# APPENDIX

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**APPENDIX A**

**IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT**

No. 17-10736

United States Court of Appeals
Fifth Circuit
**FILED**
March 19, 2019
Lyle W. Cayce
Clerk

ENCOMPASS OFFICE SOLUTIONS, INCORPORATED,

Plaintiff – Appellee,

v.

LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, doing business as BlueCross BlueShield of Louisiana,

Defendant – Appellant.

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

Before JONES, BARKSDALE, and WILLETT, Circuit Judges.

DON R. WILLETT, Circuit Judge:

Encompass Office Solutions, Inc. provided equipment and staffing for doctors to perform surgery in their own offices. Doctors and patients took to this service; insurers did not. Blue Cross and Blue Shield of Louisiana (BCBSLA) began denying Encompass's claims for in-office surgery support. BCBSLA instead paid a "Global Fee" to

the doctor who performed the surgery, as compensation for all related services.

Encompass sued BCBSLA for ERISA violations, breach of contract, defamation, and tortious interference with business relations. BCBSLA largely prevailed at trial. But the district court granted a new trial because of error in the jury charge. At the second trial, Encompass won on all claims and obtained a judgment in its favor. On appeal BCBSLA says that the new trial should never have been granted, that no reasonable jury could have answered the *contra non valentem* (discovery rule) issue in favor of Encompass, and that BCBSLA did not abuse its discretion in denying Encompass's claims.

We AFFIRM the judgment of the district court.

## I. BACKGROUND

### A. Factual

Encompass provided the equipment, drugs, supplies, and nursing staff necessary for a doctor to perform outpatient surgery in his own office, rather than in a hospital or ambulatory surgical center (ASC). This was a novel arrangement—at the time, neither Texas nor Louisiana licensed such mobile providers of ambulatory surgical care.

Generally, when a doctor performs surgery at a hospital or ASC, an insurer like BCBSLA receives three claims: one from the doctor for doing the actual surgery; one from the anesthesiologist, if used; and one from the hospital or ASC for services provided to assist the doctor. When a doctor performs surgery in his office, however, there is no facility claim because there is no separate facility.

Instead, BCBSLA pays doctors a Global Fee for these in-office surgeries. The Global Fee is greater than the fee paid to doctors for performing surgery at a hospital or ASC and is intended to compensate for all overhead costs of an in-office procedure.

When Encompass entered the market, it expanded doctors' ability to perform in-office surgeries. Encompass sought compensation from insurers by filing separate claims for its services. At all relevant times, Encompass was an out-of-network service provider for BCBSLA members. Because of this, Encompass obtained an assignment of benefits from each of its BCBSLA-insured patients. BCBSLA paid Encompass's claims for several months after Encompass entered the Louisiana market.

But in June 2010, BCBSLA received a tip that Encompass was submitting claims for services it had not provided. On investigation, BCBSLA found that Encompass was submitting claims, and being paid, for the same in-office surgeries as the performing doctors. BCBSLA's billing system would normally reject "duplicate" claims for surgery at a doctor's office. But it had been processing Encompass's claims because they used a code modifier. Encompass was using the "TC Modifier," which stands for "technical component" and covers the equipment, staff, and services necessary for surgery.

BCBSLA began denying Encompass's claims. BCBSLA also learned that other insurance companies were doing the same. In August 2010, BCBSLA Vice President Dawn Cantrell sent a letter to in-network providers directing them not to use Encompass's services. Because this letter is

the basis for Encompass's defamation and tortious interference claims, we quote it at length:

> Encompass is not eligible to participate in the BlueCross networks and is considered an out-of-network provider. Please do not use Encompass for services provided to BlueCross or [HMO Louisiana, Inc.] members since the facility fees charged by Encompass are not covered, even when they are billed by a network physician. Encompass would have to be a Louisiana licensed [Department of Health and Hospitals]-approved ambulatory surgery facility in order to be eligible for payment of these facility charges.
>
> You should also accept your contracted allowable charge for any eligible in-office surgeries you normally perform to be counted as payment in full and not allow Encompass to submit claims to Blue Cross. **Please ensure your Blue Cross patients are able to receive network benefits for the services they receive from you by using participating providers.**
>
> **If we find that any network physician is repeatedly using Encompass to deliver facility and procedure services that are not eligible for benefits and our members are being billed for these facility charges, the network physician will be subject to termination from the Blue Cross networks.**

Encompass obtained a copy of the Cantrell Letter and gave it to counsel. Encompass sought clarification from BCBSLA by calling Cantrell three times and leaving voicemail messages. It received no response. In October 2010, BCBSLA Audit Consultant Alan Lofton sent Encompass a separate letter demanding repayment of nearly $110,000 in paid claims. A few months later, Encompass sued.

**B. Procedural**

Encompass initially sued BCBSLA for payment on services provided to BCBSLA insureds. [1] Encompass alleged that BCBSLA had abused its discretion in denying Encompass's claims on ERISA-covered plans and breached its insurance contracts under state law by denying claims on non-ERISA plans.

In response, BCBSLA pleaded that under its policy a non-facility provider must seek payment from the site-of-service owner, usually the doctor who orders the services, and that Encompass knew this. BCBSLA explained that for surgeries in a "non-facility setting," the doctor's (and any other professional's) reimbursement is all-inclusive. In other words, BCBSLA pleaded its Global Fee policy.

In February 2013, Encompass deposed Cantrell and Lofton. Cantrell and Lofton testified they were not aware of a BCBSLA policy or benefit plan that said Encompass's services were not covered. And they were similarly unaware of a policy or plan

[1] Encompass's original complaint named only BlueCross BlueShield of Texas. The second amended complaint added BCBSLA and a host of BlueCross entities from other states.

permitting BCBSLA to terminate a physician for partnering with Encompass. This led Encompass to believe that the Cantrell Letter contained false statements. Because the Cantrell Letter damaged Encompass's Louisiana business, Encompass in April 2013 amended its complaint to add claims for defamation and tortious interference with business relations.

Both parties moved for summary judgment. The district court at first granted summary judgment to BCBSLA on Encompass's defamation and tortious interference claims because it held they were barred by Louisiana's one-year prescriptive period. [2] But on a motion for reconsideration it reversed this decision. It held instead that a genuine dispute of material fact existed as to whether Encompass was entitled to the benefit of a discovery rule—*contra non valentem*—that would suspend the prescriptive period.[3]

Trial arrived. Encompass tried its tort claims and non-ERISA contract claims to a jury, and its ERISA claims to the district court. The jury found no liability on the contract claims, and found that Encompass was not entitled to the benefit of *contra*

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[2] As the district court explained, "[t]he Louisiana Civil Code uses the term . . . 'liberative prescription' for statutes of limitation." *Encompass Office Sols., Inc. v. La. Health Serv. & Indem. Co.*, No. 3:11-CV-1471-P, 2013 WL 12310676, at *20 n.21 (N.D. Tex. Sept. 17, 2013) (citing *Prescription*, BLACK'S LAW DICTIONARY (9th ed. 2009)).

[3] "*Contra non valentem non currit praescriptio* means that prescription does not run against a person who could not bring his suit." *Wells v. Zadeck*, 89 So. 3d 1145, 1150 (La. 2012) (citing *Harvey v. Dixie Graphics, Inc.*, 593 So. 2d 351, 354 (La. 1992)).

*non valentem* on the tort claims. Because it resolved the prescription issue in BCBSLA's favor, the jury did not reach the merits of Encompass's tort claims.

Encompass moved for a new trial based on error in the jury charge, and the district court granted the motion. It held that the jury charge had imposed an incorrect liability standard for the non-ERISA contract claims. The original charge for these claims required the jury to find that BCBSLA "capriciously and arbitrarily" denied Encompass's claims for benefits. But it should only have required them to find the elements for Louisiana breach of contract. And, citing the potential for confusion, the court held that Encompass's tort claims must also be retried: "A finding that no breach occurred would reasonably cause the jury to find that no tort liability existed because the breach of contract claim underpins the basis for the tort claims." The district court did not rule on Encompass's ERISA claims at this stage.

At the second trial the jury found for Encompass on both its contract and tort claims, including finding that *contra non valentem* suspended prescription. The district court also found for Encompass on its ERISA claims. BCBSLA renewed its motion for judgment as a matter of law, moved for reconsideration, and moved for a new trial—all of which the district court denied. The district court entered judgment for Encompass, and BCBSLA appealed.

## II. JURISDICTION AND STANDARDS OF REVIEW

### A. Jurisdiction

The district court had jurisdiction based on complete diversity, 28 U.S.C. § 1332; and under ERISA, 29 U.S.C. §§ 1001 *et seq*. This court has jurisdiction under 28 U.S.C. § 1291.

### B. Standards of Review

#### *1. Grant of a New Trial*

"We review the district court's grant or denial of a new trial for abuse of discretion."[4] "A greater degree of scrutiny, however, is given to the grant of a new trial."[5] "[W]e exercise broad review of a court's grant of a new trial because of our respect for the jury as an institution and our concern that the party who persuaded the jury should not be stripped unfairly of a favorable decision."[6]

#### *2. Judgment as a Matter of Law*

"We review de novo the district court's denial of a motion for judgment as a matter of law, applying the same standards as the district court."[7] Judgment as a matter of law is proper if "a party has been fully heard on an issue during a jury trial

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[4] *Gutierrez v. Excel Corp.*, 106 F.3d 683, 687 (5th Cir. 1997) (citing *Allied Bank–W., N.A. v. Stein*, 996 F.2d 111, 115 (5th Cir. 1993)).

[5] *Scott v. Monsanto Co.*, 868 F.2d 786, 789 (5th Cir. 1989) (citing *Conway v. Chem. Leaman Tank Lines, Inc.*, 610 F.2d 360, 362–63 (5th Cir. 1980) (per curiam)).

[6] *Gutierrez*, 106 F.3d at 687 (alteration in original) (quoting *Stein*, 996 F.2d at 115).

[7] *Abraham v. Alpha Chi Omega*, 708 F.3d 614, 620 (5th Cir. 2013) (citing *Ill. Cent. R.R. Co. v. Guy*, 682 F.3d 381, 392–93 (5th Cir. 2012)).

and . . . a reasonable jury would not have a legally sufficient evidentiary basis to find for the party on that issue."[8]

"We review all the evidence in the record in the light most favorable to the nonmoving party and draw all reasonable inferences in favor of the nonmoving party; we do not make credibility determinations or weigh the evidence." [9] We "cannot reverse a denial of a motion for judgment as a matter of law unless the jury's factual findings are not supported by substantial evidence, or if the legal conclusions implied from the jury's verdict cannot in law be supported by those findings."[10] In other words, the party moving for judgment as a matter of law can prevail only "if the facts and inferences point so strongly and overwhelmingly in favor of the moving party that reasonable jurors could not have arrived at a contrary verdict."[11] Although our review is *de novo*, "[a]fter a jury trial, [the] standard of review is especially deferential."[12]

***3. ERISA § 502(a)(1)(B) Claims***

"On appeal from a bench trial, this court review[s] the factual findings of the trial court for clear error and conclusions of law *de novo*,"

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[8] FED R. CIV. P. 50(a).

[9] *Homoki v. Conversion Servs., Inc.*, 717 F.3d 388, 395 (5th Cir. 2013) (citing *Poliner v. Tex. Health Sys.*, 537 F.3d 368, 376 (5th Cir. 2008)).

[10] *OneBeacon Ins. Co. v. T. Wade Welch & Assocs.*, 841 F.3d 669, 676 (5th Cir. 2016) (quoting *Am. Home Assurance Co. v. United Space All., LLC*, 378 F.3d 482, 488 (5th Cir. 2004)).

[11] *Homoki*, 717 F.3d at 395 (citing *Poliner*, 537 F.3d at 376).

[12] *Abraham*, 708 F.3d at 620 (second alteration in original) (quoting *Brown v. Sudduth*, 675 F.3d 472, 477 (5th Cir. 2012)).

applying the same standard as the district court.[13] Because the plans at issue grant BCBSLA discretion to determine eligibility for plan benefits and construe the terms of the plans, we apply the abuse of discretion standard.[14] Thus, if BCBSLA's "decision is supported by substantial evidence and is not arbitrary and capricious, it must prevail."[15]

## III. DISCUSSION

### A. District Court's Grant of a New Trial

In the first trial, the court instructed the jury that BCBSLA was liable on Encompass's non-ERISA claims if it had arbitrarily and capriciously denied claims for benefits:

> The burden is on Encompass to prove that BCBS Louisiana had sufficient proof that payment on a claim was due and that the claim was capriciously and arbitrarily denied by BCBS Louisiana. An insurer is arbitrary and capricious when it does not act in a reasonable manner based on the facts known at the time of the decision.

In its motion for a new trial, Encompass successfully argued that this charge had erroneously imported the arbitrary-and-capricious

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[13] *Conn. Gen. Life Ins. Co. v. Humble Surgical Hosp., L.L.C.*, 878 F.3d 478, 483 (5th Cir. 2017) (alteration in original) (quoting *George v. Reliance Standard Life Ins. Co.*, 776 F.3d 349, 352 (5th Cir. 2015)).

[14] *Id.* (citing *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 295 (5th Cir. 1999) (en banc), *overruled on other grounds by Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115–19 (2008)).

[15] *Singletary v. United Parcel Serv., Inc.*, 828 F.3d 342, 347 (5th Cir. 2016) (quoting *Corry v. Liberty Life Assurance Co. of Boston*, 499 F.3d 389, 397 (5th Cir. 2007)).

standard and should, instead, have simply stated the Louisiana elements of contract.

**1. *New Trial on the Contract Claims***

BCBSLA contends that the original charge was correct, and the second trial should never have happened. It says that the Louisiana Prompt Payment Statute,[16] not the general contract statute, governs an insurer's breach of a health insurance contract. The Prompt Payment Statute imposes penalties on insurers who do not, within 30 days, pay any claim that does not present reasonable grounds for denial:

> All claims arising under the terms of health and accident contracts issued in this state, except as provided in Subsection B of this Section, shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the policy, are furnished to the insurer unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. . . . Failure to comply with the provisions of this Section shall subject the insurer to a penalty . . . together with attorney fees to be determined by the court.[17]

Although the words "arbitrary and capricious" do not appear in this section, Louisiana courts have adopted that standard for insurer liability.[18] This

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[16] LA. STAT. ANN. § 22:1821.
[17] *Id.* § 22:1821(A).
[18] *Stewart v. Calcasieu Par. Sch. Bd.*, 933 So. 2d 797, (La. Ct. App. 2006) (interpreting predecessor LA. STAT. ANN. § 22:657).

is because the statute is "penal in nature" and must be "strictly construed."[19] BCBSLA says that because the statute governs "[a]ll claims arising under the terms of health and accident contracts issued in this state,"[20]and specific statutes trump general ones, [21] this section provides the appropriate standard of liability for Encompass's contract claims.

BCBSLA also contends that Encompass itself invoked the Prompt Payment Statute for its non-ERISA contract claims. Besides contract damages, Encompass's operative complaint demanded attorney's fees, costs, and "statutory penalties under Texas and Louisiana law requiring the prompt payment of claims by insurance carriers." And in its submission for the joint pretrial order, Encompass listed "[w]hether BCBSLA abused its discretion by denying Encompass's claims" as a contested legal issue.

Neither of these theories can rehabilitate the first jury charge. Louisiana contract law governs Encompass's claims for benefits under non-ERISA plans because, although it is true that the Prompt Payment Statute applies to all Louisiana health insurance contracts, "[u]nder Louisiana law, the cause of action under [§ 22:1821] is separate and distinct from the cause of action for the breach of

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[19] *Id.* (quoting *Marien v. Gen. Ins. Co. of Am.*, 836 So. 2d 239, 249 (La. Ct. App. 2002)).

[20] LA. STAT. ANN. § 22:1821.

[21] *Cf., e.g.*, *Pumphrey v. City of New Orleans*, 925 So. 2d 1202, 1210 (La. 2006) ("[T]he statute specifically directed to the matter at issue must prevail as an exception to the statute more general in character." (citing *Kennedy v. Kennedy*, 699 So. 2d 351, 358 (La. 1996))).

the insurance contract."[22] Encompass alleged a Louisiana contract claim. So even if it also alleged a Prompt Payment Statute claim, it had the right to a correct jury instruction on the contract claim.[23] This is particularly true where, as here, it is easier to prove that the defendant breached a contract than that it did so arbitrarily and capriciously.

BCBSLA has another independent argument. It contends that the first jury charge was correct because the insurance plans, by their terms, granted BCBSLA discretion in choosing whether to allow or deny a claim. And in analogous contexts, "abuse of discretion" and "arbitrary and capricious" are legally equivalent.[24] Thus, BCBSLA says that the jury was properly instructed to find contract

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[22] *Hymel v. HMO of La., Inc.*, 951 So. 2d 187, 199 (La. Ct. App. 2006) (citing *Cramer v. Ass'n Life Ins. Co., Inc.*, 563 So. 2d 267, 275 (La. Ct. App.), *rev'd on other grounds*, 569 So. 2d 533 (La. 1990)) (interpreting predecessor LA. STAT. ANN. § 22:657); *see Cantrelle Fence & Supply Co., Inc. v. Allstate Ins. Co.*, 515 So. 2d 1074, 1079 (La. 1987) (holding that cause of action under analogous insurance penalty statute was "separate and distinct from the obligation arising out of the contractual relationship under the insurance policy").

[23] *See Aero Int'l, Inc. v. U.S. Fire Ins. Co.*, 713 F.2d 1106, 1113 (5th Cir. 1983) ("[The party] was entitled to have the critical issues bearing upon its liability 'submitted to and answered by the jury upon a clear and proper charge.'" (quoting *NMS Indus., Inc. v. Premium Corp. of Am.*, 451 F.2d 542, 545 (5th Cir. 1971))).

[24] *See Anderson v. Cytec Indus., Inc.*, 619 F.3d 505, 512 (5th Cir. 2010) ("[T]here is only a semantic, not a substantive, difference between the arbitrary and capricious and the abuse of discretion standards in the ERISA benefits review context." (quoting *Meditrust Fin. Servs. Corp. v. Sterling Chems., Inc.*, 168 F.3d 211, 214 (5th Cir. 1999))).

liability only if BCBSLA had arbitrarily and capriciously denied a claim.

This theory is not quite correct. BCBSLA argues that the first jury charge properly included an interpretation of the contracts. But the district court rejected this argument when it granted a new trial, holding in effect that the interpretation was not supported by Louisiana law.[25] We agree. No cited Louisiana authority supports an arbitrary and capricious standard for breach of health insurance contracts—even those that grant discretion to the insurer. And the district court has discretion of its own to either interpret contract terms as a matter of law or leave them to the factfinder. [26] "Although the interpretation of a contract is normally a question of law for the Court, that interpretation frequently depends heavily on the resolution of factual disputes. And it is the function of the trier of fact to resolve such factual disputes."[27]

In short, charging the jury with an incorrect standard of liability supports granting a new trial.[28] And the jury indicated confusion from the

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[25] *See Hymel*, 951 So. 2d at 199 (affirming general contract law jury instruction for contract claim and separate instruction for Prompt Payment Statute claim).

[26] *See Cook Indus., Inc. v. Cmty. Grain, Inc.*, 614 F.2d 978, 980 (5th Cir. 1980) (affirming district court's decision not to interpret contract as matter of law).

[27] *Id.* (citing *Gen. Wholesale Beer Co. v. Theodore Hamm Co.*, 567 F.2d 311, 313 (5th Cir. 1978)).

[28] *See Pinkerton v. Spellings*, 529 F.3d 513, 519 (5th Cir. 2008) (granting new trial because jury instruction wrongly imposed elevated standard for liability); *Aero*, 713 F.2d at 1113 ("A new trial is the appropriate remedy for prejudicial errors in jury instructions." (citing *NMS Indus., Inc. v. Premium Corp.*

improper instruction.[29] Its note to the court shows that the erroneous legal standard was front and center in deliberations: "Can you clearly define Arbitrary and Capricious in the eyes of the court[?]" [30] The district court did not abuse its discretion when it granted a new trial on Encompass's contract claims.

***2. New Trial on the Tort Claims***

The district court held that Encompass's tort claims should also be retried because they were related to the mischarged contract claims. In the district court's view, breach of the contracts was a basis of the tort claims. BCBSLA disputes this. It contends that the jury could not possibly have been confused by overlap of tort and contract issues because it never reached the merits of the tort claims. Indeed, the jury answered "no" to whether Encompass could invoke *contra non valentem* to toll prescription for the tort claims, preventing it from reaching the tort merits questions on the verdict form.

Under Federal Rule of Civil Procedure 59(a), the district court may "grant a new trial on all or some of the issues." "[P]artial new trials should not be resorted to unless it appears that the issue to be retried is so distinct and separable from the others that a trial of it alone may be had without

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*of Am., Inc.*, 451 F.2d 542, 545 (5th Cir. 1971); *Phillips v. State Farm Mut. Auto. Ins. Co.*, 437 F.2d 365 (5th Cir. 1971))).

[29] *See, e.g.*, *Aero*, 713 F.2d at 1113 n.6 (citing jury note as indication of jury confusion).

[30] The court responded by identifying this sentence in the jury charge: "An insurer is arbitrary and capricious when it does not act in a reasonable manner based on the facts known at the time of the decision."

injustice."[31] "Therefore, when the issues subject to retrial are so interwoven with other issues in the case that they 'cannot be submitted to the jury independently . . . without confusion and uncertainty, which would amount to a denial of a fair trial,' then it is proper to grant a new trial on all of the issues raised." [32] In addition to considering "interdependence of [the] issues," we also consider "an overlapping of proof" relevant to those issues.[33]

Under this standard, the district court did not abuse its discretion by granting a new trial on the tort claims. Whether Encompass's claims for benefits should have been paid was a common issue between the contract and tort claims—it affects the tort claims because it affects the truth or falsity of the Cantrell letter.[34] And proof of BCBSLA's internal decision making may be relevant to both whether it performed its contractual duties and whether it defamed or tortiously interfered with Encompass.[35]

### B. Judgment as a Matter of Law on Encompass's Tort Claims—Prescription and *Contra Non Valentem*

BCBSLA says that the district court should have granted its renewed motion for judgment as a

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[31] *Anderson v. Siemens Corp.*, 335 F.3d 466, 475 (5th Cir. 2003) (quoting *Colonial Leasing of New England, Inc. v. Logistics Control Int'l*, 770 F.2d 479, 481 (5th Cir. 1985)).

[32] *Colonial Leasing*, 770 F.2d at 481 (ellipsis in original) (quoting *Gasoline Prods. Co. v. Champlin Ref. Co.*, 283 U.S. 494, 500 (1931)).

[33] *Id.*

[34] *See Anderson*, 335 F.3d at 475.

[35] *See Colonial Leasing*, 770 F.2d at 481.

matter of law based on prescription. It is undisputed that the applicable prescriptive period for Encompass's tort claims is one year, and that over a year passed between Encompass receiving the Cantrell letter and first claiming defamation and tortious interference. But the jury in the second trial found that prescription was suspended under the doctrine of *contra non valentem*.

