structure of" the statute. *Alexander,* 532 U.S. at 288.

The Court is aware of only two cases that have addressed whether an implied right of action exists for a testing reimbursement claim under the CARES Act. *See Murphy Med. Assocs., LLC v. Cigna Health & Life Ins. Co.,* No. 3:20cv1675(JBA), 2022 U.S. Dist. LEXIS 43351, 2022 WL 743088, at *2-6 (D. Conn. Mar. 11, 2022)
(no); *Diagnostic Affiliates of Northeast Hou v. United Healthcare Servs,* No. 2:21-CV-00131, 2022 U.S. Dist. LEXIS 14132, 2022 WL 214101, at *4-9 (S.D. Tex. Jan. 18, 2022) (yes).

A. Text and Structure of the CARES Act

The text and structure of the CARES Act do not show congressional intent to create a private right of action

for COVID-19 test providers like Plaintiff. The CARES Act creates rights and duties for providers: in Section 3202(a), the right to reimbursement of the published cash price from an insurer who does not have a negotiated rate, and in Section 3202(b), the duty to publish a cash price. Section 3202(a), the substantive basis for Plaintiff's claim, has no enforcement language. Pub. L. 116-136, § 3202(a). Section 3202(b) provides that the Secretary of Health and Human Services "may impose a civil monetary penalty on any provider of a diagnostic test ... that is not in compliance with" the requirement to publish a cash price. *Id.* § 3202(b). Thus, Section 3202 only contemplates enforcement against providers, not against insurers who fail to reimburse providers, and only administrative enforcement, not a private right of action.

For its part, FFCRA Section 6001 provides that the Secretaries of Health and Human Services, Labor, and the Treasury may enforce Section 6001(a) against "group health plans and health insurance issuers." Pub. L. 116- 127, § 6001(b); *see* Pub. L. 116-136, § 3202(a) (referencing FFCRA Section 6001(a)). Assuming without deciding that FFCRA Section 6001 allows the Secretaries to enforce CARES Act Section 3202(a) against insurers, that would not show congressional intent to create a private right of action for providers like Plaintiff to enforce the provision against insurers. *See Alexander,* 532 U.S. at 289 ("Nor do the methods that § 602 goes on to provide for enforcing its authorized regulations manifest an intent to create a private remedy; if anything, they suggest the opposite."); *see also Murphy Med. Assocs., LLC,* 2022 U.S. Dist. LEXIS 43351, 2022 WL 743088, at *5 n.5 (noting

Secretaries' joint Frequently Asked Questions document and ambiguity regarding administrative enforcement scheme).

In its supplemental brief, Plaintiff argues that it is separately entitled to challenge Defendant's reimbursement through private rights of action created by the Employee Retirement Income Security Act ("ERISA"). (Dkt. No. 20.) This argument fails because nothing in Plaintiff's complaint references ERISA. The small claims complaint states, "COVID TESTING SERVICE[S] under the CARES ACT were rendered Insurance company owes $922 and the balance is punitive damages to $2,500 for the intentional violation of the Federal CARES ACT." (Dkt. No. 1 at 6.) "[U]nder the CARES ACT sec 3202(a) (2)[,] Defendants are required to pay the entire bill at posted prices . . . . Plaintiff appealed the denial of full payment mandated under the CARES ACT "*(Id.* At 7.) Thus, the complaint does not "give the defendant fair notice" that ERISA provides "the grounds upon which" Plaintiff's claim rests. *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 555, 127 S. Ct. 1955, 167 L. Ed. 2d 929 (2007) (cleaned up). CARES Act Section 3202(a)'s reference to FFCRA Section 6001, which in turn refers to ERISA, is too removed to provide notice that Plaintiff's claim rests on an ERISA private right of action. *See* Pub. L. 116-136, § 3202(a); Pub. L. 116-127, § 6001(b), (d).

B. *Cort* Factors

Turning to the *Cort* factors, to the extent they "remain relevant," *McGreevey,* 897 F.3d at 1043, three

factors weigh in favor of an implied private right of action but the most important factor does not. *See Touche Ross,* 442 U.S. at 575 *("[Cort]* did not decide that each of these factors is entitled to equal weight.").

First, the CARES Act "create[s] a federal right in favor of" Plaintiff: the right to reimbursement at the posted cash price. *Cort,* 422 U.S. at 78; *see* Pub. L. 116-136, § 3202(a)(2). Third, it is "consistent with the underlying purposes of the legislative scheme to imply such a remedy." *Cort,* 422 U.S. at 78. The purpose of this part of the CARES Act scheme is to incentivize healthcare organizations to provide COVID-19 testing and to make testing widely available to prevent the spread of COVID-19. *See Diagnostic Affiliates of Northeast Hou,* 2022 U.S. Dist. LEXIS 14132, 2022 WL 214101, at *6 ("[T]he legislative objective was to ensure that COVID-19 testing was widely available to the entire population."), *9 ("Congress wanted widespread COVID-19 testing, which could only be accomplished by private entities quickly incurring the cost of establishing testing sites across the country and procuring the necessary supplies to administer tests."). Fourth, a cause of action for diagnostic testing reimbursement, particularly with respect to the global pandemic, is not "traditionally relegated to state law" or "in an area basically the concern of the States." *Cort,* 422 U.S. at 78.