Under Louisiana law, "[t]he defendant has the initial burden of proving that a tort claim has prescribed, but if the defendant shows that one year has passed between the tortious acts and the filing of the lawsuit, then the burden shifts to the plaintiff to prove an exception to prescription."[36] "[*C*]*ontra non valentem* prevents the running of liberative prescription . . . where the cause of action is neither known nor reasonably knowable by the plaintiff even though plaintiff's ignorance is not induced by the defendant."[37] Under this standard, "[c]onstructive knowledge is whatever notice is enough to excite attention and put the injured party on guard and call for inquiry."[38] "[T]his principle will not exempt the plaintiff's claim from the running of prescription if his ignorance is attributable to his own wilfulness or neglect; that is, a plaintiff will be deemed to know

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[36] *Terrebonne Par. Sch. Bd. v. Columbia Gulf Transmission Co.*, 290 F.3d 303, 320 (5th Cir. 2002) (citing *Miley v. Consol. Gravity Drainage Dist. No. 1*, 642 So. 2d 693, 696 (La. Ct. App. 1994); *Dixon v. Houck*, 466 So. 2d 57, 59 (La. Ct. App. 1985)).

[37] *Marin v. Exxon Mobil Corp.*, 48 So. 3d 234, 245 (La. 2010) (citing *Plaquemines Par. Comm'n Council v. Delta Dev. Co.*, 502 So. 2d 1034 (La. 1987)).

[38] *Id.* at 246 n.12 (quoting *Campo v. Correa*, 828 So.2d 502, 510–11 (La. 2002)).

what he could by reasonable diligence have learned."[39]

The Supreme Court of Louisiana has not evaluated *contra non valentem* for a defamation or false-statement claim. So "we must make an 'Erie guess' and determine as best we can what the highest court of the state would be most likely to decide." [40] We may look to the decisions of intermediate state courts for guidance. "Indeed, 'a decision by an intermediate appellate state court is a datum for ascertaining state law which is not to be disregarded by a federal court unless it is convinced by other persuasive data that the highest court of the state would decide otherwise.'"[41]

BCBSLA maintains that *contra non valentem* does not apply as a matter of law. Encompass had a copy of the Cantrell Letter in 2010. The letter immediately caused Encompass to confer with counsel and seek clarification from BCBSLA. But Encompass waited until 2013 to allege tort claims. And in BCBSLA's view, Encompass is in a dilemma: Encompass's contract theory, which it was pursuing around the same time it received the Cantrell Letter, requires the letter to be wrong about coverage. But Encompass's *contra non valentem* theory only works if Encompass was ignorant of the letter's falsity.

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[39] *Id.* at 246 (quoting *Renfroe v. State ex rel. Dep't of Transp. & Dev.*, 809 So. 2d 947, 953 (La. 2002)).
[40] *Terrebonne Par.*, 290 F.3d at 317 (citing *Barfield v. Madison County*, 212 F.3d 269, 271–72 (5th Cir. 2000)).
[41] *Id.* (quoting *First Nat'l Bank of Durant v. Trans Terra Corp.*, 142 F.3d 802, 809 (5th Cir. 1998)).

Encompass contends that the Cantrell Letter falsified BCBSLA internal policies, which it could not discover until 2013 despite diligent inquiry. Although some statements in the letter were independently verifiable, Encompass says others were simultaneously false, damaging, and opaque to outsiders. Encompass argued that the letter misrepresented Encompass's "eligib[ility] to participate in the Blue Cross networks" and "eligib[ility] for benefit payment." Eligibility to be in the network, as distinct from present network status or plan coverage for a service, was a matter of BCBSLA policy. And according to Encompass, "eligib[ility]" for payment was too. Encompass says these statements damaged its business by discouraging doctors from working with it. Encompass also says its diligence to investigate the letter—calling Cantrell three times in 2010 and leaving messages without response—was reasonable under the circumstances.

We believe the Supreme Court of Louisiana would hold that *contra non valentem* was supported by the evidence here. The issue is close and we are mindful of the "especially deferential" standard of review for the jury verdict.[42] BCBSLA challenges only the sufficiency of the evidence, not the jury instruction. The district court rejected BCBSLA's argument when it denied judgment as a matter of law. We do so as well. Our dissenting colleague takes a broader view of constructive notice and a stricter one of the required diligence. But, in this instance, we find no Louisiana case standing directly against *contra non valentem* and

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[42] *Abraham*, 708 F.3d at 620 (quoting *Brown*, 675 F.3d at 477).

some cases that support it, especially given our standard of review.

Louisiana intermediate appellate court decisions show that *contra non valentem* suspends prescription for defamation and other false-statement claims if a reasonably diligent plaintiff knows about the adverse statement but has not discovered it is false. In *Quixx*, for example, the insurer plaintiff received applications containing false statements, but prescription did not begin to run until it discovered facts inconsistent with those statements.[43] (The claims were prescribed anyway because the insurer waited more than a year to file suit.[44]) In another case, *Simmons*, the plaintiffs argued that *contra non valentem* suspended prescription of a tortious interference claim until they discovered that the defendant's financial statements were falsified.[45] The court agreed. The plaintiffs did not have constructive knowledge of falsity until receiving disclosures during litigation, even though their dispute with the defendants began over a year earlier.[46] These cases show that a plaintiff can be aware of a statement without having constructive knowledge of its falsity. They also show that a plaintiff need not file suit just because an adverse party publicizes unfavorable statements that are not immediately verifiable.

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[43] *Nat'l Council on Comp. Ins. v. Quixx Temp. Servs., Inc.*, 665 So. 2d 120, 123–24 (La. Ct. App. 1995).
[44] *Id.*
[45] *Simmons v. Templeton*, 723 So. 2d 1009, 1012 (La. Ct. App. 1998).
[46] *Id.* at 1011–12.

Cases setting a stricter diligence bar are distinguishable. In *Rozas* the plaintiff, a doctor, argued that *contra non valentem* suspended prescription as long as his former employer withheld a personnel file that defamed him as clinically incompetent.[47] The court disagreed, because the plaintiff's own lack of diligence kept him from getting the file. The court said he should have taken measures "beyond making one telephone call to a secretary."[48] This initially seems comparable to Encompass's diligence. But Rozas was in a different position. He already knew the defamatory statements' general content *and falsity*: The defendant had rated him clinically incompetent.[49] This weighed heavily in the court's analysis that he had constructive knowledge of a cause of action. "[P]laintiff had sufficient facts to make him aware that he potentially had a claim against L.S.U. in 1980 when he learned that L.S.U. had given him a poor clinical evaluation."[50] But here the falsity concerned BCBSLA's internal policies, and Encompass did not discover it until 2013.

And the appellate cases *Greenblatt* and *Neyrey* are distinguishable because the plaintiffs exercised no diligence at all.[51] These are easier cases where the plaintiffs would have known about a cause of action if they took any timely action to obtain the

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[47] *Rozas v. Dep't of Health & Human Res.*, 522 So. 2d 1195, 1196–97 (La. Ct. App. 1988).
[48] *Id.* at 1197.
[49] *Id.*
[50] *Id.*
[51] *Greenblatt v. Payne*, 929 So. 2d 193, 196 (La. Ct. App. 2006); *Neyrey v. Lebrun*, 309 So. 2d 722, 723 (La. Ct. App. 1975).

defendants' adverse statements. The federal district court case *Safford* is similar.[52] Here, in contrast, Encompass sought clarification about the Cantrell Letter multiple times.

Cases stating that consulting with counsel shows constructive knowledge of a claim are also distinguishable. These cases generally involved personal injuries where consulting counsel logically showed awareness of the cause of action.[53] But here the parties were in a business dispute with many potential legal theories. Consulting counsel about one legal injury does not show that a party knew or should have known about other legal injuries that are based on different facts.[54] This is especially so given Encompass's position that the falsity was known only to BCBSLA.

Encompass can escape the posited tort-contract dilemma without contradiction. Encompass says that BCBSLA breached contracts by refusing to pay covered benefits and committed torts by spreading related statements that were false.[55] It

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[52] *Safford v. PaineWebber, Inc.*, 730 F. Supp. 15, 18 (E.D. La. 1990) (holding *contra non valentem* inapplicable because defamatory statements were available at plaintiff's request).

[53] 53 *See Med. Review Panel Proceeding of Williams v. Lewis*, 17 So. 3d 26, 30 (La. Ct. App. 2009) (medical malpractice for surgery complication); *Derrick v. Yamaha Power Sports of New Orleans*, 850 So. 2d 829, 833 (La. Ct. App. 2003) (workers compensation for gunshot wound to hand); *Clofer v. Celotex Corp.*, 528 So. 2d 1074, 1076 (La. Ct. App. 1988) (suit against former employer for lung damage).

[54] 54 *See, e.g.*, *Simmons*, 723 So. 2d at 1011–12 (explaining that transaction was in 1986, litigation began in November 1987, falsity was discovered in March 1989, and prescription did not begin to run until March 1989).

[55] *Cf. Marshall Invs. Corp. v. R.P. Carbone Co.*, No. 05-6486, 2006 WL 2644959, at *5 (E.D. La. Sept. 13, 2006) (malicious

is not implausible that Encompass immediately considered the Cantrell Letter a breach of contract but only later knew the other statements might be false. Not every anticipatory breach of contract is tortious. Consider: In a garden-variety defamation case, the truth or falsity of the statement is readily knowable to the plaintiff—because it is about the plaintiff.[56] Here, in contrast, Encompass says that BCBSLA defamed it by making false statements about Encompass's status under BCBSLA's own policies. These policies were opaque to Encompass when it received the letter. And Encompass's inquiries to BCBSLA do not show constructive knowledge either. There is no inconsistency in investigating the letter for the ongoing coverage dispute but not knowing it contained false statements.

Encompass's status as a sophisticated corporation does not change this. The Supreme Court of Louisiana teaches that the proper "blueprint" to evaluate reasonable delay for *contra non valentem* is "looking to the record for evidence of facts within plaintiff's knowledge and then examining the reasonableness of plaintiff's inaction in light of those facts, considering plaintiff's education, intelligence and the nature of defendant's conduct."[57] The circumstances of each case determine the applicability of the doctrine.[58]

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statement as element of tortious interference with business relations); *Costello v. Hardy*, 864 So. 2d 129, 139 (La. 2004) (false statement as element of defamation).

[56] *See, e.g.*, *Safford*, 730 F. Supp. at 16–17 (evaluating alleged defamatory statement that plaintiff engaged in sexual misconduct).

[57] *Wells*, 89 So. 3d at 1151.

[58] *Id.* at 1154.

Here the jury heard evidence of each blueprint factor.

Some evidence showed that in 2010 Encompass knew the Cantrell Letter stated unfavorable BCBSLA policies but not that those statements were false. Some evidence also showed that BCBSLA's conduct included misstating its policies and refusing to clarify things. And some evidence showed that Encompass was a corporation advised by counsel. So the jury had sufficient evidence to assess all the factors that Louisiana law considers.[59] It reached a "Yes" verdict on whether *contra non valentem* applied. In reviewing denial of judgment as a matter of law, we may not reweigh the evidence.[60] Drawing all inferences in favor of Encompass, as we must, the application of *contra non valentem* was not wrong as a matter of law.[61]

### C. Encompass's ERISA Claims

ERISA aims to promote the interests of plan participants and their beneficiaries and to "protect contractually defined benefits."[62] ERISA enshrines a patient's right to the "full and fair review" of her claim.[63] As a result, § 502(a)(1)(B) permits a plan participant to sue to "recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights

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[59] *Id.* at 1151.
[60] *See Homoki*, 717 F.3d at 395.
[61] *See id.*
[62] *N. Cypress Med. Ctr. Operating Co., Ltd. v. Cigna Healthcare (NCMC)*, 781 F.3d 182, 194 (5th Cir. 2015) (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113–14 (1989)).
[63] 29 U.S.C. § 1133(2).

to future benefits under the terms of the plan."[64] Here, Encompass contends that it is an assignee entitled to enforce patients' rights to benefits under BCBSLA plans. BCBSLA challenges Encompass's right to advance claims for benefits, as well as the district court's ultimate conclusion that BCBSLA abused its discretion in administering the plans.

***1. Anti-Assignment Provisions***

BCBSLA says that, under the plans' anti-assignment provisions, Encompass lacked derivative standing to sue for benefits. The district court found that BCBSLA waived the anti-assignment provisions because it made payments to, and communicated with, Encompass on at least some claims. BCBSLA's only direct challenge to this conclusion is that Encompass did not offer a jury charge on waiver. To the extent BCBSLA argues that waiver could only have been found by the jury, we disagree. It is well known that ERISA claims are the statutory cousins of equitable actions and so are tried to the court.[65] Waiver of the anti-assignment clauses—a related issue that is itself equitable—was here also properly decided by the district court.[66] So the anti-assignment

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[64] *Id.* § 1132(a)(1)(B).

[65] 65 *Calamia v. Spivey*, 632 F.2d 1235, 1237 (5th Cir. Unit A 1980) ("[S]imilar claims were previously considered equitable and . . . the kind of determination required—whether the pension fund acted arbitrarily and capriciously—was one traditionally performed by judges." (citing *Wardle v. Cent. States, Se. & Sw. Areas Pension Fund*, 627 F.2d 820, 829–30 (7th Cir. 1980))).

[66] 66 *See* FED R. CIV. P. 39(a) ("The trial on all issues so demanded must be by jury unless: . . . the court, on motion or on its own, finds that on some or all of those issues there is no

clauses do not frustrate Encompass's recovery on ERISA claims.

### *2. Contractual Limitations Periods*

BCBSLA also contends that the plans' 15-month limitations provisions bar some of Encompass's claims.[67] ERISA § 502(a)(1)(B) contains no statute of limitations, but the parties are free to agree to a reasonable limitations period.[68] The district court held that the contractual limitations provisions here were unenforceable across the board because BCBSLA never gave notice of them to Encompass. It cited decisions from other circuits holding that, based on ERISA's implementing regulations, notice is required for similar provisions to be enforceable.[69] BCBSLA does not appear to dispute this notice theory. As a result, we do not disturb the district

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federal right to a jury trial."); *Austin v. Shalala*, 994 F.2d 1170, 1177 n.7 (5th Cir. 1993) (explaining that an equitable defense—even to a legal claim—is tried to the court); *Reg'l Props., Inc. v. Fin. & Real Estate Consulting Co.*, 752 F.2d 178, 182–83 (5th Cir. 1985) (holding under Texas law that waiver is equitable defense).

[67] BCBSLA maintains that its October 4, 2010 demand letter placed Encompass on notice that its claims would be denied. Encompass waited over 15 months from this date to file suit. So BCBSLA contends that all Encompass claims submitted before October 4, 2010 are barred by limitations.

[68] *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 571 U.S. 99, 105–06 (2013).

[69] *See Santana-Diaz v. Metro. Life Ins. Co.*, 816 F.3d 172, 179–82 (1st Cir. 2016) (citing 29 C.F.R. § 2560.503–1(g)(1)(iv) for proposition that administrator must provide notice of limitations period when denying benefits); *Mirza v. Ins. Adm'r of Am., Inc.*, 800 F.3d 129, 137–38 (3d Cir. 2015) (same); *Moyer v. Metro. Life Ins. Co.*, 762 F.3d 503, 507 (6th Cir. 2014) (same).

court's conclusion that the contractual limitations provisions are unenforceable.

***3. Abuse of Discretion***

We now review the merits of Encompass's ERISA claims. To determine whether an administrator abused its discretion in construing a plan's terms, we analyze its plan interpretation in two steps.[70] First, was BCBSLA's reading "legally correct"?[71] ERISA plans must be written "to be understood by the average plan participant,"[72] so plans "are interpreted in their ordinary and popular sense as would a person of average intelligence and experience."[73] The "most important factor to consider" is whether BCBSLA's "interpretation is consistent with a fair reading of the plan[s]."[74] If so, the inquiry ends, and there was no abuse of discretion.[75] Otherwise, the court "must then determine whether [BCBSLA's] decision was an abuse of discretion."[76] "[T]his court may bypass, without deciding, the issue whether the Plan Administrator's denial was legally correct, reviewing only whether the Plan

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[70] *Humble Surgical Hosp.*, 878 F.3d at 483; *NCMC*, 781 F.3d at 195 (citing *Stone v. UNOCAL Termination Allowance Plan*, 570 F.3d 252, 257 (5th Cir. 2009)).
[71] *Humble Surgical Hosp.*, 878 F.3d at 483 (quoting *NCMC*, 781 F.3d at 195).
[72] 29 U.S.C. § 1022(a).
[73] *NCMC*, 781 F.3d at 195 (quoting *Stone*, 570 F.3d at 260).
[74] *Id.* at 195 (alteration in original) (quoting *Crowell v. Shell Oil Co.,* 541 F.3d 295, 313 (5th Cir. 2008)).
[75] *Humble Surgical Hosp.*, 878 F.3d at 483.
[76] *Id.* (quoting *Stone*, 570 F.3d at 257).

Administrator abused its discretion in denying the claim if that can be more readily determined."[77]

In the second step—deciding whether BCBSLA abused its discretion— the court considers "(1) the internal consistency of the plan under the administrator's interpretation, (2) any relevant regulations formulated by the appropriate administrative agencies, and (3) the factual background of the determination and any inferences of lack of good faith."[78] "In applying the abuse of discretion standard, we analyze whether the plan administrator acted arbitrarily or capriciously."[79]

Here, the district court only addressed the second step—whether BCBSLA abused its discretion. We take the same approach.[80] This is appropriate because all agree that Encompass's services were covered under the plans, and the only dispute is whether Encompass's claims are "duplicative" of other providers.

BCBSLA paid doctors a Global Fee for all services related to surgeries performed at their offices. The Global Fee compensated a doctor for both his professional services and the use of his facility. But when surgery was done at a hospital

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[77] *McCorkle v. Metro. Life Ins. Co.*, 757 F.3d 452, 457 n.10 (5th Cir. 2014) (alterations and internal quotation marks omitted).
[78] *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 638 (5th Cir. 1992) (citing *Batchelor v. Int'l Bhd. of Elec. Workers Local 861 Pension & Ret. Fund*, 877 F.2d 441, 445–48 (5th Cir. 1989)).
[79] *Bellaire Gen. Hosp. v. Blue Cross Blue Shield of Mich.*, 97 F.3d 822, 829 (5th Cir. 1996) (citing *Sweatman v. Commercial Union Ins. Co.*, 39 F.3d 594, 601 (5th Cir. 1994)).
[80] *See, e.g.*, *McCorkle*, 757 F.3d at 457 n.10; *Bellaire*, 97 F.3d at 829 (finding abuse of discretion without deciding legal correctness).

or ASC, BCBSLA made separate payments to those providers to compensate for use of their facilities and services. In BCBSLA's view, Encompass is distinguishable from hospitals and ASCs because it is only a service provider, not a physical facility. And for surgery at a doctor's office, BCBSLA's fee already included compensation for both his professional services and a facility. Thus, according to BCBSLA, any other payment would be duplicative.

This approach is not internally consistent. BCBSLA admits that the plans cover services like Encompass's, but cites no plan language authorizing it to limit payment based on who provided the service. [81] Nor does BCBSLA explain—in terms of the plan—why it may insist on a Global Fee when surgery is done at a doctor's office, but make separate payments when it is done at a hospital or ASC.[82] And when BCBSLA denied Encompass's claims, this arrangement was not set out in any written internal policy.

As for the other two abuse-of-discretion factors, we first note that the factual background of BCBSLA's decision shows equivocation over whether to do business with Encompass, rather than a clear understanding that its claims were

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[81] *See Vega*, 188 F.3d at 302 ("[W]e will not countenance a denial of a claim solely because an administrator suspects something may be awry. Although we owe deference to an administrator's reasoned decision, we owe no deference to the administrator's unsupported suspicions.").

[82] *See Lain v. UNUM Life Ins. Co. of Am.*, 279 F.3d 337, 347 (5th Cir. 2002) ("lack of objectivity" suggests abuse of discretion), *overruled on other grounds by Glenn*, 554 U.S. at 115–19.

improper.[83] As one BCBSLA executive emailed internally, "Quite honestly, I'm not one hundred percent sure why we are not contracting with them, because I don't believe we have a concrete policy on this provider type or maybe I missed that somewhere." Finally, neither party cites regulations that materially affect whether Encompass's claims should have been paid.[84]

In sum, BCBSLA abused its discretion by arbitrarily denying Encompass's claims for covered services, as shown by its inconsistent treatment of similar providers.

## IV. CONCLUSION

We AFFIRM the judgment of the district court.

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[83] *See Wildbur*, 974 F.2d at 638.
[84] *See id.*

EDITH H. JONES, Circuit Judge, dissenting:

I respectfully dissent from the majority's conclusion upholding the contra non valentem exception to prescription for this sophisticated medical services company that was fully represented by counsel from virtually the moment it reviewed the Cantrell letter. This is not an issue on which deference to the jury verdict is required. The facts are plain and undisputed. Encompass and its counsel were on more than "inquiry notice" from the terms of the letter— they had actual knowledge of the alleged false and defamatory statements in that letter. Encompass's counsel explained the company's position succinctly in closing argument. According to him, the letter contained three "false statements": Encompass was not "eligible to participate" in the Blue Cross networks; facility fees charged by Encompass "are not covered" even when billed by the network physician; and Encompass had to be state-licensed to be "eligible" for reimbursement.

Encompass sued BlueCross BlueShield of Louisiana ("BCBSLA") not long thereafter, following its related suit against Texas Blue Cross, on a theory of breach of contract arising from this letter and BCBSLA's failure to pay Encompass for its services on behalf of insureds. Encompass knew from the outset it was "eligible," and it knew there was no "state license" requirement. As for the third falsehood, it knew quite enough, that BCBSLA was not reimbursing it for in-office surgical assistance because of the claimed scope of insurance coverage. Whether coverage denial was because of the policy language or internal company policies, or both, or neither, is precisely the kind of

nuance a lawyer should investigate. But it took Encompass three years after filing suit to add this intimately related claim for falsehood and defamation.

"Louisiana courts have held in regard to contra non valentem that a cause of action becomes reasonably knowable to a plaintiff at the time legal counsel is sought." *Derrick v. Yamaha Power Sports of New Orleans*, 850 So.2d 829, 833 (La. Ct. App. 2003). Moreover, a defendant's refusal to provide a document that a plaintiff believes to contain information adverse to his interests does not excuse the plaintiff's lack of diligence in obtaining the document. *Rozas v. Dep't Health & Human Res.*, 522 So.2d 1195, 1197 (La. Ct. App. 1988). *See also Greenblatt v. Payne*, 929 So.2d 193, 195 (La. Ct. App. 2006) ("[Plaintiff] does not allege any facts indicating the reason for the passage of time between April of 2000, when she learned of the adverse nature of the letter, and July 2003 when her discovery request was granted by [Defendant's] counsel."); *Safford v. PaineWebber, Inc.*, 730 F. Supp. 15, 17 (E.D. La. 1990) ("[P]rescription in this case commenced to run when plaintiff received notice that documents had been filed by defendant.").

Importantly, misleading conduct by a defendant does not lift the burden of diligence from a sophisticated plaintiff who knows or reasonably should know that further inquiry would reveal a cause of action. *Marin v. Exxon Mobil Corp.*, 48 So.3d 234, 252 (La. 2010). Add to this the insurer's refusal to respond to three telephoned requests by Encompass for an explanation of coverage denial. Such stonewalling should have heightened

Encompass's and its lawyers' diligence rather than provide an excuse for non-discovery of a new claim.

Although my colleagues have diligently reviewed Louisiana law on contra non valentem, I respectfully disagree with their application of those cases to these facts. I would reverse the judgment for extracontractual and punitive damages.

**APPENDIX B**

**IN THE UNITED STATES DISTRICT FOR THE NORTHERN DISTRICT OF TEXAS DALLAS DIVISION**

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| ENCOMPASS OFFICE SOLUTIONS, INC., Plaintiff, v. LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA, Defendant. | No. 3:11-cv-01471-M [**FILED** 06/26/2017] |

**MEMORANDUM OPINION AND ORDER**

Before the Court is Defendant's Renewed Motion for Judgment as a Matter of Law, Motion for Reconsideration, and Motion for a New Trial (ECF No. 577). For the reasons stated below, the Motion is **DENIED**.

## I. Factual and Procedural Background

Encompass Office Solutions, Inc. is a vendor that provides equipment for in-office surgical services that cost less than services performed at a hospital or ambulatory surgery center. On August 16, 2010, Dawn Cantrell, the Vice President of network administration at Blue Cross Blue Shield

of Louisiana ("BCBSLA") sent a letter (the "Cantrell letter") to its in-network physicians, stating that Encompass was ineligible to bill BCBSLA for its services because certain Encompass fees were not covered by BCBSLA policy. [1] Encompass brought this suit in 2011, alleging that it was entitled to reimbursement from BCBSLA for services it provided, and that the entities that had failed to pay had insurance contracts with Encompass. On February 24, 2012, Encompass amended its Complaint and added BCBSLA as a defendant to the contract claims. On April 4, 2013, Encompass filed its Fifth Amended Complaint, adding tort claims against BCBSLA, claiming it recently learned that portions of the Cantrell letter were false.

On September 17, 2013, Judge Jorge Solis granted BCBSLA summary judgment on all of Encompass' tort claims, and found the statute of limitations not to have been tolled by the doctrine of *contra non valentem*, which is relevant to the statute of limitations in Louisiana.[2] On April 29, 2014, Judge Solis granted Encompass' Motion to Correct the Judgment, denied summary judgment on the defamation and tortious interference claims, and held that fact questions existed as to *contra non valentem*.[3] On October 2, 2014, the case went to trial, and the jury rendered a take-nothing verdict on all claims. On June 30, 2015, Judge Solis granted Encompass' Motion for a New Trial.[4]

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[1] By the time of the second trial in 2016, Cantrell's official position had changed to Vice President of care management.
[2] (ECF No. 413).
[3] (ECF No. 424).
[4] (ECF No. 507).

Judge Solis has retired and this case was reassigned to this Court, which conducted a second trial beginning on June 20, 2016.[5] The jury found for Encompass on its claims of breach of contract, defamation, and tortious interference. The jury also found that the doctrine of *contra non valentem* tolled the statute of limitations on Encompass' tort claims. BCBSLA sought to overturn the jury's verdict by filing a Renewed Motion for Judgment as a Matter of Law, Motion for Reconsideration, and Motion for a New Trial. On March 13, 2017, the Court advised it was denying Defendant's requested relief and advising that this opinion would follow.[6]

## II. Legal Standard

A. Motion for Judgment as a Matter of Law

A court may grant a motion for judgment as a matter of law if a party has been fully heard on an issue during a jury trial and the court finds that a reasonable jury did not have a legally sufficient evidentiary basis to find for the party on that issue. Fed. R. Civ. P. 50(a). District courts "must deny a motion for judgment as a matter of law unless the facts and inferences point so strongly and overwhelmingly in the movant's favor that reasonable jurors could not reach a contrary conclusion." *Baisen v. I'm Ready Prod., Inc.*, 693 F.3d 491, 498 (5th Cir. 2012). The Court denied the motion made at the conclusion of the Plaintiff's case, and for the reasons set out below, does so again because the requisite standard for granting such a motion has not been met.

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[5] (ECF No. 539).
[6] (ECF No. 593).

B. Motion for Reconsideration

A court may revise any order or other decision "that adjudicates fewer than all the claims or the rights and liabilities of fewer than all the parties." Fed. R. Civ. P. 54(b). However, motions for reconsideration should be limited to correct manifest errors of law or fact or to present newly discovered evidence, and may not rehash old arguments, introduce new arguments, or advance theories of the case that could have been presented earlier. *See LeClerc v. Webb*, 419 F.3d 405, 412 n.13 (5th Cir. 2005); *see also Wolf Designs, Inc. v. Donald McEvoy Ltd.*, No. 3:03-CV-2837-G, 2005 WL 827076 at *1 (N.D. Tex. Apr. 6, 2005) (Fish, J.).

C. Motion for a New Trial

Following a jury trial, a court may grant a new trial on all or some of the issues and to any party "for any reason for which a new trial has heretofore been granted in an action at law in federal court." Fed. R. Civ. P. 59(a)(1)(A). Courts must uphold a jury's verdict unless the evidence, viewed in the light most favorable to the prevailing party at trial, required a reasonable jury to find in favor of the movant. *See Crest Ridge Const. Grp. Inc. v. Newcourt Inc.*, 78 F.3d 146, 150 (5th Cir. 1996). Courts should also grant a new trial where it is "reasonably clear that prejudicial error has crept into the record or that substantial justice has not been done." *Sibley v. Lemaire*, 184 F.3d 481, 487 (5th Cir. 1999). The party seeking a new trial bears the burden of proving harmful error. *Id.*

## III. Analysis

A. Motion for Judgment as a Matter of Law

i. The Jury Reasonably Found *Contra Non Valentem* Tolled Prescription

Tort claims in Louisiana are subject to a one-year statute of limitations.[7] However, under the doctrine of *contra non valentem*, the prescription period in Louisiana does not begin to run if the "cause of action is not known or reasonably knowable by plaintiff, even though his ignorance was not induced by the defendant." *Eldredge v. Martin Maretta Corp*., 207 F.3d 737, 743 (5th Cir. 2000). On April 4, 2013, Encompass first asserted against BCBSLA tort claims for defamation and tortious interference. Those claims stemmed from the Cantrell letter of August 16, 2010. At trial, the jury found that the doctrine of *contra non valentem* tolled Encompass' tort claims.

BCBSLA argues the prescription period began to run on August 19, 2010, when Encompass learned of the Cantrell letter and suffered injury, and that it thus ran on August 19, 2011, before the tort claims were added. However, in evaluating the applicability of *contra non valentem*, the Fifth Circuit has distinguished between awareness of an injury and awareness of a cause of action. *Id*. Despite knowledge of an injury, prescription would not begin to run if Encompass was "ignorant of the facts upon which the claim is based as long as the ignorance is not unreasonable." *Ducre v. Mine Safety Appliances*, 963 F.2d 757, 760 (5th Cir. 1992). If Encompass

[7] La. C.C. Art. 3492.

was reasonably ignorant about an element of its claim, the prescription period would not start.

Falsity is an essential element of a defamation claim under Louisiana law. *Costello v. Hardy*, 864 So. 2d 129, 139 (La. 2004). The Cantrell letter indicated that Encompass was ineligible to bill BCBSLA because company policy [8] dictated BCBSLA would not cover Encompass' services. Encompass did not learn of the alleged falsity of the Cantrell letter and the lack of such a policy until she was deposed on February 19, 2013. Encompass urges that the doctrine of *contra non valentem* tolls the prescription period until February 19, 2013. BCBSLA counters that the defamation claim was reasonably knowable more than one year before Encompass asserted it, so that *contra non valentem* does not apply.

When prescription begins "depends on the reasonableness of a plaintiff's action or inaction." *Knaps v. B&B Chem. Co., Inc.* 828 F.2d 1138, 1140 (5th Cir. 1987). After extensive briefing, Judge Solis found there was a genuine issue of fact as to when Encompass could have reasonably determined the veracity of the Cantrell letter.[9] At the trial before this Court, Encompass presented evidence that it did not have access to BCBSLA's policies when the Cantrell letter came out, and therefore had no way to assess its accuracy.[10]

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[8] The alleged policy stated a non-facility provider must seek payment from the site of service owner. The policy was called the "Surgical Procedures Performed in the Physician's and Other Professional Provider's Office" policy. (ECF No. 586 at App. 121).

[9] (ECF No. 424).

[10] Trial Tr. Volume 1 at 174:18-175:2, 180:14-24 (ECF No. 581); Trial Tr. Volume 2 at 264:21-265:2 (ECF No. 582).

Encompass also presented evidence that it contacted BCBSLA about the policy described in the Cantrell letter, but never received a response.[11] Further, Dawn Cantrell stated at trial that no BCBSLA policy substantiated the content of the Cantrell letter.[12]

BCBSLA cites *Dominion Exploration & Production v. Waters*, 972 So. 2d 350 (La. Ct. App. 2007), for the proposition that when a party is represented by competent counsel, the doctrine of *contra non valentem* is unavailable to that party as a matter of law. In *Dominion*, the Louisiana court of appeals found plaintiff's inaction in pursuing potential claims was unreasonable, because it could have used discovery to learn the necessary information. *Id.* at 360-61. One of the factors the court cited for its decision was that "Dominion was represented by able counsel as early as May 2004," and had "a discovery vehicle available to it in the ongoing Audit Litigation whereby it could have reasonably obtained the information it contends that it needed, but apparently chose not to heed it." *Id.* However, *Dominion* does not stand for the proposition that the retention of competent counsel makes *contra non valentem* inapplicable per se. Further, the case at bar is distinguishable from *Dominion*, as Encompass used the discovery process to learn about the veracity of the policy described in the Cantrell letter. The fact that Encompass had competent counsel throughout this litigation was before the jury, but the jury could have, and apparently did reasonably conclude that Encompass could not have reasonably known of

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[11] Trial Tr. Volume 2 at 57:24-58:12 (ECF No. 582).
[12] Trial Tr. Volume 3 at 22:6-14, 78:16-81:15 (ECF No. 583).

the accuracy of the Cantrell letter until after April 3, 2012.

BCBSLA further cites *Safford v. PaineWebber, Inc.* 730 F. Supp. 15 (E.D. La. 1990) and *Neyrey v. Lebrun*, 309 So.2d 722 (La. Ct. App. 1975), two defamation cases which found *contra non valentem* to be inapplicable in defamation cases. However, *Safford* is distinguishable, because the plaintiff in that case knew the defendant made statements about him to a third party, which he believed to be false, but never sought to learn the content of the statements. 730 F. Supp. at 17. The plaintiff knew or had reason to know the statements in question were false, so the prescription period was not tolled by *contra non valentem*. Similarly, in *Neyrey*, the prescription period ran because the plaintiff knew the defendant made some statement about him to the state bar, but he never sought to obtain a copy of the statement to see if it was inaccurate. 309 So. 2d at 723–24. Here, Encompass inquired of BCBSLA to obtain the policy described in the Cantrell letter, but it did not receive a response. That distinguishes this case from *Safford* and *Neyrey*.

The Court finds there was a legally sufficient evidentiary basis for the jury to conclude that Encompass established that "it did not know, or should not reasonably have known, of the false content in the August 16, 2010, letter before April 3, 2012."[13]

[13] Court's Charge to the Jury (ECF No. 567 at 9).

ii. The Jury Reasonably Found Tortious Interference With a Business Relationship

Louisiana law requires a plaintiff seeking to recover on a tortious interference claim to show that a defendant had actual malice, which is defined as a "showing of spite or ill will." *JCD Mktg. Co. v. Bass Hotels & Resorts, Inc.*, 812 So. 2d 834, 841 (La. Ct. App. 2002). BCBSLA argues that Encompass did not offer at trial legally sufficient evidence that proved that BCBSLA acted with actual malice. At trial, Encompass presented evidence that: the Cantrell letter was sent to doctors in BCBSLA's network, articulating BCBSLA policies that did not exist, that neither Cantrell nor three other BCBSLA employees reviewed health benefit plans before writing the letter,[14] an email from a BCBSLA employee stated she was unsure why BCBSLA was not contracting with Encompass because BCBSLA did not have "a concrete policy on this provider type," [15] and testimony that BCBSLA had decided before the Cantrell letter was sent, and before BCBSLA investigated, that it would not pay Encompass.[16]

The Court finds this evidence provides a legally sufficient basis for the jury to have concluded that BCBSLA acted with spite or ill will, so that Encompass could recover for tortious interference with a business relationship. BCBSLA did not show that the "facts and inferences point so strongly and overwhelmingly in the movant's favor that

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[14] Trial Tr. Volume 3 at 50:22-52:22 (ECF No. 583).
[15] Plaintiff's Trial Exhibit 138 at App. 126 (ECF No. 586).
[16] Trial Tr. Volume 2 at 230:6-25 (ECF No. 582); Trial Tr. Volume 3 at 11:16-20, 73:20-74:5 (ECF No. 583).

reasonable jurors could not reach a contrary conclusion." 693 F.3d at 498.

iii. The Jury Reasonably Found BCBSLA Abused Its Privilege

The parties do not dispute that as a matter of law BCBSLA had a qualified privilege to communicate the Cantrell letter to its in-network providers. [17] A qualified privilege thus protects BCBSLA from a defamation claim by Encompass unless BCBSLA abused its privilege with either "knowledge of falsity or reckless disregard for truth." *Kennedy v. Sheriff of E. Baton Rouge*, 935 So. 2d 669, 686 (La. 2006). False statements made "with a high degree of awareness of their probable falsity" meet the reckless disregard for truth standard. *Id.* at 688. BCBSLA argues that based on the evidence presented at trial, a reasonable jury would not have a legally sufficient evidentiary basis to find that BCBSLA abused its privilege. However, as noted above, Encompass presented evidence that nobody at BCBSLA reviewed policies or health benefit plans to verify its policies before the Cantrell letter was sent, BCBSLA did not have policies that supported the contents of the letter, and BCBSLA employees testified to facts that were at odds with the letter being accurate. This evidence was legally sufficient to allow a reasonable jury to conclude BCBSLA acted with a reckless disregard for the truth and abused its privilege with respect to the Cantrell letter.

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[17] *See* Order Granting in Part and Denying in Part Motion to Correct the Judgment (ECF No. 424 at 17).

B. Motion for Reconsideration

In response to Encompass' Fifth Amended Complaint, BCBSLA raised the affirmative defense that Encompass' claims were barred by the health benefit plans' anti-assignment language. BCBSLA previously moved for summary judgment, and urges the Court to reconsider its motion. Judge Solis previously denied BCBSLA summary judgment for two reasons: first, the record did not indicate a single instance where BCBSLA attempted to invoke or give effect to the anti-assignment clause, and second, BCBSLA paid money to Encompass directly instead of the insured.[18] Thus, there was a fact question over whether BCBSLA waived the anti-assignment language in the plan. At trial before this Court, the jury found BCBSLA failed to comply with the health benefit agreement.

i. BCBSLA's Motion Makes Improper Arguments

Motions for reconsideration may not be used to rehash rejected arguments or introduce new arguments, and should be limited to correct manifest errors of law or fact or to present newly discovered evidence. *LeClerc v. Webb*, 419 F.3d 405, 412 n.13 (5th Cir. 2005). BCBSLA does not present any new evidence that would justify changing Judge Solis' Order denying summary judgment with respect to the anti-assignment language. BCBSLA instead argues that the Court should reconsider the Motion for Summary Judgment because Encompass did not ask the Court to charge the jury on the anti-assignment

[18] (ECF No. 413 at 20-23).

language, and that its failure to do so forecloses all of Encompass' claims as a matter of law. In other words, BCBSLA asserts that because Encompass did not seek to include in the jury charge a question on whether BCBSLA waived the anti-assignment language, Encompass has no right of action against it for breach of contract. BCBSLA makes a new argument based on Encompass' trial strategy and does not present any new facts or evidence for its summary judgment motion.[19] BCBSLA also does not seek to correct any manifest errors of law. Because introducing new arguments is improper in a motion for reconsideration, the Court rejects BCBSLA's arguments.

ii. BCBSLA Has the Burden of Proof to Prove Affirmative Defenses

Contrary to BCBSLA's assertion that Encompass was obligated secure a jury answer on BCBSLA's anti-assignment defense, a defendant bears the burden to establish all of the elements of its affirmative defenses. *See Terrebonne Parish Sch. Bd. v. Mobil Oil Corp.*, 310 F.3d 870, 877 (5th Cir. 2002). BCBSLA did not meet its summary judgment burden on the anti-assignment issue, so it had the burden to prove the facts to prevail at trial. Thus, BCBSLA was required to tender a proposed instruction and to object to the Court's failure to give a jury instruction on its anti-assignment defense, but did not do so. *See* Fed. R.

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[19] The Fifth Circuit has repeatedly held that once a trial begins, summary judgment motions effectively become moot. *Daigle v. Liberty Life Ins. Co.*, 70 F.3d 394, 396–97 (5th Cir. 1995) (citing *Black v. J.I. Case Co., Inc.* 22 F.3d 568, 570–71 (5th Cir. 1994)).

Civ. P. 51(c). The jury found that BCBSLA failed to comply with the health benefit agreement, and in doing so, rejected BCBSLA's affirmative defense. BCBSLA urges the Court to reconsider its motion for summary judgment based on Encompass' conduct at trial. However, BCBSLA has not established its anti-assignment affirmative defense as a matter of law, nor has BCBSLA presented new evidence. BCBSLA has not met the burden required to grant a motion for reconsideration.

iii. BCBSLA Rehashes Its Prudential Standing Argument

BCBSLA also argues Encompass failed to prove its standing to sue for breach of contract because of the plans' anti-assignment language. Though framed as an Article III constitutional standing issue, BCBSLA's claim that Encompass may not sue under the contract is in fact one of prudential standing.[20] This argument was rejected by Judge Solis and this Court feels no differently. The issue presented a fact question, which BCBSLA waived by not submitting proposed jury instructions on the assignment.

C. Motion for a New Trial

BCBSLA moves for a new trial based on the trial testimony of Debbie Woods, chief operating officer of Encompass, and the instruction that followed:[21]

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[20] Article III standing requires a party to show 1) injury in fact, 2) causation, and 3) redressability. *See Lujan v. Def. of Wildlife*, 504 U.S. 555 (1992). Encompass has established these requirements.

[21] Tr. Transcript Volume 2 at 49:1-23 (ECF No. 582).

> Q: So when you received a letter saying that you were misrepresenting yourself as an ambulatory surgery center from Aetna, did you believe that letter had any merit?
>
> A: No.
>
> Q: And what actions specifically did you take to address that letter?
>
> A: We had to go ahead and sue Aetna, and Aetna settled with us.
>
> Mr. Herman: Your Honor, objection.
>
> The Court: All right. All right. Ladies and Gentlemen, I instruct you to disregard that. Any resolution that might have taken place with respect to another insurance company the Court has determined as not relevant. You may not consider that for any purpose. Let me see you-all at the bench for a moment.
>
> (Bench conference) The Court: You had a responsibility to instruct her not to divulge that. So if you—if you didn't like that instruction, the next one is going to be devastating. Do not let that happen again. If you need to talk to her, then do that.
>
> Ms. Ecklund: Yes, Your Honor. (End of bench conference.)

BCBSLA argues that evidence of Encompass' settlements with other insurers was so prejudicial as to cause the jury to be prejudiced and rule for

Encompass in the second trial.[22] To alleviate such possible prejudice, the Court immediately instructed the jury to disregard such testimony, and the Court gave an agreed upon instruction to the jury in the charge not to consider Encompass' other lawsuits or the outcome of those lawsuits.[23] BCBSLA did not object to that provision in the charge, and a jury is presumed to follow the Court's instructions. *Wellogix, Inc. v. Accenture, L.L.P.*, 716 F.3d 867, 876 (5th Cir. 2013) (citing *Weeks v. Angelone*, 528 U.S. 225, 234 (2000)). BCBSLA has not presented any evidence to overcome this presumption, nor has it met its burden to demonstrate that the stricken evidence interfered with substantial justice. The record contained sufficient proper evidence for a reasonable jury to find as this jury did.

## IV. Conclusion

For the reasons stated above, the Defendant's Renewed Motion for a Judgment as a Matter of Law, Motion for Reconsideration, and Motion for a New Trial is **DENIED**. The Court will enter a separate order rendering judgment for Plaintiff.

**SO ORDERED.**

June 26, 2017.

**BARBARA M. G. LYNN**
**CHIEF JUDGE**

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[22] BCBSLA also insinuates that Encompass' counsel deliberately engaged in misconduct by directing Ms. Woods to introduce evidence of prior settlements. Notwithstanding its current position, BCBSLA never moved for a mistrial at any point. The Court that the steps it took alleviated any potential prejudice.

[23] Tr. Transcript Volume 3 at 282:1-15 (ECF No. 583).

**APPENDIX C**

**IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS DALLAS DIVISION**

| | |
|---|---|
| ENCOMPASS OFFICE SOLUTIONS, INC., *Plaintiff*, v. LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA, *Defendant*. | No. 3:11-cv-01471-M [**FILED** 06/26/2017] |

**FINDINGS OF FACT AND CONCLUSIONS OF LAW**

The Court enters the following Findings of Fact and Conclusions of Law as to the ERISA claims which were tried to the Court. Other claims and counterclaims were tried to a jury, which reached a unanimous decision in the Plaintiff's favor. Encompass' claim against Defendant BlueCross BlueShield of Louisiana ("BCBSLA") under Section 502(a)(1)(B) of ERISA and BCBSLA's counterclaim against Encompass under Section 502(a)(3) of ERISA were the issues tried by the Court. Any of the findings of fact set out below that are properly considered to be conclusions of law, and vice versa, shall be so treated.

## I. FINDINGS OF FACT

1. Encompass provides equipment, drugs, supplies, and licensed nursing personnel to assist a physician to perform a surgery in the physician's office.

2. The State of Louisiana does not license mobile providers of ambulatory surgical care such as Encompass.

3. The State of Texas does not license mobile providers of ambulatory surgical care such as Encompass.

4. Encompass is not licensed by the Louisiana Department of Health and Hospitals or the Texas Department of State Health Services.

5. Encompass was accredited for Ambulatory Health Care by the Joint Commission, effective April 17, 2009, after it ceased operations in the State of Louisiana.

6. Encompass does not participate in BCBSLA's provider networks.

7. Encompass billed $6,200 for the services it provided to BCBSLA members.

8. Encompass submitted 143 healthcare claims to BCBSLA for services it provided for members whose health benefit plans are governed by ERISA. Of those 143 claims, 102 have not been paid.

9. 123 BCBSLA participants/beneficiaries with a health benefit plan governed by ERISA explicitly assigned their health plan benefits to Encompass.

10. Twenty BCBSLA participants/beneficiaries with a health benefit plan governed by ERISA

implicitly assigned their health benefit plan benefits to Encompass.

11. BCBSLA paid Encompass directly for 41 healthcare claims that Encompass submitted for services to BCBSLA members whose health benefit plans are governed by ERISA.

12. BCBSLA waived the right to rely on any clause prohibiting assignment by its members/beneficiaries to Encompass, because BCBSLA made payments directly to, and communicated directly with, Encompass on certain claims.

13. Apart from what it learned in this suit, Encompass did not know of the existence of an anti-assignment clause in any health benefit plan that BCBSLA administers or insures as to which Encompass made claims.