The second, most important factor echoes *Alexander* in considering whether there is "any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one." *Id.* As explained above, there

is no indication of implicit intent to create such a remedy and Plaintiff concedes there is no indication of explicit intent. Although there is no indication of intent to deny a remedy, *see Diagnostic Affiliates,* 2022 U.S. Dist. LEXIS 14132, 2022 WL 214101, at *8, that is not enough to imply one. *See McGreevey,* 897 F.3d at 1043-44; *Murphy Med.,* 2022 U.S. Dist. LEXIS 43351, 2022 WL 743088, at *5 ("[I]
f Congress has manifested no intent to provide a private right of action, the Court cannot create one." (cleaned up)).

The district court's opinion in *Diagnostic Affiliates* does not persuade the Court otherwise. On the most important *Cort* factor and the primary inquiry under *Alexander,* the court concluded that "the administrative enforcement scheme cannot be said to evidence an intent to deny a private right of action." 2022 U.S. Dist. LEXIS 14132, 2022 WL 214101, at *8. "[C]lear 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.* This reasoning does not square with the Supreme Court's directive in *Alexander:* "The judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy. Statutory intent on this latter point is determinative." 532 U.S. at 286 (citation omitted). Thus, the reasoning in the other district court case, *Murphy Medical,* is more persuasive. 2022 U.S. Dist. LEXIS 43351, 2022 WL 743088, at *2-6.

Appendix B

* * *

The CARES Act does not provide an implied private right of action for Plaintiff to seek reimbursement of its posted cash price. Accordingly, Plaintiff's complaint does not state a claim on which relief could be granted. *See Johnson v. Riverside Healthcare Sys.,* 534 F.3d 1116, 1121 (9th Cir. 2008) (noting that dismissal under Rule 12(b)
(6) "may be based on either a lack of a cognizable legal theory or the absence of sufficient facts alleged under a cognizable legal theory" (cleaned up)).

Although amendment of a CARES Act claim would be futile, Plaintiff argues that it could amend its complaint to state a claim under ERISA. Without the benefit of full briefing, the Court cannot conclude that such claim would fail as a matter of law. Accordingly, leave to amend is proper. *See Yagman v. Garcetti,* 852 F.3d 859, 863 (9th Cir. 2017).

CONCLUSION

Defendant's motions to dismiss are GRANTED. Plaintiff may file amended complaints that assert claims under ERISA on or before **July 25, 2022.**

This Order disposes of Docket No. 5 in Case No. 22-cv- 01696-JSC; Docket No. 7 in Case No. 22-cv-01702-JSC; Docket No. 5 in Case No. 22-cv-01703-JSC; Docket No. 6 in Case No. 22-cv-01704-JSC; and Docket No. 7 in Case No. 22-cv-01706-JSC.

IT IS SO ORDERED.

Dated: June 23, 2022

/s/ Jacqueline Scott Corley
JACQUELINE SCOTT CORLEY
United States District Judge

APPENDIX C - RELEVANT STATUTORY PROVISIONS

THE CORONAVIRUS AID, RELIEF AND ECONOMIC SECURITY ("CARES") ACT

H.R. 748 PUB. L. NO.116-136

PART II-ACCESS TO HEALTH CARE FOR COVID-19 PATIENTS Subpart A-Coverage of Testing and Preventive Services

SEC. 3201. COVERAGE OF DIAGNOSTIC TESTING FOR COVID-19. Paragraph (1) of section 6001(a) of division F of the Families First Coronavirus Response Act (Public Law 116-127) is amended to read as follows: "

(1) An in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such a test, that-

"(A) is approved, cleared, or authorized under section 510(k), 513,515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb-3);

"(B) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb- 3), unless

and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable time frame;

"(C) is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID 19; or

"(D) other test that the Secretary determines appropriate in guidance.".

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 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.

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

(1) **IN GENERAL.-During** the emergency period declared under section 319 of the Public Health Service Act (42 U.S.C. 247d), 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.

Appendix C

SEC. 3203. RAPID COVERAGE OF PREVENTIVE SERVICES AND VACCINES FOR CORONAVIRUS.