14. BCBSLA sent a letter from its agent, Dawn Cantrell, to its in-network OB/GYNs stating that Encompass' services were not covered by BCBSLA. BCBSLA intentionally blocked payments to Encompass in August 2010, and did not pay any claims submitted by Encompass thereafter. On October 4, 2010, BCBSLA sent a letter to Robert D. Gates, Encompass' CEO, demanding that Encompass return $109,676.55, the amount that Encompass had been paid for claims it submitted to BCBSLA (including claims for which BCBSLA was only the "host" plan under the BlueCard program). The evidence proves that BCBSLA would continue to deny any further claims submitted to BCBSLA by Encompass.

15. No BCBSLA agent or representative reviewed the terms of any benefit plan before deciding to deny Encompass' claims.

16. BCBSLA does not have a written policy about payment for expenses incurred when an operating surgeon is paid a fee that includes payment for the services Encompass provided when a surgeon performed a surgery in his office.

17. The services Encompass provided are a "Covered Service" under the health insurance plans BCBSLA insures or administers.

18. BCBSLA did not establish what amount was an Allowable Charge under the plan(s) or negotiate a maximum amount allowed for the services Encompass provides.

19. In response to the claims Encompass submitted, BCBSLA sent a number of letters to Encompass requesting information about Encompass. Encompass, through its billing company, responded to those inquiries.

20. When it denied or failed to adjudicate an Encompass claim, BCBSLA did not send an explanation of benefits to Encompass; instead, it sent an explanation of benefits to the patient. Because Encompass did not receive explanations of benefits from BCBSLA, reflecting denial of the claims at issue in this case, Encompass did not submit an appeal of any claims not paid by

21. BCBSLA did not provide notice to Encompass nor to its patients of any time limitations provided in the plan for protesting the declination of benefits by BCBSLA.

## II. CONCLUSIONS OF LAW

1. Encompass has statutory and Article III standing to pursue the subject claims.

2. Whether Encompass was licensed to do business in the State of Louisiana is irrelevant to its ability to recover on its claims from BCBSLA. However, if licensure were required, its accreditation to do business in the State of Louisiana retroactively cured any prior license and registration issues.

3. The employee benefit plans that BCBSLA administers that are at issue in this case cover the services Encompass provided to BCBSLA's members.

4. When BCBSLA denied certain Encompass claims, it did so with the following explanation: "Reimbursement considered a portion of another service which has been allowed. Therefore, no payment can be made for this service." BCBSLA is estopped from advancing any other justification for denying those particular claims.

5. No other provider was reimbursed for providing those services provided by Encompass for BCBSLA's members.

6. BCBSLA abused its discretion by interpreting each of the employee benefit plans at issue in this case to exclude reimbursement for Encompass' services on the basis that another provider had been reimbursed for providing those services to BCBSLA's members.

7. Because BCBSLA did not establish what amount was an Allowable Charge nor did it negotiate a maximum amount allowed for the

services Encompass provided, Encompass is entitled to be paid its billed charge for the services it provided to BCBSLA's members.

8. Even if BCBSLA had not waived the right to rely on an anti-assignment clause, such clauses are ineffective to deprive Encompass of standing because they are void under Texas law for the patients for whom Encompass provided services in Texas, because BCBSLA did not introduce evidence that Encompass had knowledge of the clauses' inclusion in the health benefit plans BCBSLA administers.

9. Encompass could not administratively appeal any of the claims at issue in this case because BCBSLA did not issue an explanation of benefits to Encompass stating that the claims had been denied and on what basis.

10. Encompass was excused from exhausting administrative appeals for claims that BCBSLA denied because it would have been futile for Encompass to do so, in light of BCBSLA's October 4, 2010, demand letter to Encompass, its posture before and during this litigation that it intended to reject any claim by Encompass, its long-standing policy to deny the type of claims Encompass submits, and its assertion of counterclaims against Encompass.

11. Encompass became aware on October 4, 2010, that it was futile for it to exhaust administrative appeals. Encompass' claims under Section 502(a)(1)(B) of ERISA therefore accrued on that date.

12. BCBSLA did not provide Encompass, as its patients' assignee, with a full and fair review of

assigned claims, in that it did not provide notice to Encompass or its patients of any deadline in the plan constituting limitations on the receipt of the explanations of benefits BCBSLA issued in denying Encompass' claims. Those provisions are therefore unenforceable.

13. Encompass' claims for services provided on or before July 4, 2009, are not barred by any limitations provisions contained in any of the benefit plans that BCBSLA administers, because Encompass had no notice its claims would be rejected and never had an opportunity to sue for those claims. Therefore, such a provision is, as a matter of law, unreasonable and unenforceable.

14. 94 of the claims on which Encompass seeks to recover were timely as a matter of law.

15. Encompass is entitled to recover the benefits due to it under the benefit plans that BCBSLA administers, pursuant to 29 U.S.C. § 1132(a)(1)(B). Benefits due to Encompass are its billed charge of $6,200 per claim, on 94 claims that BCBSLA failed to pay for BCBSLA members whose benefit plan is subject to ERISA. The eight claims for services provided after October 4, 2010, are untimely.

16. BCBSLA's counterclaim to recoup the benefits it had previously paid to Encompass is barred by the Louisiana Revised Statute 22:1834 and Louisiana Department of Insurance Regulation 74 § 6015, because BCBSLA's request for recoupment was not asserted within 90 days of the dates of the payments it seeks to recoup, as Louisiana law requires.

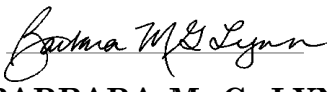
17. BCBSLA's counterclaim to recoup the benefits it previously paid to Encompass does not

seek "appropriate equitable relief . . . to . . . the terms of the [benefit] plan[s]" at issue in this case. 29 U.S.C. § 1132(a)(3). BCBSLA has not cited a plan provision that would entitle it to recover any amounts from Encompass. The benefit plans at issue only permit BCBSLA to recover payments made in error for services that are not "covered." Because the Court has determined that the services Encompass provides are "covered," BCBSLA abused its discretion by failing to pay Encompass' claims for benefits. BCBSLA is not entitled to recover any of the benefits it paid to Encompass under 29 U.S.C. § 1132(a)(3).

18. Encompass is entitled to recover its costs of court and reasonable attorneys' fees incurred in pursuit of its claims under 29 U.S.C. § 1132(a)(1)(B) and 29 U.S.C. § 1132(g). Encompass shall file the appropriate motions by July 30, 2017.

**SO ORDERED.**

**June 26, 2017.**



**BARBARA M. G. LYNN**
**CHIEF JUDGE**

**APPENDIX D**

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 17-10736

[**FILED**
4/16/2019]

ENCOMPASS OFFICE SOLUTIONS, INCORPORATED,

Plaintiff - Appellee

v.

LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, doing business as BlueCross BlueShield of Louisiana,

Defendant – Appellant

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

ON PETITION FOR REHEARING AND REHEARING EN BANC

(Opinion March 19, 2019, 5 Cir., ___ F.3d ___ )

Before JONES, BARKSDALE, and WILLETT, Circuit Judges.

PER CURIAM:

(**X**) The Petition for Rehearing is DENIED and no member of this panel nor judge in regular active service on the court having requested that the court be polled on Rehearing En Banc, (FED. R. APP. P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc is also DENIED.

( ) The Petition for Rehearing is DENIED and the court having been polled at the request of one of the members of the court and a majority of the judges who are in regular active service and not disqualified not having voted in favor, (FED. R. APP. P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc is also DENIED.

( ) A member of the court in active service having requested a poll on the reconsideration of this cause en banc, and a majority of the judges in active service and not disqualified not having voted in favor, Rehearing En Banc is DENIED.

ENTERED FOR THE COURT:

Don R. Willett

UNITED STATES CIRCUIT JUDGE

*Judge Haynes did not participate in the consideration of the rehearing en banc.

**APPENDIX E**

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 17-10736

United States Court of Appeals
Fifth Circuit
**FILED**
March 19, 2019
Lyle W. Cayce
Clerk

D.C. Docket No. 3:11-CV-1471

ENCOMPASS OFFICE SOLUTIONS, INCORPORATED,

Plaintiff - Appellee

v.

LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, doing business as BlueCross BlueShield of Louisiana,

Defendant – Appellant

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

Before JONES, BARKSDALE, and WILLETT, Circuit Judges.

J U D G M E N T

This cause was considered on the record on appeal and was argued by counsel.

It is ordered and adjudged that the judgment of the District Court is affirmed.

IT IS FURTHER ORDERED that defendant-appellant pay to plaintiff-appellee the costs on appeal to be taxed by the Clerk of this Court.

EDITH H. JONES, Circuit Judge, dissenting.

**APPENDIX F**

**IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS DALLAS DIVISION**

| | |
|---|---|
| ENCOMPASS OFFICE SOLUTIONS, INC., *Plaintiff*, v. LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA, *Defendant*. | No. 3:11-cv-01471-M [**FILED** 06/26/2017] |

**FINAL JUDGMENT**

On June 20, 2016, the Court called this case for trial. Plaintiff Encompass Office Solutions, Inc. and Defendant Louisiana Health Service & Indemnity Co. d/b/a Blue Cross Blue Shield of Louisiana appeared in person and through their attorneys announced ready for trial. The Court determined that it had jurisdiction over the subject matter and the parties in the case. The Court then impaneled and swore in the jury, which heard the evidence and arguments of counsel. At the conclusion of the evidence, the Court submitted definitions, instructions, and questions to the jury. After deliberation, the jury returned and announced its verdict in open court, which verdict was unanimous

and duly received and filed by the Court. The jury's verdict was in favor of Plaintiff Encompass Office Solutions, Inc.

The Court has entered its Findings of Facts and Conclusions of Law in favor of Encompass as to the ERISA claims, which were tried to the Court.

IT IS THEREFORE ORDERED and ADJUDGED that Encompass Office Solutions, Inc. shall recover from Louisiana Health Service & Indemnity Co. d/b/a Blue Cross Blue Shield of Louisiana as follows:

(1) Encompass Office Solutions, Inc. shall recover from Louisiana Health Service & Indemnity Co. d/b/a Blue Cross Blue Shield of Louisiana, the following amounts: (a) $7,353,010.00, in actual damages based on Plaintiff's tort claims; (b) prejudgment interest on that amount of $1,167,617.70 (calculated at the rate of 4% per annum from April 4, 2013 until March 23, 2017); (c) additional prejudgment interest of $805.81 per day from March 24, 2017 until the day before this Judgment is entered; (d) $182,500.00 in actual damages on Plaintiff's breach of contract claims; (e) prejudgment interest on contract damages for $37,080.00 (calculated at the rate of 4% per annum from February 24, 2012 until March 23, 2017); (e) additional prejudgment interest of $20.00 per day from March 24, 2017 until the day before this Judgment is entered; (f) $582,800.00 in actual damages on Plaintiff's ERISA claims; (g) prejudgment interest on ERISA claims of $118,502.67 (calculated at the rate of 4% per annum from February 24, 2012 until March 23, 2017); and (h) additional prejudgment interest

of $69.30 per day from March 24, 2017 until the day before this judgment is entered. The total amount of recovery on all claims is $9,525,650.71, excluding post-judgment interest and attorneys' fees.

(2) The total award of actual damages and prejudgment interest shall bear post-judgment interest at the rate of 1.21% per annum, compounded annually, from the date judgment is signed until the day judgment is satisfied.

IT IS FURTHER ORDERED that taxable costs of court are to be paid by Louisiana Health Service & Indemnity Co. d/b/a Blue Cross Blue Shield of Louisiana. Encompass Office Solutions, Inc. may seek attorneys' fees by separate motion to be filed by July 30, 2017.

**SO ORDERED.**

**June 26, 2017.**

**BARBARA M. G. LYNN**
**CHIEF JUDGE**

## APPENDIX G

## IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS DALLAS DIVISION

| | |
|---|---|
| ENCOMPASS OFFICE SOLUTIONS, INC., Plaintiff, v. LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA, and BLUECROSS BLUESHIELD OF TENNESSEE, INC., Defendants. | 3:11-cv-1471-P [**FILED** 04/29/14] |

**ORDER**

Now before the Court is Defendant BlueCross and BlueShield of Louisiana's Motion to Correct Judgment, filed on October 15, 2013. Doc. 418. Plaintiff filed a Response on November 5, 2013. Doc. 421. Defendant filed a Reply on November 7, 2013. Doc. 422.

Also before the Court is Plaintiff Encompass Office Solutions, Inc.'s Motion to Reconsider and, in the Alternative, Motion to Certify Controlling Question of Law for Immediate Appeal, filed on October 4, 2013. Doc. 416. Defendant filed a

Response on October 15, 2013. Doc. 417. Plaintiff filed a Reply on October 29, 2013. Doc. 420.

After reviewing the parties' briefing, the evidence, and the applicable law, the Court treats Defendant's Motion to Correct Judgment as a Motion to Reconsider and GRANTS IN PART and DENIES IN PART its motion. The Court GRANTS IN PART and DENIES IN PART Plaintiff's Motion to Reconsider and, in the Alternative, Motion to Certify Controlling Question of Law for Immediate Appeal. Consequently, the Court modifies its previous Order, dated September 17, 2013, in accordance with the following opinion.

## I. Background

The general background of the case can be found in the Court's Order dated September 17, 2013 ("Summary Judgment Order"). The gist is that Encompass Office Solutions ("Encompass") provided certain services to patients insured by BlueCross and BlueShield of Louisiana ("BCBSLA"). For some time, BCBSLA covered the procedures performed by Encompass, but ultimately changed its mind and rejected the claims. Both Encompass and BCBSLA moved for summary judgment on a barrage of issues. The Court granted in part and denied in part both motions and granted a separate summary judgment motion on Encompass's three tort claims. Now both parties want the Court to revisit its Summary Judgment Order by ruling on unaddressed issues and revising certain portions.

## II. Reconsideration Of An Interlocutory Order Before Final Judgment

"[A]ny order or other decision ... that adjudicates fewer than all the claims or the rights and liabilities of fewer than all the parties does not end the action as to any of the claims or parties and may be revised at any time before the entry of a judgment adjudicating all the claims and all the parties' rights and liabilities." Fed. R. Civ. P. 54(b). Whether to grant a motion to reconsider is in the discretion of the court. United States v. Renda, 709 F.3d 472, 478-79 (5th Cir. 2013). A district court may reconsider a prior interlocutory order "for any reason it deems sufficient." *Saqui v. Pride Cent. Am., LLC*, 595 F.3d 206, 210-11 (5th Cir. 2010). Parties should not use a motion to reconsider as an opportunity to rehash old arguments or raise arguments that could have been presented earlier. *Arrieta v. Yellow Tramp., Inc.*, No. 3:05-CV-2271-D, 2009 WL 129731, at *1 (N.D. Tex. Jan. 20, 2009).

After reviewing the issues in the briefing, the Court agrees that re-consideration of the Summary Judgment Order is appropriate. The order is only modified with respect to the issues addressed by the Court in this Order; the rest of the Summary Judgment Order remains intact.[1]

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[1] BCBSLA filed its motion to correct judgment under Fed. R. Civ. P. 60(a). As Encompass correctly points out, Rule 60(a) is an improper vehicle to substantively reconsider an interlocutory order. *See Rivera v. PNS Stores, Inc.*, 647 F.3d 188, 193-94 (5th Cir. 2011) ("To be correctable under Rule 60(a), the mistake must not be one of judgment or even of misidentification, but merely of recitation, of the sort that a clerk or amanuensis might commit, mechanical in nature.") (internal quotations omitted). However, in the interest of

## III. Summary Judgment Standards

The same summary judgment standards that applied to the Court's Summary Judgment Order apply to its reconsideration of those issues here.

## IV. Unaddressed Issues In Summary Judgment Motions

BCBSLA argues that it moved for summary judgment on three categories of claims, but that the Court failed to address its arguments.

The first category is a group of 13 claims covered under the Federal Employee Health Benefit Act ("FEHBA"). The second category is a single claim that was outside of the service dates for the respective patient. Encompass agrees that it is no longer seeking recovery on the FEHBA claims and does nothing to contest the outside-coverage claim. Doc. 330 at 2 (admitting in a statement of uncontested facts that it cannot recover on those claims); Doc. 421 at 4. Consequently, the Court GRANTS summary judgment as to the 13 claims covered by FEHBA and the single claim outside of the service dates.

The third category is not as straightforward, but also went un-addressed in the Summary Judgment Order. In its original motion, BCBSLA argued that it deserved summary judgment on claims from patients "covered under health benefit plans issued or administered by BCBSLA." *See* Doc. 323 at 14. As evidence, it offered business records showing that the individuals were covered by BlueCross and

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efficiency and justice, the Court interprets BCBSLA's motion as a motion for reconsideration under Rule 54(b), the same provision that Encompass has availed itself of.

BlueShield programs in other states. *See* Doc. 301-2 at 45-47 (affidavit and business record identifying home plans); *see also* Doc. 301-3 at 24-50, 301-4 at 1-15 (underlying business record). The only place that Encompass contested the issue was in its response to BCBSLA's Statement of Uncontested Facts, arguing that the claims were "blocked due to the block[2] that BCBSLA placed on Encompass's claims." Doc. 330 at 2. To support that assertion, Encompass cited a group of emails about the institution of a block on Encompass claims, Doc. 288-9 at 1-7, a project management document detailing the block, *see* Doc. 288-12 at 8, and deposition testimony about the block. In the current briefing, Encompass states, "There is no dispute that those claims were submitted to BCBSLA as the 'host plan' under the BCBS Interplan (or Blue Card) program, and that BCBSLA blocked all of Encompass's claims from being processed whatsoever." The implication is that BCBSLA may play some role that makes it an "administrator" of the individuals' plans.

Neither party has adequately explained the details surrounding these claims. BCBSLA failed to make an initial showing that it cannot be held liable for those individuals being denied benefits.[3] While none of Encompass's evidence does a good job of showing why BCBSLA should be held liable, it is not its burden to carry. The evidence and law on these claims is too muddled to grant summary

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[2] The "block" refers to when BCBSLA instituted an internal policy to reject all claims made by Encompass.

[3] Encompass mentions that almost all of the claims have been settled with other parties, but again fails to provide evidence that those claims were part of other settlement discussions.

judgment. Therefore, the Court DENIES summary judgment as it applies to all claims filed by individuals not insured by BCBSLA.

**V. Litigation Limitations Period**

Encompass requests the Court re-consider its ruling regarding the time limit set by the plan for beneficiaries to sue.

The plans that Encompass seeks to recover on include a provision that limits the time a beneficiary has to sue for benefits: "No lawsuit may be filed: any earlier than the first sixty (60) days after notice of Claim has been given; or any later than fifteen (15) months after the date services are rendered." Doc. 288-10 at 89. Early on, BCBSLA initially accepted many of Encompass's claims, making a lawsuit unnecessary. However, in early 2010, BCBSLA gradually began denying Encompass's claims, culminating in a letter sent on October 4, 2010. In it, BCBSLA informs Encompass that it "advised [its] Providers that Encompass' services for our members are not covered, even if the service is billed by the Provider." Doc. 288-4 at 3-4. It included a spreadsheet of previously accepted claims that it was then rejecting and seeking repayment for. *See* Doc. 288-4 at 5-6. BCBSLA also rejected any new claims that Encompass filed after the letter was sent. In February 2012, Encompass named BCBSLA in this suit, seeking payment for the rejected claims.

BCBSLA argues that Encompass may not sue on any claim for services rendered more than 15 months before the date Encompass filed suit. That includes both claims identified in the October 2010 letter as well as other claims that BCBSLA never

accepted. Originally the Court granted BCBSLA summary judgment for all claims that were for dates of service before November 24, 2010. *See* Doc. 413 at 26-27. With the benefit of Supreme Court guidance on the issue of limitations periods in ERISA plans, the Court now believes that its Summary Judgment Order was incorrect. Consequently, the Court modifies the Summary Judgment Order and GRANTS IN PART and DENIES IN PART BCBSLA's Motion for Summary Judgment on the claims brought outside the 15-month period.

a. The Supreme Court's Recent Decision On ERISA Limitations Periods

The guidance from the Supreme Court came in December 2013 when it decided *Heimeshoff v. Harford Life & Accident Insurance Co.*, 134 S. Ct. 604 (2013). The facts were similar to this case, albeit for a disability insurance claim. The plaintiff first filed a claim in August 2005, followed by a series of events that dragged out the process until a final denial in November 2007. It was not until November 2010 that she decided to file a lawsuit. But the plan contained a limitation provision that barred suits filed "more than 3 years after the time written proof of loss is required to be furnished according to the policy." *Id.* at 609 (internal alterations omitted). Because the limitations period commenced from proof-of-loss date (which was sometime in 2005)—not the date of final denial (which was in November 2007)—her suit was outside the limitations period and therefore was barred.

The Court rejected the plaintiffs' attempt to invalidate the limitations provision. "Absent a

controlling statute to the contrary, a participant and a plan may agree by contract to a particular limitations period, even one that starts to run before the cause of action accrues[4], as long as the period is reasonable." *Id.* at 610. That the accrual date of a claim was different than the commencement date of the limitations was inconsequential. *Id.* at 610-12. The real issue was whether the time from accrual to the expiration of the limitations period was unreasonable. *See id.* at 612 (evaluating the time period "on its face" and based on how much time would be left to file suit after accrual of a claim). In Heimeshoff's case, beneficiaries effectively had 20 months to file suit, which was reasonable. *Id.* The only example the Supreme Court gave of an unreasonable time period was one that completely barred individuals from filing suit. *See id.* at 613 (drawing on *Occidental Life Ins. Co. of Cal. v. EEOC*, 432 U.S. 355 (1977)). But concluding that the limitations period was reasonable was not the end. The Court went on to explain that plaintiffs can still resort to "one of the traditional defenses to a statute of limitations," *id.* at 614, such as waiver or estoppel, *id.* at 615, to avoid harsh application of a limitations provision; state tolling rules, however, do not apply. *Id.* at 616.

*Heimeshoff*, thus, identifies two ways that beneficiaries may avoid a limitations provision. First, the beneficiary can show the time from

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[4] In a typical ERISA case, the cause of action does not accrue until a beneficiary has exhausted administrative appeals procedures. Consequently, in *Heimeshoff*'s case the cause of action did not accrue until November 2007 when the final appeal was denied.

accrual of a claim to expiration of the limitation provision is so short it is unreasonable. Second, plaintiffs can rely on traditional defenses to a statute of limitations.

In the Summary Judgment Order, this Court briefly analyzed the limitations period and considered it reasonable. The Court also, sua sponte, considered whether equitable estoppel of the limitations period applied and concluded it might. But because Encompass failed to bring suit within 15 months after it received notice that BCBSLA intended to reject the claims—the date the Court believed equitable estoppel tolled the limitations period until—the Court found that not even that would help Encompass. Now, the Court re-evaluates whether the limitations period is reasonable in light of *Heimeshoff*, the only binding precedent on the issue.

b. Is The Limitations Period Unreasonable?

To determine whether the limitations period is reasonable requires understanding the mechanics of limitations period under ERISA and identifying the right method to evaluate it.

Under BCBSLA's plans, the limitations period expires fifteen months after the date the services are rendered. Of course nothing is per se wrong with a fifteen-month limitation. But people do not leave the doctor's office knowing they will need to sue their insurance company for declining a claim. It is not until they have a final denial that people expect to sue—or even have an accrued claim to sue. *Id.* at 610 ("A participant's cause of action under ERISA accordingly does not accrue until the plan issues a final denial.") For that to happen

under the plans in this case, the patient's provider has to file the claim with BCBSLA. The plan "encourage[s] providers to file claims in a form acceptable to [BCBSLA] within ninety (90) days from the date of services are rendered, but no later than fifteen (15) months after the date of service." Doc. 288-10 at 88. Neither party indicates that the plan requires BCBSLA to respond to the claim within a certain amount of time and the Court's independent examination of the plan's terms did not reveal a time limit. After BCBSLA denies a claim—whenever that is—BCBSLA requires beneficiaries to file a mandatory appeal within 180 days of denial. Doc. 288-10 at 98. Once an appeal is taken, BCBSLA has up to 45 days to accept or reject the appeal. Doc. 288-10 at 98. All of that must happen before an individual has the opportunity to sue.

Those are the mechanics of the limitations period—now to evaluate it. A few potential methods for determining whether a limitation period is unreasonable present themselves. First, courts could evaluate how much time a typical claim would take, taking into account the plan specifics and past industry performance. The Supreme Court used that approach in *Heimeshoff* when it discussed how long before "mainstream claims" accrue. *Id.* at 9. Second, courts could look at how a specific claim was actually handled in practice. While *Heimeshoff* did not focus on that method, it applied it in passing. *See id.* ("Even in this case, where the administrative review process required more time than usual, Heimeshoff was left with approximately one year in which to file suit."). And it is the same method Judge Haynes advocated for

in her dissent in the unpublished Fifth Circuit case, *Baptist Memorial Hospital.—DeSoto Inc. v. Crain Automotive. Inc.*, 392 F. App'x 288, 299 (5th Cir. 2010) (unpublished) ("[I]n ascertaining whether the period of limitations was 'reasonable,' I would consider only how the limitations period applied under the facts of this case."). Finally, courts could evaluate how much time would be left to a beneficiary if claims processing took the maximum amount of time under the plan. The panel majority in *Baptist Memorial Hospital* used that method, what Judge Haynes referred to as the "worst case scenario" method. *See id.* at 295 (evaluating the limitations period based on each step taking as long as possible); *id.* at 300 (Haynes, J., dissenting) ("[T]he majority opinion assesses the contractual limitations period under a 'worst case scenario' approach to conclude that a fully exhausted claim could leave a party with only thirty-five days to file suit.") (emphasis in original). At least one of these three methods—"mainstream claim," "case specific," or "worst case scenario"—must be used to assess the reasonableness of a limitations period and it may be that more than one may be used.

And it does matter which may be used. Both the "mainstream claim" and "worst case scenario" methods invalidate limitations periods facially. Under them, if Encompass shows the limitations period is unreasonable, then the limitations period would not apply to any of the claims. The "case specific" method, however, depends on the events surrounding the processing and treatment of a particular claim. To show the limitations period is unreasonable, a plaintiff would have to demonstrate that the execution of the limitations

period was unreasonable under the particular circumstances of that claim.

Because *Heimeshoff* suggests that both the mainstream claim and the case specific methods apply, the Court adopts them.

The "worst case scenario" method, however, is inappropriate for a couple reasons. First, the Court is not bound to apply it. True, the *Baptist Memorial Hospital* majority used it in their unpublished opinion, but they provide no authority for taking such an approach. Second, it is at odds with *Heimeshoff*'s approach which looks at how claims are processed in the real world, not under the assumption that ERISA plan administrators are working to bar all claimants from court. *Heimeshoff*, 571 U.S. __, at 12 ("The United States suggests that administrators may attempt to prevent judicial review by delaying the resolution of claims in bad faith. But administrators are required by the regulations governing the internal process to take prompt action, and the penalty for failure to meet those deadlines is immediate access to judicial review for the participant."). Since neither precedent nor common sense support applying the "worst case scenario" method, the Court declines to use it.

Now that the Court has established what methods to use to determine if the limitations period is unreasonable—the "mainstream claim" and the "case specific" methods—it will apply them.

Encompass fails to show that the limitations period should be considered unreasonable under the "mainstream claim" method. The party seeking to invalidate a limitations period bears the burden

of showing it is unreasonable. And, on that issue, the record is decidedly silent. Encompass has not provided any information about how long a typical claim takes to process. Without establishing that measuring stick, the Court cannot invalidate the limitations period.

That leaves the Court with the unenviable task of applying the "case specific" method.

Rather than looking at claims or plan terms generically, the Court must look at each claim individually and determine whether the time afforded was reasonable. As in *Heimeshoff*, the focus is on the effective time to sue—that is the amount of time an individual has to sue after a claim accrues, but before the expiration of the limitations period. The reasonableness of the effective time to sue depends, in part, on the actions of both parties with respect to the benefits processing. Any claim that accrues after the expiration of the limitations period is presumptively unreasonable, unless the party seeking to enforce the limitations period can attribute fault for the claim's delayed accrual to unreasonable actions by the party seeking to invalidate it.

The limitation period is clearly unreasonable with respect to some of Encompass's claims. In BCBSLA's October 2010 letter to Encompass, it reneged on payment for a long list of claims. This was the first time these claims could have accrued since Encompass had no notice they would be rejected. And some of the claims on the list were more than 15 months old, meaning that Encompass never had an opportunity to sue for them. See, e.g., Doc. 288-4 at 5 (Patient T.E. had a date of service

on August 24, 2007). The limitations period is unreasonable with respect to any claim included in BCBSLA's October 2010 letter that was for services rendered more than 15 months earlier.

The rest of the claims—both identified in BCBSLA's October 2010 letter and listed in its business records, *see* Doc. 301-3 at 6—are a mixed and convoluted bag. The date the claims accrue is critical to analyzing the reasonableness of a limitations period, and here it is almost impossible to pinpoint. Typically a claim accrues once administrative procedures are exhausted. In this case, however, Encompass raised a genuine issue of material fact that it should be excused from exhausting its claims because further appeals would have been futile. *See* Doc. 413 at 28-33. Futility essentially accelerates the time an ERISA claim accrues because beneficiaries are excused from exhausting administrative claims. So, in this case, the claims accrued when Encompass was on notice that it was futile to pursue further administrative procedures.

Specifying that exact date in this case is difficult for two reasons. First, as of right now, a finding of futility is not definitive. Encompass used the potential of futility to stave off BCBSLA's request for summary judgment. The legal question of whether futility applies still depends on the development of factual information at trial. Second, even assuming futility applies, the record is unclear as to when Encompass was on notice of it. The Summary Judgment Order permitted the futility argument to proceed to trial based on the combination (1) a letter sent by BCBSLA to providers notifying them that Encompass claims

would be blocked and (2) Encompass's exhaustion of a single claim that was rejected. However, neither party has provided sufficient evidence for the Court to establish when that date was. Without knowing when Encompass's claims accrued, the Court cannot evaluate whether the limitations period was reasonable for the remaining claims under the "case specific" method.

Though the Court cannot establish a specific date, it can, however, conclude that it would not have extended past receipt of the October 2010 letter. If exhaustion was futile, Encompass would have all of the necessary information to establish futility through that letter. Some of the claims that Encompass is suing on were for dates of service after October 4, 2010. *See, e.g.*, Doc. 301-3 at 6 (Patient 18 B.B., Patient 31 D.B.) As applied to those claims, the 15-month limitations period was reasonable. Encompass would have had notice of futility and could have pursued litigation immediately, giving it a full 15-months to bring suit on those claims.

The end result is this. The limitations period is unreasonable with respect to claims identified in the October 2010 letter that were for dates of services more than 15 months before that letter.[5] The limitations period is reasonable for claims filed after October 4, 2010. And everything between is unsettled because the Court has not definitively concluded that futility applies and, even if it does,

[5] For these claims, the limitations provision falls out and is replaced by the state statute of limitations. Under Louisiana law, that is ten years. *See Total Sleep Diagnostics, Inc. v. Unit. Healthcare Insurance Co.*, Civ. Action No. 06-4153, 2009 WL 152537, at *6 (E.D. La. Jan. 21, 2009).

the date that Encompass was on notice that it applies is undetermined.

In modification of the Summary Judgment Order, the Court GRANTS BCBSLA's Motion for Summary Judgment on claims filed between October 4, 2010, and November 24, 2010.[6] The Court DENIES BCBSLA's Motion for Summary Judgment with regards to the other claims. The issues of (1) whether exhaustion was futile and (2) what date Encompass knew they exhaustion would be futile are reserved for trial. From that, the Court will determine whether limitations period was reasonable with respect to the remaining ERISA claims.

**VI. Tort Claims**

In the Summary Judgment Order, the Court granted BCBSLA summary judgment on Encompass's three tort claims—defamation, business disparagement, and tortious interference with prospective business relations—because it found them time barred under Louisiana law. Encompass now requests that the Court re-consider the issue. After another review, the Court believes that Encompass has raised a genuine issue of material fact about whether *contra non valentem* tolled the running of the prescription period. Consequently, the Court revises its order and addresses the other arguments that BCBSLA raised against Encompass's three tort claims.

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[6] To be clear, the Court withdraws its application of equitable estoppel. Encompass focused its argument on whether the limitations period was unreasonable and the Court need not pass on whether equitable estoppel provides a better result than what Encompass has achieved.

a. Prescription Period And *Contra Non Valentem*

All of the tort claims revolve around a letter that BCBSLA sent to providers in August 2010. The letter was an effort to discourage them from using Encompass's services. It contains three specific claims (identified in the accompanying footnote) [7] that Encompass believes give rise to defamation, business disparagement, and tortious interference with prospective business relations. Those tort claims are all subject to a one-year prescription period that runs from the date of injury. La. Civ. Code. Ann. art. 3492. The parties agree that injury occurred when the letter was sent and that the suit was filed more than one year after that. What they disagree on, is whether the limitations period was tolled.

Under the Louisiana doctrine of *contra non valentem*, a prescription period does not "commence

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[7] For ease of reference, the Court will list out the statements and accompanying short-hand appellation. All statements are found at Doc. 288-4 at 2:

Out-of network Provider Statement : "Encompass is not eligible to participate in the Blue Cross networks and is considered an out-of-network provider."

Facility Fees Statement: "The facility fees charged by Encompass are not covered, even when they are billed by a network physician.... Encompass would have to be a Louisiana licensed DHH-approved ambulatory surgery facility in order to be eligible for benefit payments for these facility charges."

Network Termination Statement: "If we find that any network physician is repeatedly using Encompass to deliver facility and procedure services that are not eligible for benefits and our members are being billed for these facility charges, the network physician will be subject to termination from the Blue Cross networks."

to run until plaintiff has actual or constructive knowledge of the tortious act, the damage and the causal relation between the tortious act and the damage." *Duhon v. Saloom*, 323 So. 2d 202, 204 (La. Ct. App. 1975). The Fifth Circuit has stated that the action must be known or "reasonably knowable." *Eldredge v. Martin Marietta Corp.*, 207 F.3d 737, 743 (5th Cir. 2000). "When prescription begins to run depends on the reasonableness of a plaintiff's action or inaction." *Knaps v. B&B Chemical Co.*, 828 F.2d 1138, 1140 (5th Cir. 1987) (citations omitted) (citing Jordan v. Emp. Transfer Corp., 509 So.2d 420, 423 (La. 1987)).

The heart of Encompass's argument is that *contra non valentem* applies because they could not have known the statements were false as long as BCBSLA maintained that they had a policy against reimbursing providers like Encompass. *See* Doc. 416 at 7-8 ("While Encompass had knowledge that the letter had been sent in the fall of 2010, it had no reason to know that the statements in the letter were false, and therefore actionable, until February 2013."). Even until the early stages of this suit, BCBSLA averred that it had such a policy. For example, in BCBSLA's Answer to Encompass's Fourth Amended Complaint, filed on January 4, 2013, it quoted an alleged "global fee" policy that "[w]hen performing surgical procedures in a non-facility setting, the physician's and other professional provider's reimbursement is all inclusive." Doc. 217 at 34. Therefore, Encompass argues, the first time it could have known that these statements were false was on February 19, 2013, after depositions of BCBSLA employees revealed that the alleged policy did not exist at all.

Encompass has raised a genuine issue of material fact as to whether *contra non valentem* applies. Initially the Court concluded it did not because Encompass "enjoyed every reasonable opportunity to investigate the statements in the letter and file suit within one year to conduct further discovery on the matter." Doc. 413 at 46. A second-look at the issue has shown that the circumstances surrounding BCBSLA's policies may have made it impossible for Encompass to discover the falsity of the statements. Encompass has argued and BCBSLA does not contest—that "knowledge of the falsity was uniquely restricted to BCBSLA." Doc. 416 at 9. "When prescription begins to run depends on the reasonableness of a plaintiff's action or inaction." *See Knaps*, 828 F.2d at 1140. Neither party has provided sufficient evidence about whether Encompass could or could not reasonably determine the existence of the policy; both sides' arguments consist largely of naked assertions that they could or could not find out. [8] Background information about the availability of the policy information is critical to apply *contra non valentem*. Without sufficient evidence to show that Encompass could not determine the policy's existence, BCBSLA fails to

[8] In the briefing, Encompass argues that prescription is unconcerned with "whether plaintiff had a reasonably opportunity to investigates its claim." But not taking a reasonable "opportunity to investigate its claim" is precisely the kind of "inaction" that would allow the prescription period to run. If the record were clear that Encompass could have discovered that the statements were false by investigating the claim, then *contra non valentem* would not apply. However, because it is unclear, the Court cannot grant summary judgment on the issue.

meet its summary judgment burden. The Court revises its previous order and DENIES BCBSLA's Motion for Summary Judgment on Three Tort Claims based the prescription period.[9]

Because the Court has revised its order, it must now evaluate un-reached arguments posed in the original briefing.

b. Business Disparagement

Encompass cannot bring a claim for business disparagement because "Louisiana law does not recognize disparagement as an independent tort." *Lamar Adver. Co. v. Cont'l Cas. Co.*, 396 F.3d 654, 664 (5th Cir. 2005). Instead, it merges with defamation. *Id.* Consequently, the Court GRANTS BCBSLA's Motion for Summary Judgment on Three Tort Claims as it applies to Encompass's claim for business disparagement.

c. Defamation

BCBSLA moves for summary judgment on the Encompass's defamation claims on two other grounds: first, that the statements are subject to a qualified privilege that prevents liability; second, that Encompass has conceded the statements are true.

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[9] BCBSLA also asserted that *contra non valentem* should not apply because "it sued another major health insurer for defamation six weeks before the Cantrell Letter based on virtually identical statements." Doc. 378-1 at 14. Even if the statement at issue in the other suit was identical to the one in BCBSLA's letter—it's not—it is only a single one of the statements that Encompass objects to; the suit against BCBSLA features statements on subjects not covered in the other suit.

The first argument—that BCBSLA enjoyed a qualified privilege to make the statements—hinges on a genuine issue of material fact. Qualified privilege is a defense to defamation actions. *See Kennedy v. Sheriff of E. Baton Rouge*, 935 So.2d 669, 681 (La. 2006). Determining whether an individual speaks pursuant to a qualified privilege is a two-step process. The first step, an issue of law, asks "whether the attending circumstances of a communication occasion a qualified privilege." *Id.* at 682. Generally Louisiana courts have looked at whether the speaker has an interest or duty related to the subject of the statement and that the listener has a corresponding duty or interest. *See e.g., Roy v. Coco*, 649 So.2d 1139, 1140 (La. App. 1995) (citing *Alford v. Georgia-Pacific Corp.*, 331 So.2d 558 (La. App. 1976)). The second step, an issue of fact, is "whether the privilege was abused, which requires that the grounds for abuse—malice or lack of good faith—be examined." *Kennedy*, 935 So.2d at 682.

While BCBSLA's statement was made in circumstances that would enjoy a qualified privilege, Encompass has raised an issue of fact about whether BCBSLA abused it through malice or lack of good faith. Encompass insists that BCBSLA's statements are not privileged because they do not concern the public interest. *See* Doc. 384-1 at 21-22 (citing *Phillips v. Lafayette Parish Sch. Bd.*, 935 So.2d 739, 744 (La. App. 2010)). But the Louisiana Supreme Court has stated that "there are a variety of situations" when a conditional privilege may arise because the subject is "sufficiently important to justify some latitude for making mistakes." *Id.* at 681. Thus, "it is

impossible to reduce the scope of a conditional or qualified privilege to any precise formula" and that includes limiting it just to statements in the public interest. *Id.* Indeed, this case is a good example of circumstances where a business would be entitled to a qualified privilege. BCBSLA has an important interest in informing its providers of policies and even discussing how those policies apply to specific entities like Encompass. So they are entitled to a qualified privilege.

But they also cannot abuse that privilege. The second step of the analysis prevents the privilege from attaching if BCBSLA made the statement with malice or lack of good faith. And on that factual issue, Encompass has certainly submitted evidence tending to show malice of lack of good faith. In particular, it cites an email from Shannon Taylor, a BCBSLA employee, who, in discussing the formulation of the letter stated, "Quite honestly, I'm not 100% sure why we aren't contracting with [Encompass] because I don't believe we have a concrete policy on this provider type (or maybe I missed that somewhere ...)." Doc. 288-8 at 1 (ellipsis in the original). [10] This evidence is

[10] The context of the email does not make it unambiguously non-malicious either:

I've been thinking about this letter all week. It needs to include information about our reimbursement policy on global reimbursement of office services. Meaning, if these physicians perform these services in their office, the global fee applies and it includes payment of the resources used to perform the service. If Encompass is used, the services are non-covered (that is our policy today anyway).

I don't want to get into why they are nonpar, because then we will get calls from physicians campaigning to put Encompass in the network and then they will think the member will have coverage/benefits paid for the service. Our

sufficient to let a jury determine whether BCBSLA spoke maliciously or with lack of good faith when it sent the letter.

BCBSLA's second argument—that Encompass has conceded the statements are true—also depends on disputed issues of fact."[11] For the Out-of-network Provider Statement, BCBSLA cites (really, stretches) deposition testimony to say that Encompass conceded it "was an out-of-network provider and that [the Encompass representative] had no personal knowledge of the requirements to participate in a Blue Cross network." Doc. 378-1 at 23 (citing Doc. 325 at 18-19). That misses Encompass's point altogether, which is that the Out-of-network Provider Statement is false because Encompass's network status is irrelevant to whether it may be reimbursed. BCBSLA's argument about the Facility Fees Statement similarly founders, arguing that Encompass concedes that it is not a brick and mortar facility which is irrelevant to Encompass's point that any such policy could not apply to them. Doc. 378-1 at 23 (citing Doc. 325 at 2). The Network Termination Statement, viewed in a light favorable to Encompass, could be a statement that Encompass is an uncovered provider which may be considered false. None of the statements are unambiguously true and Encompass has not conceded the issue.

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reason for not contract [sic] is between us and Encompass. Quite honestly, I'm not 100% why we aren't contracting with them because I don't believe we have a concrete policy on this provider type (or maybe I missed that somewhere ... ). Anyway, I think we just state they are non-par and leave it at that. Doc. 288-8 at 1.

[11] When referring to the statements, the Court uses the designation from *supra* note 7.

Consequently, the Court DENIES BCBSLA's Motion for Summary Judgment on the Three Tort Claims as applied to Encompass's claim for defamation.

d. Tortious Interference With A Business Relationship

BCBSLA also moved for summary judgment on Encompass's claim for tortious interference with a business relationship. In its brief supporting the motion, BCBSLA cites to precedent that discusses tortious interference with a contract, rather than the separate tort of interference with a business relationship. *See* Doc. 378-1 at 19-20 (setting out the elements of tortious interference with a contract). Encompass believes that makes BCBSLA argument inapplicable to their claim, while BCBSLA counters that Louisiana courts cross-apply the principles of tortious interference with a contract to tortious interference with a business relationship.

Louisiana law on the tortious interference torts is not clear, but the best reading is that they are independent causes of action with independent requirements. The Louisiana appellate court decision that BCBSLA cites undeniably treats interference with a business relationship as interchangeable with interference with a contract. *See Guilbeaux v. Times of Acadiana, Inc.*, 661 So.2d 1027 (La. App. 1995) (addressing an appeal for "tortious interference with business relations" and citing the element of interference with a contract). However, the development and modern treatment

of the two causes of action show they are indeed separate torts.[12]

The Louisiana Supreme Court first recognized tortious interference with a contract in *9 to 5 Fashions, Inc. v. Spurney*, 538 So.2d 228 (1989). In doing so, it was explicit and self-aware that it was creating a new cause of action. See id. at 231 (enumerating the elements of interference with a contract "in light of modern empirical considerations and the objectives of delictual law" based on "precepts derived from the contemporary doctrine of interference with contractual relations existing in other jurisdictions"). Subsequent courts have identified the elements as "(1) the existence of a contract or a legally protected interest between the plaintiff and the corporation; (2) the corporate officer's knowledge of the contract; (3) the officer's intentional inducement or causation of the

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[12] As a federal court applying state law, the Court would typically defer to Louisiana appellate court's interpretation of state law. However, when law from the highest court in a state contradicts a lower court opinion or the Court is "convinced by other persuasive data" that the highest court would rule otherwise, it may depart. *See Mem'l Hermann Healthcare Sys. Inc. v. Eurocopter Deutschland, GMBH*, 524 F.3d 676, 678 (5th Cir. 2008) (internal citations and quotations omitted).

The Court is convinced that *Guilbeaux* is an outlier that is inconsistent with Louisiana law. Beyond the reasoning in the body of this opinion, departing from Guilbeaux is appropriate for another reason. The *Guilbeaux* Court was not actually addressing whether the two causes of action were identical; it just used the terms fluidly without ever addressing whether they were two different actions. Certainly the implication from *Guilbeaux* is that they are the same. But since it did not directly answer the question, this Court cannot be sure that it was an oversight rather than an intentional collapsing of those doctrines.

corporation to breach the contract or his intentional rendition of its performance impossible or more burdensome; (4) absence of justification on the part of the officer; (5) causation of damages to the plaintiff by the breach of contract or difficult of its performance brought about by the officer." *Constance v. Jules Albert Const., Inc.,* 591 So.2d 1238, 1239 (La. App. 1991).

In contrast, interference with a business relationship has an older source, *Graham v. St. Charles St. R. Co.*, 18 So. 707 (1895). While courts have expounded on it, the law surrounding the tort remains largely undeveloped. The plaintiff bears the burden of showing that the "defendant improperly influenced others not to deal with the plaintiff." *Junior Money Bags, Ltd. v. Segal*, 970 F.2d 1, 10 (5th Cir. 1992). The interference must be "malicious and wanton interference, permitting only interferences designed to protect a legitimate interest of the actor." *Id.* (citing *Dussouy v. Gulf Coast Inv. Corp.*, 660 F.2d 594, 601 (Former 5th Cir. Nov. 1981). "The malice elements seem to require a showing of spite or ill will" though "its meaning is not perfectly clear." *JCD Marketing Co. v. Bass Hotels and Resorts, Inc.*, 812 So. 2d 834, 841 (La. App. 2002) (citing George Denegre, Jr., et al., *Tortious Interference and Unfair Trade Claims: Louisiana's Elusive Remedies for Business Interference*, 45 Loy. L. Rev. 395, 401 (1999)). Louisiana courts have noted that its "jurisprudence has viewed [the tort] with disfavor." *Id.*

So interference with a contract and interference with a business relationship do not overlap in their development by the Louisiana Supreme Court. Intermediate courts also analyze them differently,

the one exception being *Guilbeaux* which this Court believes is an outlier. Each tort has its own requirements, independent of the other.