(a) IN GENERAL.-Notwithstanding 2713(b) of the Public Health Service Act (42 U.S.C. 300gg-13), the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall require group health plans and health insurance issuers offering group or individual health insurance to cover (without cost sharing) any qualifying coronavirus preventive service, pursuant to section 2713(a) of the Public Health Service Act (42 U.S.C. 300gg-13(a)) (including the regulations under sections 2590.715-2713 of title 29, Code of Federal Regulations, section 54.9815-2713 of title 26, Code of Federal Regulations, and section 147.130 of title 45, Code of Federal Regulations (or any successor regulations)). The requirement described in this subsection shall take effect with respect to a qualifying coronavirus preventive service on the specified date described in subsection (b)(2).

(b) DEFINITIONS.-For purposes of this section:

(1) **QUALIFYING CORONAVIRUS PREVENTIVE SERVICE.-The** term "qualifying coronavirus preventive service" means an item, H. R. 748-88 service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is-

(A) an evidence-based item or service that has in effect a rating of *"A:.'* or "B" in the current recommendations of the United States Preventive Services Task Force; or

(B) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(2) **SPECIFIED DATE.-The** term "specified date" means the date that is 15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service as described in such paragraph.

(3) **ADDITIONAL TERMS.-In** this section, the terms "group health plan", "health insurance issuer", "group health insurance coverage", and "individual health insurance coverage" have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91), section 733 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Code, as applicable.

Appendix C

FAMILIES FIRST CORONAVIRUS RESPONSE ACT ("FFRCA'_) PUB. L. NO. 116-1127 (2020)

DIVISION F-HEALTH PROVISIONS

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 (including a grandfathered health plan (as defined in section 1251(e)ofthe Patient Protection and Affordable Care Act)) 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 defined in paragraph (l)(B) of section 1135(g) of the Social Security Act (42
U.S.C. 1320b-5(g)) beginning on or after the date of the enactment of this Act:

(1) In vitro diagnostic products (as defined in section 809.3(a) of title 21, Code of Federal Regulations) for the detec- tion of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized under section 510(k), 513, 515 or 564 of the Federal Food, Drug,and Cosmetic Act, and the administration of such in vitro diagnostic products.

(2) 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 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 purposesof 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 offering group or individual health insurance coverage 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, and subchapter B of chapter 100 of the Internal Revenue Code of 1986, as applicable.

(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.

(d)TERMS.-The terms "group health plan"; "health insurance issuer"; "group health insurance coverage", and "individual health insurance coverage" have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91), section 733 of the

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Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Codeof 1986, as applicable.

FILED

OCT 16 2023

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

SALOOJAS, INC., Plaintiff-Appellant, v. AETNA HEALTH OF CALIFORNIA, INC., Defendant-Appellee.	No. 22-16034 D.C. No. 3:22-cv-01696-JSC Northern District of California, San Francisco ORDER
SALOOJAS, INC., Plaintiff-Appellant, v. AETNA HEALTH OF CALIFORNIA, INC., Defendant-Appellee.	No. 22-16035 D.C. No. 3:22-cv-01702-JSC
SALOOJAS, INC., Plaintiff-Appellant, v. AETNA HEALTH OF CALIFORNIA, INC., Defendant-Appellee.	No. 22-16036 D.C. No. 3:22-cv-01703-JSC
SALOOJAS, INC.,	No. 22-16037

Plaintiff-Appellant, v. AETNA HEALTH OF CALIFORNIA, INC., Defendant-Appellee.	D.C. No. 3:22-cv-01704-JSC
SALOOJAS, INC., Plaintiff-Appellant, v. AETNA HEALTH OF CALIFORNIA, INC., Defendant-Appellee.	No. 22-16038 D.C. No. 3:22-cv-01706-JSC

Before: WARDLAW, NGUYEN, and KOH, Circuit Judges.

The panel has voted to deny the petition for panel rehearing en banc. The full court has been advised of the petition for rehearing en banc and no judge has requested a vote on whether to rehear the matter en banc. *See* Fed. R. App. P. 35. The petition for rehearing en banc, Dkt. 50, is DENIED.

CERTIFICATE OF WORD COUNT

Case No.
Case Name: *Saloojas, Inc vs. Aetna Health of California, Inc*
Title: Petition for Writ of Certiorari

Pursuant to Rule 33.1(h) of the Rules of this Court, I certify that the accompanying Petition for Writ of Certiorari, which was prepared using Century Schoolbook 14-point typeface, contains 6.029 words, excluding the parts of the document that are exempted by Rule 33.1(d). This certificate was prepared in reliance on the word-count function of the word-processing system (Microsoft Word) used to prepare the document.

I declare under penalty of perjury that the foregoing is true and correct.

DATED this 16th day of January 2023

Respectfully submitted,

/s/Michael Lynn Gabriel

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