Because they are separate, BCBSLA's arguments for summary judgment based on tortious-interference-with-contract principles is inapplicable to Encompass's claim for tortious interference with a business relationship. [13] Therefore, the Court DENIES BCBSLA's Motion for Summary Judgment on Three Tort Claims as it applies to Encompass's claim of tortious interference with a business relationship.

## VII. Certification For Immediate Appeal Is Improper

Encompass alternatively requests that the Court certify the Summary Judgment Order for immediate appeal under 28 U.S.C. § 1292(b). The Court frnird that request.

Section 1292(b) permits a district court to certify that an order "involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the litigation." The Court does not believe that certifying the order would

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[13] In its Reply brief, BCBSLA argues that Encompass cannot show the malice necessary to avoid summary judgment. However, "The purpose of a reply brief under local rule 7.1(f), is to rebut the nonmovants' response." *Penn. Gen. Ins. Co v. Story*, No. 3:03-cv-0330-G, 2002 WL 21435511, at *1 (N.D. Tex. June 10, 2003) (citations and internal quotations omitted). Consequently, "a court generally will not consider arguments raised for the first time in a reply brief." *Id.* The Court declines to consider that argument here since Encompass has not had a meaningful opportunity to respond.

"materially advance the ultimate termination of the litigation." The Summary Judgment Order and this order are rife with unresolved issues of material facts. Certifying the orders for appeal would force the Court of Appeals to wade through these disputed issues without the benefit of factual developments at trial. The more prudent course is to hold a trial prior to the parties exercising their rights on appeal, requiring the Fifth Circuit Court of Appeals to review this Court's work only once.

**VIII. Conclusion**

For the foregoing reasons, the Court GRANTS IN PART and DENIES IN PART Defendant's Motion to Correct Judgment. The Court GRANTS IN PART and DENIES IN PART Plaintiff's Motion to Reconsider and, in the Alternative, Motion to Certify Controlling Question of Law for Immediate Appeal.

The Court's Summary Judgment Order is revised accordingly. It GRANTS BCBSLA's Motion for Summary Judgment with regards to claims under FEHBA and a single claim outside of the coverage dates. It is DENIED with respect to the claims filed by participants in non-BCBSLA plans submitted through the Interplan program. Regarding the ERISA limitations period, the Court GRANTS summary judgment for claims with dates of service after October 4, 2010, that were not sued on within 15 months of the date of service. For all other ERISA claims, summary judgment is DENIED on the basis of the limitations period.

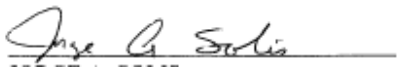
BCBSLA's Motion for Summary Judgment on Three Tort Claims is now GRANTED with respect to business disparagement and DENIED with

respect to defamation and tortious interference with a business relationship.

Furthermore, the Court ORDERS the parties to jointly submit three proposed dates for trial. The joint proposal must be filed within fourteen days of the date of this Order.

**IT IS SO ORDERED.**

Signed this 29th day of April, 2014.



JORGE A. SOLIS
UNITED STATES DISTRICT JUDGE

## APPENDIX H

## IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS DALLAS DIVISION

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| ENCOMPASS OFFICE SOLUTIONS, INC., Plaintiff, v. LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA, and BLUECROSS BLUESHIELD OF TENNESSEE, INC., Defendants. | 3:11-CV-1471-P [**FILED** 09/17/13] |

**ORDER**

Now before the Court are three pending Motions for Summary Judgment, a Motion to Strike Evidence, a Motion *In Limine*, a Motion for Summary Judgment on Three Tort Claims, and a Motion to Exclude Testimony.

Plaintiff Encompass Office Solutions, Inc. filed its Motion for Summary Judgment on May 17, 2013. (Doc. 288.) Defendant Louisiana Health Service & Indemnity Co. d/b/a Bluecross and Blueshield of Louisiana filed a Response on June 7, 2013. (Doc. 324.) Defendant Bluecross Blueshield of

Tennessee, Inc. filed a Response on June 7, 2013. (Doc. 336.) Plaintiff filed a Reply on June 21, 2013. (Doc. 344.) After reviewing the parties' briefing, the evidence, and the applicable law, the Court DENIES Plaintiff Encompass Office Solutions, Inc.'s Motion for Summary Judgment.

Plaintiff Encompass Office Solutions, Inc. also filed a Motion to Strike Evidence in Defendant Bluecross Blueshield of Louisiana's Motion for Summary Judgment on June 7, 2013. (Doc. 331.) Defendant Bluecross Blueshield of Louisiana filed a Response on June 28, 2013. (Doc. 351.) Plaintiff filed a Reply on July 12, 2013. (Doc. 358.) After reviewing the parties' briefing, the evidence, and the applicable law, the Court DENIES Plaintiff Encompass Office Solutions, Inc.'s Motion to Strike Evidence in Defendant Bluecross Blueshield of Louisiana's Motion for Summary Judgment.

Defendant Bluecross and Blueshield of Louisiana filed its Motion for Summary Judgment on May 17, 2013. (Doc. 291.) Plaintiff Encompass Office Solutions, Inc. filed its Response on June 7, 2013. (Doc. 327.) Defendant Bluecross and Blueshield of Louisiana filed its Reply on June 21, 2013. (Doc. 345.) After reviewing the parties' briefing, the evidence, and the applicable law, the Court GRANTS IN PART and DENIES IN PART Defendant Bluecross and Blueshield of Louisiana's Motion for Summary Judgment.

Defendant Bluecross Blueshield of Tennessee, Inc. filed its Motion for Summary Judgment on May 17, 2013. (Doc. 297.) Plaintiff Encompass Office Solutions, Inc. filed its Response on June 7, 2013. (Doc. 333.) Defendant Bluecross Blueshield of Tennessee, Inc. filed its Reply on June 21, 2013.

(Doc. 347.) After reviewing the parties' briefing, the evidence, and the applicable law, the Court GRANTS IN PART and DENIES IN PART Defendant Bluecross Blueshield of Tennessee, Inc.'s Motion for Summary Judgment.

Defendant Bluecross and Blueshield of Louisiana's First (Amended) Motion *In Limine*, filed on July 2, 2013. (Doc. 354.) Plaintiff Encompass Office Solutions filed a Response on July 23, 2013. (Doc. 367.) Defendant filed a Reply on August 6, 2013. (Doc. 373.) After reviewing the parties' briefing, the evidence, and the applicable law, the Court GRANTS IN PART and DENIES IN PART Defendant Bluecross and Blueshield of Louisiana's First (Amended) Motion *In Limine*.

Defendant Bluecross and Blueshield of Louisiana filed its Motion for Summary Judgment on Three Tort Claims on August 16, 2013. (Doc. 378.) Plaintiff Encompass Office Solutions, Inc. filed its Response on August 27, 2013. (Doc. 384.) Bluecross and Blueshield of Louisiana filed its Reply on September 10, 2013. (Doc. 387.) After reviewing the parties' briefing, the evidence, and the applicable law, the Court GRANTS Bluecross and Blueshield of Louisiana's Motion for Summary Judgment.

Defendant Bluecross and Blueshield of Louisiana filed its Motion to Exclude, and Objection to, Testimony of Robert Daniel Gates as an Expert on August 16, 2013. (Doc. 379.) Defendant Bluecross Blueshield of Tennessee joined in the motion. (Doc. 381.) Plaintiff Encompass Office Solutions, Inc. filed its Response on August 27, 2013. (Doc. 383.) Because the Court granted Defendant Bluecross and Blueshield of

Louisiana's Motion for Summary Judgment on Three Tort Claims, the Court DENIES the Motion to Exclude as MOOT.

## I. Background[1]

This is a suit seeking payment for medical services. Plaintiff Encompass Office Solutions, Inc. ("Encompass") is a healthcare provider. (Doc. 335-1 at 28.) The primary business of Encompass is provision of specially trained nurses, supplies, and equipment so that a physician may perform in-office outpatient surgery while the patient is under anesthesia. (*Id.* at 28-29.) As opposed to a traditional "brick-and-mortar" ambulatory surgery center ("ASC"), Encompass's business operations bring the necessary staff and equipment directly to the doctor's office rather than bringing the physician to the ASC or a hospital. (*Id.*; Doc. 288-3 at 28.)

When a patient undergoes an in-office surgical procedure using Encompass's services, the patient first signs a form styled as an assignment of benefits ("AOB"), which contains the following language:

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[1] Both Encompass and BCBSLA have submitted factual summaries styled as statements of uncontested facts. (Doc. 294 & Doc. 288-1 at 8-16.) Both sections have garnered responses contesting the facts as outlined. (Doc. 330 & Doc. 321 at 7-10.) In light of the voluminous contentions as to the facts of this case, the Court resolves that the only facts not in dispute in this case are those which are unrebutted by admissible summary judgment evidence. *See Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 249–50 (1986) (mere assertions of a factual dispute unsupported by probative evidence will not prevent summary judgment).

> I hereby instruct and direct [patient's health insurer] to pay by check made out to Encompass below. Or, if my insurance policy prohibits direct payment, I hereby direct myself to make a check payable to Encompass...For the medical benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee. *See e.g.* (Doc. 329-3 at 22.)

Before the patient underwent the surgical procedure, representatives of Encompass would also explain the nature of Encompass and its role in billing the patient's health insurer for services provided to the patient. (Doc. 288-3 at 75, 80.) Upon completing an AOB, a patient would then be immediately billed for a prompt pay coinsurance amount which, though not exactly equal to the patient's actual out-of-network coinsurance amount, was based upon objective data and designed to approximate this amount to the fullest extent possible. (Doc. 329-1 at 55.) Encompass never pursued the patient for any additional amounts and instructed them that they would not be billed for the balance of costs associated with their procedure. (Doc. 301-2 at 6.) In short, the prompt pay coinsurance amount was the patient's sole out-of-pocket expense for the medical treatment.

Although the patients executed AOB forms, the plan language of their insurance policies expressly forbids such assignment. The plan language states that "A Member's rights and benefits under this Benefit Plan are personal to the Member and may not be assigned in whole or in part by the Member." *See e.g.* (Doc. 295-1 at 23-24; 93-94.) The plan language reiterates this prohibition, noting that "We will not recognize assignments or attempted assignments of benefits." *See e.g.* (Doc. 295-1 at 23-24; 93-94.)

Once the surgery was complete, Encompass employed a third-party billing company to file a claim for reimbursement with the patient's health insurer for the services rendered. (*Id.* at 76.) Often, the claims submitted largely mirrored the claims for reimbursement submitted by the treating physician, including identical billing dates, identical site of service codes,[2] and identical billing numbers. (*See* Doc. 301-5 at 6-15.) However, Encompass's claims frequently included an additional technical component modifier [3] ("TC Modifier"). (Doc. 288-3 at 18.)

Defendant Louisiana Health Service & Indemnity Co. d/b/a Bluecross and Blueshield of Louisiana ("BCBSLA") is a health insurer which provides coverage to various participants in its health plans throughout Louisiana. Initially,

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[2] The relevant site of service code for claims submitted was 11, indicating that the surgery was performed in a physician's office as opposed to in a hospital or ASC. (Doc. 288-3 at 18.)

[3] A TC Modifier represents "[a] portion of the health care service that identifies the provision of the equipment, supplies, technical personnel, and costs attendant to the performance of the procedure other than the professional services." (Doc. 288-13 at 17.)

BCBSLA received claims for reimbursement from Encompass and promptly paid the submitted claims. *See* (Doc. 288-4 at 3-6.) The total value of claims paid out by BCBSLA was initially believed to be approximately $109,676.55 for claims submitted by Encompass on behalf of BCBSLA members. (*Id*.) However, BCBSLA later ceased to compensate Encompass for reimbursement claims submitted on behalf of BCBSLA's insureds. In explaining why the claims were denied, BCBSLA repeatedly determined that "Reimbursement is considered to be a portion of another service which has been allowed. Therefore, no payment can be made for this service." (Doc. 324 at 11-13; Doc. 321 at 26; *see also e.g.* 289-6 at 23 (explanation of benefits form)). Upon receipt of a claim's denial, Encompass elected not to pursue administrative review of the denials as contemplated under the health insurance plans. (Doc. 301-5 at 22.)

Matters came to a head in October 2010, when Alan Lofton, acting on behalf of BCBSLA, sent a letter to the President of Encompass stating that BCBSLA had erroneously paid $109,676.55 for claims submitted by Encompass on behalf of BCBSLA members. (Doc. 288-4 at 3-6.) BCBSLA informed Encompass that it demanded repayment in full for all claims erroneously paid. (*Id.*) The letter also contains a spreadsheet itemizing the 53 claims which were paid previously, but which BCBSLA denied as of October 4, 2010. (*Id.* at 5-6.) Around this same time, BCBSLA also sent a letter to its Blue Cross network physicians. (Doc. 288-4 at 1.) This letter informed the physicians that "Encompass is not eligible to participate in the Blue Cross networks and is considered an out-of-network

provider." (*Id.*) BCBSLA also asked its physicians not to use Encompass, and warned that any physician who repeatedly used Encompass "to deliver facility and procedure services" would "be subject to termination from the Blue Cross networks." (*Id.*)

Defendant Bluecross Blueshield of Tennessee, Inc. ("BCBSTN") is also a health insurer. Encompass submitted reimbursement claims to BCBSTN, which paid an amount which was less than Encompass claimed was owed. (Doc. 335-1 at 3-4.)

Seeking redress for the many payment disputes between the parties, Encompass filed a series of complaints in the U.S. District Court for the Northern District of Texas which culminated in a Fifth Amended Complaint. (Doc. 255.) The Fifth Amended Complaint brought causes of action against BCBSLA and BCBSTN for breach of contract [*id.* at 18], quantum meruit [*id.* at 20], and reimbursement under Section 502(a)(1)(B) of the Employee Retirement Income Security Act ("ERISA") [*id.* at 255]. In addition, Encompass brought a cause of action Order against BCBSLA for defamation, alleging that BCBSLA's letter to its network physicians was materially false and brought about significant financial injury. (*Id.* at 24-27.)

## II. Legal Standards & Analysis

### A. Motion to Strike

Arguing that BCBSLA has included inadmissible summary judgment evidence, Encompass has moved to strike a list of evidence in the summary judgment record, including the

affidavits of Patricia Crochet, Tyronda Moses-Childs, Thomas Groves, certain exhibits attached thereto, as well as other evidentiary citations throughout BCBSLA's briefing. (Doc. 331 at 210.) In Response, BCBSLA contends that the disputed evidence is both admissible and proper in the summary judgment setting. (Doc. 351 at 6-17.)

As to the affidavits of Patricia Crochet and Tyronda Moses-Childs, Encompass claims that BCBSLA failed to identify these witnesses during discovery. (Doc. 331 at 2-3.) According to BCBSLA, such witnesses were identified in designation A.2. (Doc. 351 at 6, 10.) Although the cited language in designation A.2 is broad, it sufficiently outlines certain persons capable of authenticating documents as representatives of BCBSLA, and also notes that they may be contacted via counsel for BCBSLA. (Doc. 352 at 80-85.) This is sufficient to avoid the severe penalties which Plaintiff seeks under Rule 37 of the Federal Rules of Civil Procedure.[4] Plaintiff also argues that the exhibits attached to Ms. Crochet's affidavit, including the spreadsheet detailing plan information and claims are inadmissible under the best evidence rule. (Doc. 331 at 7.) Federal Rule Evidence 1002 states: "To prove the content of a writing ..., the original

[4] Under the Federal Rules of Civil Procedure, "If a party fails to provide information or identify a witness as required by Rule 26(a) or (e), the party is not allowed to use that information or witness to supply evidence on a motion, at a hearing, or at a trial, unless the failure was substantially justified or is harmless." Fed. R. Civ. P. 37(c)(1). Encompass has not identified how any purported failure to disclose the witnesses in question has resulted in harm, and the Court therefore finds any failure to name a specific employee would be harmless.

writing ... is required, except as otherwise provided in these rules or by Act of Congress." Fed. R. Evid. 1002. However, Encompass has only complained that BCBSLA did not file the actual plans, it does not dispute or argue the correctness of the contents of the exhibit. Finding that the actual contents of the writing at issue are not in dispute, and that the Plan language can be adequately verified through other plans already received in evidence, the Court declines to strike this evidence.

Encompass also argues that the affidavit of Thomas Groves violates the best evidence rule and is contradicted by other evidence in the record. (Doc. 331 at 3-5.) Mr. Groves's testimony details certain policies of BCBSLA, including the existence of a hotly contested global fee payment, whereby payment to a physician is intended to cover the costs of services provided by other healthcare providers such as Encompass. (Doc. 301-5 at 17.) First, the Court finds that Groves, as Director of Provider Contracting and Service, asserted that he has personal knowledge of the facts in his affidavit. (*Id.* at 16.) Moreover, Groves's testimony does not purport to establish the terms of healthcare plans—as Encompass insists—but instead outlines BCBSLA policies, practices, and procedures. The fact that Encompass has submitted other evidence which contradicts or casts doubt on the existence of a global fee payment speaks not to the admissibility of Groves's testimony, but instead to its weight. The Court therefore declines to strike Groves's affidavit.

Encompass has also requested that the Court strike a laundry list of other miscellaneous evidence cited sporadically throughout BCBSLA's

briefing. (Doc. 331 at 6-11.) The Court has neither cited to much of this evidence in the instant Order, nor has it considered it in reaching a ruling. *See e.g. Henderson v. Paul Revere Life Ins. Co.*, No. 3:11–CV–1992–D, 2013 WL 1875151, at *3 n. 5 (N.D. Tex. May 6, 2013) ("The court need not address objections to the Order declarations that pertain to evidence that the court is not considering in deciding the merits of defendants' summary judgment motion.") Thus Plaintiff's arguments concerning many of the remaining evidentiary objections are moot. To the extent that the Court considered any remaining evidence to which Encompass objects, such arguments speak only to the weight of the evidence, not its admissibility. *See Williamson v. United States Dep't of Agric.,* 815 F.2d 368, 383 (5th Cir. 1987) (finding that the district court did not improperly consider inadmissible portions of affidavits and writing because "[t]hose portions of affidavits that do not comply with the requirements of Federal Rule of Civil Procedure 56(e) are entitled to no weight.") Plaintiff's Motion to Strike is therefore DENIED.

**B. Motion *In Limine***

Throughout the briefing on the summary judgment motions and in its separate Motion *In Limine*, BCBSLA has maintained that the Court may only consider evidence that was on the administrative record. *See* (Doc. 321 at 22; 324 at 9-11; 345 at 12; Doc. 354.) It further requests that the Court limit any evidence at trial, for both ERISA and non-ERISA claims, to the information on the administrative record. (Doc. 354 at 1) (requesting that the Court "exclude from... consideration, whether on [Encompass's] pending Motion for

Summary Judgment or at any other time in this proceeding, all proffered evidence that is deemed to be outside of the administrative record of each of the 212 claims at issue, regardless of whether the individual claim is being presented against an ERISA or non-ERISA plan").

Motions *in limine* are disposed of "pursuant to the district court's inherent authority to manage the course of trials." *Luce v. United States*, 469 U.S. 38, 41 n.4 (1984). During the summary judgment stage of trial, a party may object to summary judgment on the grounds that evidence supporting or disputing a fact will not be admissible at trial. Fed. R. Civ. P. 56(c)(2). The Court decides preliminary questions about whether evidence is admissible under the Federal Rules of Evidence. Fed. R. Evid. 104(a).

Evidence about "the merits of the coverage determination [under ERISA]—i.e. whether coverage should have been afforded under the plan—" *Crosby v. La. Health Serv. & Indemnation Co.*, 647 F.3d 258, 263 (5th Cir. 2011), is limited to evidence that "is in the administrative record, relates to how the administrator has interpreted the plan in the past, or would assist the court in understanding medical terms and procedures." *Id.* "The administrative record consists of relevant information made available to the administrator prior to the complainant's filing of a lawsuit and in a manner that gives the administrator a fair opportunity to consider it." *Estate of Bratton v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 215 F.3d 516, 521 (5th Cir. 2000) (citing *Vega v. Nat'l Life Ins. Services*, 188 F.3d 287, 295, 299 (5th Cir. 1999) (en banc)). Evidence is not so limited, however, "to

resolve other questions that may be raised in an ERISA action." *Crosby*, 647 F.3d at 263. Common issues that arise in ERISA actions that are not limited to the evidentiary record include "the completeness of the administrative record; whether the plan administrator complied with ERISA procedural regulations; and the existence and extent of a conflict of interest created by a plan administrator's dual role in making benefits determination and funding the plan." *Id.*

The evidentiary limitations on the Court for these motions and at trial apply narrowly. The Court is limited to the administrative record only when it is determining the "merits of the coverage determination" for ERISA claims. Crosby, 647 F.3d at 263. The bulk of the motions before the Court relate to non-coverage issues, such as Article III standing, validity of assignment forms, and exhaustion of administrative remedies. When addressing those issues, the Court is not constrained by any evidentiary limitation because they are not "the merits of coverage determination." *Id.*

Neither is the Court limited to the administrative record when considering the merits of coverage determination for non-ERISA claims. BCBSLA argues that the standard for ERISA claims should apply to non-ERISA claims "because 1) the non-ERISA pertinent plan provisions are identical to the ERISA plan provisions; and 2) Encompass' claim submissions were equally as duplicative under both the ERISA and non-ERISA plans." (Doc. 354 at 3-4.) In essence, BCBSLA believes that ERISA law applies to non-ERISA claims when the underlying plan has similar terms

to plans covered by ERISA. But the evidentiary restriction for ERISA claims comes from ERISA's control over the plans, not the terms of the plans. *See Wildbur v. ARCO Chemical Co.*, 974 F.2d 631, 639 (5th Cir. 1992) (connecting the restriction on evidence to ERISA's exhaustion requirements). BCBSLA has not brought to the Court's attention any plan term or case law that restricts evidence in breach of contract suits to the administrative record. ERISA's evidentiary standard does not apply to the non-ERISA claims. The Court denies the motion as it applies to any non-ERISA claims.

That leaves the merits of coverage determination for the ERISA claims. Courts are limited to the administrative record in reviewing the merits of coverage determination, *Crosby*, 647 F.3d at 263, but that restriction is not as sweeping as BCBSLA suggests. (Doc. 324 at 10-11) ("[V]irtually all of Encompass' evidentiary citations in its 51-page Brief in Support are inadmissible and incapable of consideration when judging BCBSLA's discretion."). Moreover, BCBSLA's definition of the administrative record is unduly narrow. (Doc. 354 at 3) (defining the record as only the health benefit plan, the physician's billing to BCBSLA, Encompass's invoice, and the explanation of benefits).

The term "merits of coverage determination" refers to the factual determinations by the plan administrator, not policy interpretations. *See S. Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 102 (5th Cir. 1993). For example, a plan administrator may make a factual determination about causation between two health conditions. In reviewing the determination about the causation,

the Court is limited to the administrative record. But it would not be so limited in addressing whether the plan should be interpreted to exclude such causation from coverage. *Id.* ("We may consider only the evidence that was available to the plan administrator in evaluating whether he abused his discretion in making the factual determination that the tumor caused or contributed to Mr. Moore's death, but we may consider other evidence, which was unavailable to the plan administrator as it relates to his interpretation of the policy."). Because the parties in this case primarily dispute policy interpretations, the evidentiary limitation will apply infrequently, if ever.

Even if Encompass does contest factual determinations, the administrative record includes more than the four documents that BCBSLA enumerated. *See Estate of Bratton*, 215 F.3d at 521 ("The administrative record consists of relevant information made available to the administrator prior to the complainant's filing of a lawsuit and in a manner that gives the administrator a fair opportunity to consider it."). As long as the information was available to BCBSLA's administrator prior to Encompass's suit and the administrator had fair opportunity to rely on it, the Court will consider it part of the administrative record.

Thus, the Court GRANTS IN PART BCBSLA's Motion *In Limine*. With respect to ERISA claims, the Court will only consider evidence from the administrative record to make any determination about the merits of coverage determination. The

Court DENIES IN PART BCBSLA's Motion *In Limine* as it applies to all other claims and issues.

**C. Summary Judgment Standard**

Summary judgment shall be rendered when the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *see also Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). The moving party bears the burden of informing the district court of the basis for its belief that there is an absence of a genuine issue for trial and of identifying those portions of the record that demonstrate such absence. *See Celotex*, 477 U.S. at 323. However, all evidence and reasonable inferences to be drawn there from must be viewed in the light most favorable to the party opposing the motion. *See United States v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

Once the moving party has made an initial showing, the party opposing the motion must come forward with competent summary judgment evidence of the existence of a genuine fact issue. Fed. R. Civ. P. 56(e); *see also Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586–87 (1986). The party defending against the motion for summary judgment cannot defeat the motion, unless he provides specific facts demonstrating a genuine issue of material fact, such that a reasonable jury might return a verdict in his favor. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247–48 (1986). Mere assertions of a factual dispute unsupported by probative evidence will not prevent summary judgment. *See id.* at 249-

50. In other words, conclusory statements, speculation, and unsubstantiated assertions will not suffice to defeat a motion for summary judgment. *See Douglass v. United Servs. Auto. Ass'n*, 79 F.3d 1415, 1429 (5th Cir. 1996) (en banc); *see also Abbott v. Equity Grp., Inc.*, 2 F.3d 613, 619 (5th Cir. 1993) ("[U]nsubstantiated assertions are not competent summary judgment evidence." (citing *Celotex*, 477 U.S. at 324)). Further, a court has no duty to search the record for evidence of genuine issues. Fed. R. Civ. P. 56(c)(1) & (3); s*ee Ragas v. Tenn. Gas Pipeline Co.*, 136 F.3d 455, 458 (5th Cir. 1998). It is the role of the fact finder, however, to weigh conflicting evidence and make credibility determinations. *Liberty Lobby*, 477 U.S. at 255.

**D. Standing**

*1. Article III Standing*

Claiming that Encompass lacks standing to pursue its claims, BCBSLA [5] first argues that Encompass suffered no injury "by agreeing not to 'balance bill' the patient or otherwise pursue the patient for any additional amounts." (Doc. 321 at 13.) Noting that Encompass, as an assignee of benefits, "stands in the shoes of the ERISA beneficiary to assert its rights under the plan terms," BCBSLA argues that the ERISA beneficiary is not at risk of any injury where it only must pay a "prompt pay discounted coinsurance amount." (*Id.* at 12.) In response, Encompass notes

[5] BCBSTN made similar arguments in its Motion, claiming that Encompass lacked Article III standing due to its lack of "injury-in-fact that is distinct and palpable." (Doc. 297-1 at 13.)

that the prompt-pay coinsurance amount was calculated to be "20% of the average payment that Encompass received from insurers for its services." (Doc. 328 at 18.) Encompass further claims that the patient suffers an injury because BCBSLA's "failure to pay the benefits owed to Encompass...[deprives] her of her full, paid-for benefits." (*Id.* at 21.) Finally, Encompass claims that it has itself directly been injured because "it accepted the patient's assignment of benefits that BCBSLA now refuses to pay." (*Id.*)

Article III, Section 2 of the United States Constitution grants judicial power over justiciable cases and controversies. U.S. Const. art. III, § 2; *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 559–60 (1992). The doctrine of standing is the 'irreducible constitutional minimum' that "serves to identify those disputes which are appropriately resolved through the judicial process." *Whitmore v. Arkansas.*, 495 U.S. 149, 155 (1990). Constitutional standing has three elements: (1) an "injury in fact"—an invasion of a legally protected interest which is (a) concrete and particularized and (b) actual or imminent and not merely conjectural or hypothetical; (2) a causal connection between the injury and the conduct complained of; and (3) a likelihood, as opposed to speculation, that a favorable decision will redress the claimed injury. *Lujan*, 504 U.S. at 560–61. Importantly, at the summary judgment stage of litigation, a plaintiff's burden to show standing is only to raise an issue of material fact, not to conclusively establish that the plaintiff has standing. *See Croft v. Governor of Tex.*, 562 F.3d 735, 746 (5th Cir. 2009).

Here, Encompass has introduced evidence that it received a valid AOB form which was signed and executed by patients who received the medical services in this case. (Doc. 289-1 at 1-44; 289-2 at 1-44; 289-3 at 1-44; 289-4 at 1-44; 289-5 at 1-42.) These forms "instruct and direct" the insurer "to pay...for the medical benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered." (*Id.*) Evidence in the record suggests that upon completing an AOB, a patient would then be billed a prompt pay coinsurance amount which, though not exactly equal to the patient's actual out-of-network coinsurance amount, was based upon objective data and designed to approximate this amount to the fullest extent possible. (Doc. 329-1 at 55.) Other evidence indicates that Encompass never pursued the patient for additional amounts and instructed them that they would not be billed for the balance of costs associated with their procedure. (Doc. 3012 at 6.)

BCBSLA and BCBSTN find primary support for their standing arguments in *N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, No 4:09–CV–2556, 2012 WL 8019265 (S.D. Tex. June 25, 2012) wherein Judge Ellison analyzed similar arguments on the issue of Article III standing pursuant to an assignment of benefits to a healthcare provider. (Doc. 321 at 12 n. 30, n. 31 & Doc. 297-1 at 13-14.) Under the facts of *North Cypress*, the court held that "the patients did not suffer injuries-in-fact sufficient to confer standing" on the healthcare provider. *N. Cypress,* 2012 WL 8019265, at *11. Although the Court in *North Cypress* found that the

patients suffered no injury in fact where patients were under no immediate threat of additional out-of-pocket damages, the holding does not comport with fundamental principles of health insurance or ERISA law, under which "assignees of beneficiaries to ERISA-governed plans have standing to sue under ERISA." [6] *Biomed Pharm., Inc. v. Oxford Health Plans, Inc.*, No. 10 Civ. 7427(JSR), 2011 WL 803097, at *3–4 (S.D.N.Y. Feb. 18, 2011) (citations omitted) (collecting cases). Moreover, the plain language of the AOB forms clearly directs the health insurer to remit all payment for covered services to Encompass, as an assignee of the patient. (Doc. 289-1 at 144; 289-2 at 1-44; 289-3 at 1-44; 289-4 at 1-44; 289-5 at 1-42.) Although it did not lead to a direct out-of-pocket damage to the patient, failure to pay as directed would nonetheless amount to an injury on the part of the patient in that BCBSLA and BCBSTN refused to honor the directions of the insured concerning services within the purview of the insurance contract.[7] *Biomed*, 2011 WL 803097, at *4 ("[A]s in any assignment relationship, the Patient's assignment of his rights under the contract does not extinguish Oxford's obligation to perform under

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[6] Although the Court in *Biomed* noted that none of the cited decisions directly addressed Article III standing under these facts, it correctly noted that constitutional standing is appropriately inferred in these cases due to a federal court's "obligation to police their own subject matter jurisdiction." *Biomed*, 2011 WL 803097, at *4.)

[7] The standing arguments of BCBSLA and BCBSTN, if accepted, would also lead to an imprudent windfall in their favor. By precluding suit based upon standing grounds, these defendants would be able to avoid all payments for services rendered and would effectively be granted immunity from suit as against third-party healthcare providers.

the contract, and Biomed stands in the Patient's shoes to ensure that Oxford performs those obligations"). Accordingly, the Court finds that Encompass has demonstrated a genuine issue of material fact as to its standing for Article III purposes, and the respective motions of BCBSLA and BCBSTN as to Article III standing are therefore DENIED.

*2. Section 502(a)(1)(B) Standing*

ERISA Section 502(a)(1)(B) establishes that a civil action may be brought by either a participant or a beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." *Lone Star OB/GYN Assocs. v. Aetna Health, Inc.*, 579 F.3d 525, 529 (5th Cir. 2009) (quoting 29 U.S.C. § 1132(a)(1)(B)). As assignee of reimbursement benefits from an insurer, a medical service provider stands in the shoes of the insured and may bring suit under ERISA Section 502(a)(1)(B). *Dall. Cnty. Hosp. Dist. v. Assocs.' Health & Welfare Plan*, 293 F.3d 282, 285 (5th Cir. 2002); *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1289–90 (5th Cir. 1988).

The uncontested evidence submitted suggests that Encompass received an Assignment of Benefits ("AOB") form which was signed and executed by patients who actually received the contested medical services in this case. (Doc. 289-1 at 1-44; 289-2 at 1-44; 289-3 at 1-44; 289-4 at 1-44; 289-5 at 1-42.) These forms "instruct and direct" the insurer "to pay...for the medical benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total

charges for the services rendered." (*Id.*) Encompass has also introduced evidence which suggests that it had a common and routine practice of speaking with insureds and explaining the nature of Encompass and its role in billing the insurer for services provided to the patient. (Doc. 288-3 at 75, 80.) This evidence, unrebutted in the summary judgment record, is sufficient to indicate that Encompass was the assignee of medical benefits for the applicable claims at issue in this case.[8] *Dall. Cnty. Hosp. Dist.*, 293 F.3d at 285; *Hermann Hosp.*, 845 F.2d at 1289–90.

**E. Registration in Louisiana**

According to BCBSLA, Encompass did not enjoy the right to transact business in Louisiana before March 30, 2011. (Doc. 321 at 13.) BCBSLA claims that because Encompass failed to secure a Certificate of Authority to transact business in Louisiana it should be barred from billing BCBSLA for all services performed in Louisiana before that time. (*Id.* at 14.) According to Encompass, the failure to secure a Certificate of Authority does not

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[8] According to BCBSTN, Encompass has failed to provide evidence of either a signed AOB or other assignment of benefits for approximately 30 BCBSTN reimbursement claims. (Doc. 297-1 at 11.) However, as Robert Gates testified, Encompass had a common and routine practice of speaking with insureds and explaining the nature of Encompass and its role in billing the insurer for services provided to the patient. (Doc. 288-3 at 75, 80.) Such evidence, even in the absence of a signed AOB form, is sufficient to create a fact issue as to whether BCBSTN-insured patients impliedly assigned their insurance benefits to Encompass. *See LifeCare Mgmt. Servs., LLC v. Ins. Mgmt. Adm'rs Inc.,* 703 F.3d 835, 840 n. 3 (5th Cir. 2013) (consent to treatment indicated assignment of claims). BCBSLA makes essentially the same argument in its Motion. (Doc. 321 at 17.) It is denied for the same reason.

invalidate or otherwise preclude it from seeking recovery against BCBSLA. (Doc. 328 at 16.) Encompass further claims that the only material consequence of its failure to secure a Certificate of Authority is its inability to sue within a Louisiana state court, which is obviously inapplicable in this Texas federal district court setting. (*Id.* at 16-17.) BCBSLA replies by again affirming, without authority, that the failure to procure a Certificate of Authority renders all acts during the applicable period "a nullity." (Doc. 345 at 22.)

Reference to the applicable case law and the facts of this case yields a result in favor of Encompass. Neither party disputes the fact that Encompass registered to do business in the state of Louisiana on March 30, 2011. The crux of the parties' disagreement on this point instead lies in the consequences of pre-registration business activities conducted in Louisiana before that time. According to BCBSLA, the consequences are draconian, and mean that Encompass is without recourse for all pre-registration conduct. (Doc. 321 at 13-14.) In support of this proposition, BCBSLA cites to La. Rev. Stat. Ann. § 12:301 (1968). (*Id.*) That statute reads, in part:

> No foreign corporation or association, except [certain corporations not applicable under the facts of the instant matter], shall have the right to transact business in this state until it shall have procured a certificate of authority to do so from the secretary of state. La. Rev. Stat. Ann. § 12:301.

By its clear terms, La. Rev. Stat. Ann. § 12:301 indicates that Encompass did not have the right to conduct business in Louisiana before March 30, 2011. However, BCBSLA has failed to demonstrate or provide any further illumination into the question of why transacting business without the right to do so automatically precludes recovery by Encompass. In fact, Encompass has cited to other statutory law which directs as follows:

> The failure of a foreign corporation to obtain a certificate of authority to transact business in this state shall not impair the validity of any contract or act of such corporation, and shall not prevent such corporation from defending any action, suit or proceeding in any court of this state. La. Rev. Stat. Ann. § 12:314(B) (1968).

This statute clearly and unambiguously explains that Encompass's failure to register in Louisiana before March 30, 2011 only results in its inability or incapacity to bring suit in Louisiana state courts.[9] *Id.* The statutory text also explains that even while conducting business without proper registration, contracts of such unregistered foreign

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[9] Nor can such a statute be reasonably construed to mean that Encompass is deprived of the right to suit in federal court due to its failure to register in Louisiana. *See Fehr Banking Co. v. Bakers' Union*, 20 F. Supp. 691, 697 (D.C. La. 1937) ("As to the contention that [Louisiana statutory law], denies to a citizen of another state the right to appeal to the courts until he or it has complied with [Louisiana statutes], no citation of authorities is required to support the conclusion that a state is without power to impose such restrictions upon litigation in a federal court.")

corporation remain valid.[10] *Id.* BCBSLA has failed to cite any controlling case law suggesting that Encompass's failure to register before March 30, 2011 nullifies the instant claims, and the Court's independent research yields none either. Accordingly, the Court finds BCBSLA's arguments as to Encompass's failure to register before March 30, 2011 to be insufficient grounds for summary judgment. The Court therefore DENIES BCBSLA's motion as to the same.

**F. Anti-Assignment Clauses**

In an additional attack upon Encompass's ability to assert claims on behalf of the individual patients in this matter, BCBSLA claims that the plans governing claims for payment each contain anti-assignment clauses which expressly forbid assignment of benefits to providers such as Encompass. (Doc. 321 at 15-16.) Encompass responds by claiming that Texas and Louisiana law prohibit anti-assignment provisions. (Doc. 328 at 23-25.) Additionally, Encompass argues that even if the anti-assignment language is valid and enforceable, its application under the facts of this case would be inappropriate based upon BCBSLA's conduct, which allegedly invokes the doctrines of waiver and estoppel. (*Id.* at 25-28.)

Ample evidence in the record indicates that plan beneficiaries assigned their benefits to Encompass via an AOB form that was signed and dated. (Doc. 289-1 at 1-44; Doc. 289-2 at 144; Doc. 289-3 at 1-44;

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[10] Additional consequences may include tax liability to the state for those periods of unregistered business conduct. *See.* La. Rev. Stat. Ann. §12:314(C) (1968). These penalties do not apply for purposes of this suit.

Doc. 289-4 at 1-45; Doc. 289-5 at 1-42.) The summary judgment evidence also indicates that the plans at issue include anti-assignment language. *See e.g.* (Doc. 295-1 at 23-24; 93-94.) Exemplary plan language states that "A Member's rights and benefits under this Benefit Plan are personal to the Member and may not be assigned in whole or in part by the Member." *See e.g.* (*Id.*) The plan language reiterates this prohibition, noting that "We will not recognize assignments or attempted assignments of benefits." *See e.g.* (*Id.*)

Anti-assignment clauses in ERISA plans are generally enforceable. *See e.g., Trinity Health–Mich. v. Blue Cross Blue Shield of S. C.,* 408 F. Supp. 2d 483, 485 (W.D. Mich. 2005) ("Most courts have held that ERISA does not prohibit an anti-assignment clause in an employee welfare benefit plan and that an unambiguous anti-assignment provision invalidates an assignment to a health care provider"). However, some cases have held that plans are precluded from enforcing anti-assignment provision under theories of waiver and equitable estoppel. For example, in *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 959 F.2d 569, 574 (5th Cir. 1992) (*overruled on other grounds by Access Mediquip, L.L.C. v. UnitedHealthcare Ins. Co.,* 698 F.3d 229 (5th Cir. 2012)), the Fifth Circuit Court of Appeals found an assignment valid despite the anti-assignment clause in the plan, based upon the course of dealing between the plan and the health care provider. *Id.* ("It had to be clear to [the insurer] that [the hospital], in admitting and providing services to Mrs. Nichols, was relying on that assignment as its entitlement to recover

payment for those Plan benefits...furnished to Mrs. Nichols.").

In the instant case, the undisputed evidence suggests that during the course of dealing between BCBSLA and Encompass, BCBSLA never once challenged the AOBs as prohibited by the plans' anti-assignment language. From parties' course of dealing, it had to be clear to BCBSLA that Encompass was not a patient or insured but was instead relying on completed AOB forms. As BCBSLA repeatedly insists in its briefing, when it denied claims furnished by Encompass, it uniformly did so because of its global fee already paid to physicians and explained that "[r]eimbursement is considered to be a portion of another service which has been allowed. Therefore, no payment can be made for this service." (Doc. 324 at 11-13; Doc. 321 at 26; *see also e.g.* Doc. 289-6 at 23 (explanation of benefits form)). A thorough delve into the record submitted to the Court does not yield a single instance prior to suit where BCBSLA attempted to invoke and give effect to the anti-assignment clauses. In fact, the record indicates that on a number of occasions BCBSLA paid money directly to Encompass instead of directly to the insured, giving a reasonable impression at the time that BCBSLA did not intend to enforce the strict anti-assignment language in the plans. (Doc. 288-4 at 3-4.) The record does not support BCBSLA's insistence that the decision in *Letourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores, Inc.*, 298 F.3d 348, 349–50 (5th Cir. 2002) is controlling, as the Fifth Circuit in that case did not analyze waiver and estoppel due to the absence of such in both the record and the district court's

ruling. (Doc. 345 at 15); *Letourneau,* 298 F. 3d at 349–50 ("Here, however, the district court did not rely on estoppel. Rather, it relied on our alternative holding in *Hermann II* that the anti-assignment clause was ineffectual against the hospital.) Accordingly, the Court finds that there is a genuine issue of material fact as to whether BCBSLA waived the anti-assignment language contained in its plans. The Court therefore DENIES BCBSLA's Motion with respect to the plans' anti-assignment language.

**G. Claims for Benefits under § 502(a)**

The bulk of Encompass's claims are under § 502(a) of ERISA. *See* 29 U.S.C. § 1132(a) (providing civil remedies under ERISA). BCBSLA asserts that the claims fail because the suit was brought outside the plans' limitations periods or Encompass did not exhaust its administrative remedies. Both BCBSLA and Encompass believe they are entitled to summary judgment on the merits of the § 502(a) claims.

*1. 15 Month Limitations Period*

According to BCBSLA, the plans at issue in this case contained limitations language setting forth the time to file suit as no later than 15 months from the date the patient received his or her medical services. (Doc. 321 at 18.) Although Encompass has claimed that BCBSLA failed to cite to admissible evidence of any limitations period, the summary judgment evidence submitted by Encompass confirms the existence of plan-based limitations. *See e.g.* (Doc. 288-10 at 89.) The relevant provision states:

> No lawsuit may be filed: any earlier than the first sixty (60) days after notice of the claim has been given; or any later than fifteen (15) months after the date services are rendered.[11] (*Id.*)

BCBSLA cites to the plans' limitations period to contend that the vast majority of claims against it are untimely and should therefore be dismissed as a matter of law.[12] (Doc. 321 at 18.) According to Encompass, the limitations period is not binding because it is unreasonable as a matter of law and should not be enforced. (Doc. 328 at 29.)

"Under ERISA, a cause of action accrues after a claim for benefits has been made and formally denied. Because ERISA provides no specific limitations period, [courts] apply state law principles of limitation. Where a plan designates a reasonable, shorter time period, however, that lesser limitations schedule governs." *Harris Methodist Fort Worth v. Sales Support Servs. Inc. Emp. Health Care Plan*, 426 F.3d 330, 337 (5th Cir. 2005) (citations omitted). In other words, "contractual limitations periods on ERISA actions are enforceable, regardless of state law, provided they are reasonable." *Northlake Reg'l Med. Ctr. v. Waffle House Sys.*, 160 F.3d 1301, 1302 (11th Cir.

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[11] *See also e.g.* (Doc. 290-1 at 45; 290-2 at 44; 290-3 at 58; 290-4 at 57; 290-5 at 66.)

[12] BCBSLA does not argue that all claims against it are untimely. BCBSLA was named a party to this suit in the Second Amended Complaint, which was filed on February 24, 2012. (Doc. 45.) Relying on the applicable 15 month limitations period, BCBSLA claims that only 13 claims for services were rendered after November 24, 2010, or within the 15 month period. (Doc. 321 at 18.)

1998). The reasonableness of a plan's limitations period is a question of law. *See Harris*, 426 F.3d at 333.

In explaining why the 15 month limitation period is unreasonable, Encompass cites extensively to *Ponstein v. HMO La. Inc.,* No. 08-663, 2009 WL 1309737 (E.D. La. May 11, 2009) and *Baptist Mem'l Hosp.-Desoto, Inc. v. Crain Auto., Inc.*, 392 F. App'x 288 (5th Cir. 2010). (Doc. 328 at 29-32.) In *Baptist Memorial*, the Fifth Circuit found an ERISA limitations agreement of one year from the date a completed claim was filed was unreasonable under the circumstances. *Baptist Mem'l Hosp,* 392 F. App'x at 294 ("We conclude that the...Plan's one-year limitations period is unreasonable under the circumstances presented."). The first circumstance which the Fifth Circuit found troubling was the fact that the limitations period began to run "when a participant merely files a completed claim, long before the claimant's ERISA cause of action even accrues." *Id.* at 294–95. This left claimants with an unreasonably short 35 days to file suit once the administrative appeal process ran its course. *Id.* at 295. Second, the record was replete with instances where the plan administrator "repeatedly assured" that the claim was "under review, that payment was still possible, or even that payment was imminent" and that the claimant "had no reason to believe that the administrator had denied the claim, reasonably expecting that it would provide a clear decision to that effect." *Id.* Noting these two key considerations, the Fifth Circuit held that the administrator's "failure to follow its obligation to properly deny the claim, coupled with its

communications leading [claimant] to believe that its claim was actively under consideration, caused the one year limitations period to be unreasonably short in this case." *Id.* (citing *Doe v. Bluecross & Blueshield of Wis.,* 112 F.3d 869, 876 (7th Cir. 1997)).

Similar considerations appear in the *Ponstein* decision, where Judge Fallon noted that the administrator initially paid the claim, but then withdrew payment three months later. *Ponstein,* 2009 WL 1309737, at *1. Noting this fact, the court found that the administrator withdrew payment "less than fifteen (15) months before the plaintiff filed suit." *Id.* at *4. The court went on to find the fifteen month limitation period, which began on the date services were provided, unreasonable under the facts before it because "Plaintiff had no reason or basis to file suit until, at the very least, October 2006 when his claim was reevaluated and benefits withdrawn." *Id.* Finally, *Ponstein* did not substitute state law limitations in the place of the unreasonable plan language, but instead noted that the plaintiff filed suit within fifteen months of the date payment was withdrawn, thereby constituting a timely filed claim under the plan language. *Id.* ("Suit was filed within fifteen (15) months of that date [of payment withdrawal]. This was reasonable. Thus the claim was timely filed").

Examining the fifteen month period in the abstract, nothing appears facially unreasonable about such a limitation. Courts have routinely enforced shorter limitations absent special circumstances. *See, e.g.*, *Northlake Reg'l Med. Ctr.*, 160 F.3d at 1304 (finding that a ten month appeals process combined with a ninety day limitations

period provided an adequate opportunity to investigate a claim and file suit); *Sheckley v. Lincoln Nat'l Corp. Employees' Ret. Plan*, 366 F. Supp. 2d 140, 147 (D. Me. 2005) (finding that, under the pled facts, "there [was] no causal connection between the Plan's failure to follow the claims procedures laid out in [the plan document] and Plaintiff's failure to file this action ... [until] after the Plan's six-month limitation period had run"). However, the reasoning outlined in *Baptist Memorial* and *Ponstein* is persuasive and raises issues of fairness as to certain of the claims for benefits in this case. In a letter dated October 4, 2010, Alan Lofton, acting on behalf of BCBSLA, sent a letter to the President of Encompass stating that BCBSLA had erroneously paid $109,676.55 for claims submitted by Encompass on behalf of BCBSLA members. (Doc. 288-4 at 3-6.) BCBSLA informed Encompass that it demanded repayment in full of all claims erroneously paid. (*Id.*) The letter also contains a spreadsheet itemizing the 53 claims which were paid previously, but which BCBSLA now denied as of October 4, 2010. (*Id.* at 5-6.) As to these claims, the Court finds that immediately holding Encompass to the 15 month limitations period from the date of service would be imprudent, since under the applicable administrative review process the insured would have 180 days to file under the mandatory first level of appeal, marked from the date of the adverse decision. *See e.g.* (Doc. 288-10 at 98.) The plan language then obligates the administrator to provide a review decision within 30 days from the date of receipt. (*Id.*) Under this timetable, the limitations period would already

preclude recovery for claims submitted by those who filed claims early in this suits factual history.[13] (Doc. 288-4 at 5-6.) Precluding these claims based upon the plan's limitations period from the date of service would be improper where these claims had been initially paid and were then retroactively denied on October 4, 2010. *See Ponstein ,* 2009 WL 1309737, at *4 ("Where the limitations period is measured from the date [services] are rendered, the Court must take care to ensure the limitations period is reasonable and that the specter of the substantial compression of a Plaintiff's time to sue does not materialize.") (citation omitted); *Baptist Mem'l Hosp.,* 392 F. App'x at 295–96; *Doe,* 112 F.3d at 876 ("[W]e have trouble seeing why a defendant whose own activities made the plaintiff miss the deadline should be allowed to litigate over whether the plaintiff could have sued earlier").

Notwithstanding the Court's reluctance to apply the 15 month limitations period to the 53 claims listed in the demand letter, the Court is unwilling to strike the 15 month limitation altogether.[14] *See*

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[13] Examples of those claims which would be barred include claims submitted by A.W., T.E., and C.H., who filed their claims as early as 2007 and 2008. (Doc. 288-4 at 5.)

[14] Although Plaintiff has cited *Ponstein* for the proposition that a court may invalidate an unreasonable limitations agreement, the Court in *Ponstein* appears to have invoked equitable tolling principles rather than a wholesale dismantling of the 15 month limitations period under the plan. *See Ponstein*, 2009 WL 1309737, at *4 (Under the undisputed facts of the instant case, the Plaintiff had no reason or basis to file suit until, at the very least, October 2006 when his claim was reevaluated and benefits withdrawn. Suit was filed within fifteen (15) months [the applicable term outlined in the plan] of that date. This was reasonable. Thus, the claim was timely filed.")

*Baptist Mem'l Hosp,* 392 F. App'x at 300–02 (Haynes, dissenting) ("To the extent [the administrator], misled [claimant] with his continued entreaties, his conduct at most merely tolled the statute of limitations until his final communication...rather than, as the majority opinion suggests, invalidating the limitation in its entirety.") Instead, the Court finds that the principles of equitable estoppel are appropriately applied to these facts so as to toll the limitations period until Encompass had effective notice of the denial of the 53 claims and demand for repayment. The doctrine of equitable estoppel, often called "ERISA estoppel" in this context, operates to toll the statute of limitations until BCBSLA affirmatively and conclusively denied the claims. *See Mello v. Sara Lee Corp.,* 431 F.3d 440, 444–45 (5th Cir. 2005) (expressly adopting ERISA estoppel); *Piecznski v. Dril-Quip, Inc.,* 354 F. App'x 207, 211 (5th Cir. 2009) (applying ERISA estoppel to determine whether a contractual period of limitations should be tolled due to misrepresentations by a plan administrator). "To establish an ERISA-estoppel claim, the plaintiff must establish: (1) a material misrepresentation; (2) reasonable and detrimental reliance upon the representation; and (3) extraordinary circumstances." *Mello*, 431 F.3d at 444–45; *see also Piecznski*, 354 F. App'x at 211.

Assuming that the record contains sufficient summary judgment evidence to satisfy each element of ERISA estoppel, Encompass has still not outlined—and no evidence in the record explains—why it was reasonable for Encompass to wait over sixteen months to pursue its claims against

BCBSLA. As noted above, the demand letter to Encompass was dated October 4, 2010. (Doc. 288-4 at 3-6.) Encompass named BCBSLA as a Defendant in this action on February 24, 2012 via the Second Amended Complaint. (Doc. 45.) Knowing that the plans at issue contained a 15 month limitations period in which to file suit, neither argument from counsel nor evidence in the summary judgment record explains why a 16 month time period was necessary or why it was reasonable to wait so long to file suit in the face of (1) an explicit demand letter denying coverage, (2) express contractual language limiting claims to 15 months, and in (3) the absence of even a single administrative appeal extending the matter. *Baptist Mem'l Hosp,* 392 F. App'x at 300–02 (Haynes, dissenting) (claimant's claims should be time barred by applying principles of ERISA estoppel to toll limitations agreement, not by wholesale judicial invalidation of limitations agreement; noting that claimant "did nothing to advance its claim for more than ten months" during time between decision from plan administrator and filing suit). Accordingly, the Court finds that all claims for reimbursement submitted before November 24, 2010 are barred as a matter of law pursuant to the plan-based 15 month limitation period.

*2. Exhaustion of Administrative Remedies and Futility of Exhaustion under ERISA*[15]

The parties do not dispute the fact that Encompass did not exhaust its administrative

[15] As the Court finds that all claims submitted before November 24, 2010 are time-barred, the discussion *infra* examines only those claims which were submitted after November 24, 2010 and were therefore timely.

remedies before filing the instant suit. According to BCBSLA, Encompass's failure to exhaust its administrative remedies before seeking relief from the federal court system is a fatal error which precludes an award. (Doc. 321 at 19-21.) Encompass claims that it should be excused from the ERISA's administrative exhaustion requirement because pursuing an administrative appeal of its claims would be futile. (Doc. 328 at 34) ("[T]here is no doubt that any appeal of the claims BCBSLA denied would have been futile.")

Under the plans, two levels of administrative appeal were available to Encompass. Conspicuous plan language indicates that the first level of appeal is "[m]andatory prior to instituting legal action." (Doc. 288-10 at 98.) Following an "adverse initial benefit determination," a member, authorized representative, or a provider acting on a member's behalf must submit an initial request within 180 days. (Doc. 288-10 at 98.) Plan language encourages members to "submit written comments, documents, records, or other information" relating to the claim at issue. (*Id.* at 97.) Moreover, the plan separates the appeal process from the initial decisionmaker by involving only "persons not involved in previous decisions [16] regarding the member's claim" in the appeal process. (*Id.*) The second level of administrative appeal was optional. (*Id.*)

Generally, "claimants seeking benefits from an ERISA plan must first exhaust available

[16] Neither party has cited to evidence outlining the actual persons who were responsible for the appeals, including members of any relevant appeals committee as to particularized claims in this case.

administrative remedies under the plan before bringing suit to recover benefits." *Bourgeois v. Pension Plan for Emps. of Santa Fe Int'l Corp*., 215 F.3d 475, 479 (5th Cir. 2000); *Denton v. First Nat'l Bank of Waco*, 765 F.2d 1295, 1300 (5th Cir. 1985). Absent unusual circumstances, a federal court should not address an ERISA claim if the claimant fails to raise the issue before the plan administrator, because courts lack the ability to review the administrator's determination for an abuse of discretion. *Harris v. Trustmark Nat'l Bank*, 287 F. App'x 283, 288 (5th Cir. 2008) (citing *Pub. Citizen, Inc. v. United States Envtl. Prot. Agency*, 343 F.3d 449, 461 (5th Cir. 2003)) ("Absent exceptional circumstances [in the agency law context], a party cannot judicially challenge agency action on grounds not presented to the agency at the appropriate time during the administrative proceeding"). However, the Fifth Circuit has indicated that under certain circumstances, plaintiffs in an ERISA case are not required to exhaust their remedies if doing so would be futile. *Coop. Benefit Adm'rs, Inc. v. Ogden*, 367 F.3d 323, 336 n.61 (5th Cir. 2004); *Hall v. Nat'l Gypsum Co*., 105 F.3d 225, 232 (5th Cir. 1997). In other words, if a claimant can produce evidence that shows "certainty" of an adverse decision by the plan, the individual does not need to pursue all required appeals. *See Bernstein v. Citigroup, Inc.,* No: 3:06–CV–209–M, 2006 WL 2329385, at *2 (N.D. Tex. July 5, 2006) (citing *Commc'ns Workers of Am. v. AT&T,* 40 F.3d 426, 433 (D.C. Cir. 1994)). The Fifth Circuit has emphasized that the focus of futility is on the bias in the review process, not based on company officials' views. *See Bourgeois*, 40 F.3d at 479-80 (reasoning that a "company's preclusive

interpretation... does not establish that the actual Committee would not have considered his claim."); *see also Commc'ns Workers of Am.*, 40 F.3d at 433 ("[T]his Court will not assume that, merely because members of a pension-plan review committee are drawn from a company's management, the review committee will never reach an interpretation of the plan different from that of the company.").

Each party disputes whether further appeal was futile. Encompass identifies three types of evidence to show futility. First, it argues, an adverse decision was certain because "several"[17] witnesses testified that there was nothing Encompass could have submitted to change the decision to deny the claims. (Doc. 328 at 34.) During her deposition, Shannon Taylor testified that once BCBSLA decided not to contract with Encompass and BCBSLA declined to pay the submitted claims, "if a doctor called [her] and tried to persuade [her] to change [her mind]...the only factor that would have affected [her] decision was if they met [BCBSLA's] credentialing criteria." (Doc. 329 at 12.) Second, Encompass claims that a "permanent block on all claims submitted by Encompass" and an allegedly defamatory letter sent "to all in-network OB/GYNs instructing them to no longer use Encompass's services" prove futility. (Doc. 328 at 34.) And third, Encompass identifies a claim that went through administrative appeals process that was ultimately denied, arguing it shows other appeals would be useless. (Doc. 329-2 at 8.) BCBSLA counters that

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[17] Though Encompass claims several witnesses testified as to this point, they have chosen to cite only the deposition testimony of a single witness, Shannon Taylor. (Doc. 324 at 34 n. 65.)

"we will never know how [an appeals committee] might have decided" the claims because Encompass chose not to appeal the vast majority of them. (Doc. 345 at 18.)

Shannon Taylor's deposition is of limited applicability to the futility of an administrative appeal because the hypothetical question presented during the deposition only referenced an informal telephone conversation, not a formal appeal in writing and a complaint under the plan language. (Doc. 329 at 12.) No evidence in the record suggests that Ms. Taylor was herself ever personally involved in an appeal procedure or that she ever would be in the future. *See Shepherd v. Worldcom, Inc.*, No. H–03–5292, 2005 WL 3844069, at * 6 (S.D. Tex. Sept. 9, 2005) ("Moreover, [deponent executive] is only one member of the Subcommittee. Absent evidence that other members of the [administrative review] Subcommittee exhibited some personal bias or harbored some bitterness or ill will for Plaintiffs, any representations [deponent executive] may have made or beliefs she may have held regarding the viability of Plaintiffs' contentions do not relieve Plaintiffs from following the Plan's prescribed administrative procedures") (citation omitted). Also, Encompass has not cited to any evidence permitting an inference of Ms. Taylor's influence over or control of the appeal processes or a majority of the committee members. *See Denton,* 765 F.2d at 1300–02 (rejecting contention that it would have been futile to appeal to the benefits review committee—the same committee that initially denied his claim—where there was no evidence that a majority of the committee members were hostile or bitter toward

plaintiff). Statements made by BCBSLA employees who have not been shown to exercise responsibility for adjudicating benefits claims during the appeals process do not show that a claim submitted by Encompass would be futile if properly presented it for administrative review. *See McGowin v. Manpower Intern., Inc.,* 363 F.3d 556, 559–60 (5th Cir. 2004) ("A failure to show hostility or bias on the part of the administrative review *committee* is fatal to a claim of futility.") (emphasis added); *Shepherd*, 2005 WL 3844069, at *6 ("In other words, the legal department's letter [denying claim for ERISA benefits] constitutes no evidence that the Plan's Subcommittee was biased against or hostile toward Plaintiffs or that it would not have considered a claim regarding the proper construction of the Plan") (citation omitted). Although relevant to the issue of futility, Taylor's deposition is, by itself, insufficient to establish futility.

The permanent block and letter to physicians, by themselves, would also be insufficient to show futility. That is because they are evidence of the company's position, not the review committee's interpretations. S*ee Bourgeois*, 40 F.3d at 479-80 ("[A] company's preclusive interpretation... does not establish that the actual Committee would not have considered his claim.").

But Encompass provides other critical evidence that seeking further review would have been futile: the exhausted benefits claim. It went through BCBSLA's entire administrative process and was ultimately rejected. *See* (Doc. 329-2 at 8.) The reason it was rejected was the same reason every other claim was initially rejected and that, to this

day, BCBSLA maintains they should be rejected—as duplicative. *See* (*id.*) That is evidence about a review committee's actions and disposition, not just the company's position.

Though only one claim was exhausted, it, taken together with the other evidence, provides a factual inference about the futility of seeking further review of the claims. The Seventh Circuit Court of Appeals held in an analogous context that when claims are "very similar," exhaustion is not required for each claim; instead, exhaustion of just one claim is sufficient to litigate the rest. *See In re Household International Tax Reduction Plan*, 441 F.3d 500, 501-02 (2006). The situation that the Seventh Circuit considered—eligibility of unnamed members in a class-action suit to join though they have not exhausted their claims, *see id.* at 501—and the current one parallel each other. Encompass has a representative claim that looks "very similar" to its other claims. *Id.* While that claim cannot vicariously exhaust every other claim, *see id.* at 502, it can provide an inference that reviewing committees in the administrative process are hostile to the claims. The inference is even stronger when company officials loom in the background, potentially setting company policies that are hostile to the claims. Requiring exhaustion "would merely produce an avalanche of duplicative proceedings... and so is not required." *Id.* at 502. Thus, the one claim is sufficient to raise a genuine issue of material fact about whether exhausting the other claims was futile.

The Court therefore DENIES BCBSLA's Motion as to Encompass's failure to exhaust its administrative remedies.

*3. Denial of Benefits*

BCBSLA and Encompass each asserts it deserves summary judgment on the merits of the claims under § 502(a).

The parties do have some common ground. They agree on the legal standards that govern review of the claims. *See* (Doc. 288-1 at 22; 324 at 5.) When an ERISA plan gives the plan administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan—as in this case—the administrator's decision is subject to an abuse of discretion standard. *See Koehler v. Aetna*, 683 F.3d 182, 187 (5th Cir. 2012). Where an ambiguity exists, administrators are "empowered to resolve it, exercising 'interpretive discretion.'" *High v. E-Systems Inc.*, 459 F.3d 573, 579 (5th Cir. 2006). In reviewing an administrator's interpretation, the Court must first determine if the administrator gave the plan its legally correct interpretation. *Wildbur v. ARCO Chemical Co.*, 974 F.2d 631, 636 (5th Cir. 1992). That is determined by "whether the administrator has (1) given the plan a uniform construction; (2) whether the interpretation is consistent with a fair reading of the plan; and (3) whether there are any unanticipated costs resulting from different interpretations." *Id.* at 638. If the administrator did not give it the legally correct interpretation, then the Court must determine if the administrator's interpretation was an abuse of authority. *Id.* at 636. That question is resolved by "(1) the internal consistency of the plan under the administrator's interpretation, (2) any relevant regulations formulated by the appropriate administrative agencies, and (3) the factual

background of the determination and any inferences of lack of good faith." *Id.* at 638.

The parties also agree that the procedures were medically necessary and were procedures typically covered by the plans' terms. *See* (Doc. 288-1 at 24-26) (Encompass stating that claims were medically necessary and would typically be covered under the plan); (Doc. 324 at 11-16) (BCBSLA only raising the issue of duplicative billing in response). At the very least, BCBSLA did not raise any contention against that conclusion.[18]

From there, the parties diverge. The dispute is about whether Encompass's services are considered duplicative under the plan. *See* (Doc. 288-1 at 27-30; 321 at 19-20.) BCBSLA's argument for why the claims are duplicative goes like this: When a physician performs in-office surgery, BCBSLA pays the physician a global fee that is meant to cover overhead costs; Encompass's services are included in that overhead cost; thus, the claims were properly rejected because they are considered to be duplicative of claims filed by physicians. *See* (Doc. 321 at 25.) The plan at issue, BCBSLA argues, "implicitly requires that BCBSLA only [sic] pay each submitted claim one time." (Doc. 288-12 at 25.)

Encompass argues that such an interpretation is legally incorrect and abusive. *See* (Doc. 328 at 40-

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[18] BCBSLA's decision not to raise other issues was sound legal strategy. When litigating over denial of benefits, the plan administrator is limited to "the actual basis on which the administrator denied the claim." *Robinson*, 443 F.3d at 395-96 n.4. Attempting to refute Encompass's initial showing would have been barred because BCBSLA, as both parties agree, denied it as duplicative.

49.) While Encompass agrees that duplicative services are not covered, it does not believe its services can be categorized as duplicative. *See* (Doc. 288-1 at 28) ("Of course, an ERISA plan is not required to pay for services twice; however, implicit in this argument is that the plan actually paid someone for these services.") Encompass's argument rests on two main points: First, when physicians perform surgery in a hospital or ASC, the physician receives a fee and the hospital or ASC receive a separate fee; second, physicians are not paid any more for performing surgery in their offices then they are when performing surgery at a hospital or ASC. *See* (Doc. 328 at 39.) The inference is that calling the physician's un-changed rate for in-office surgery a "global fee" is a smokescreen to prevent Encompass from recovering. *See* (Doc. 328 at 39.)

In short, the parties agree about what legal standard governs, what the plan terms are, and whether the procedures would typically be covered. The only issue is whether the fees BCBSLA paid to surgeons for in-office work reflect the services that Encompass provided. BCBSLA says yes. Encompass says no. The Court must, considering all evidence and inferences in favor of the non-moving party, determine whether BCBSLA's chosen interpretation is legally correct or reasonable enough to not be abusive.

BCBSLA fails to make an initial showing that it deserves summary judgment. It relies extensively on a single affidavit by Thomas Groves, the company's Director of Provider Contracting and Service. (Doc. 301-5.) This affidavit purports to set out the company's policy regarding "global fees"

paid to physicians for in-office surgeries and duplicative claims. *See* (Doc. 301-5 at 16-18.) It asserts that physicians are reimbursed at different rates depending on the "site of service," and that difference captures the amount that would have been paid to a hospital or ASC. *See* (Doc. 301-5 at 17.) Apparently to bolster that claim, Groves states that BCBSLA models their site-of-service differentials after Medicare's. *See* (Doc. 301-5 at 18.)

Encompass attacks the affidavit on various grounds. First, it believes that affidavit is inconsistent with an earlier deposition when Groves could not recall precise details about compensation differences for in-office surgeries. *See* (Doc. 329-1 at 22, 25-26) (answering that he could not remember whether the cost of drugs or other unspecified items were included in the global fee and what the differences in physician fees were based on the "site-of-service" code). Second, Encompass asserts that Groves never checked the plan to determine that information. *See* (Doc. Doc. 329-1 at 25) ("Q. Okay. Have you ever looked up the site-of-service differential for BlueCross for any code in relation to this lawsuit? A. No.").

The Court does not accept Encompass argument that the affidavit is entirely unreliable, but still finds that it is insufficient to carry BCBSLA's evidentiary burden for summary judgment. Rather than an interpretation of plan terms, the affidavit is an *ipse dixit* of BCBSLA's practices. Neither the affidavit nor BCBSLA's briefs direct the Court toward any plan terms that permits BCBSLA to interpret Encompass's claims as duplicative. The strongest evidence it provides is that BCBSLA

currently models its site-of-service differentials after Medicare's. But BCBSLA does not direct the Court to anything that indicates how long it has done so or what Medicare's actual practices are. Without connecting the policy interpretation to plan language, settled practices, or documents that cogently explain the policy at the time of the claims, the affidavit is too factually ambiguous to be the basis for summary judgment.

Encompass makes out a stronger case, but is also unable to receive summary judgment. To prove that BCBSLA's interpretation is legally incorrect, Encompass relies on a few sources of evidence. First, it resorts to the terms of the plan to show that the procedures Encompass performed would be covered. *See* (Doc. 288-10 at 33, 49-51, 58) (Groupcare Plan details). Second, Encompass relies on various depositions and emails to prove that physicians were not

paid an increased amount. (Doc. 288-3 at 8) (deposition of Shawn Cantrell); (Doc. 288-4 at 9, 14) (emails between plan administrators). Third, it cites to the terms of the plan to show that similar work by hospitals or ASCs would be covered. *See* (Doc. 288-10 at 49-51) (Groupcare Plan details).

BCBSLA rebuts Encompass's evidence with the Groves' affidavit, an affidavit by Patricia Crochet, and a deposition from Katherine Crosby. *See* (Doc. 324 at 12-13.) The facts from Groves' affidavit have been covered. Crochet's affidavit includes a spreadsheet of claims made by Encompass, showing that physicians and Encompass used similar codes for reimbursement. *See* (Doc. 301-5 at 6-15.) Crosby's deposition is mostly redundant of Groves' affidavit, stating that "site-of-service" codes

increased physician pay depending on the location of the surgery and that BCBSLA modeled its "site-of-service" differentials after Medicare's. *See* (Doc. 325 at 42-43.) All of this evidence contradicts Encompass's evidence that physicians did not receive any more payment than usual.

These details about BCBSLA's compensation practices at the time Encompass provided service are material to the Court's analysis under *Wildbur*. Two of *Wildbur's* critical factors are the uniformity of the plan's construction and the consistency of the interpretation with other parts of the plan. *See Wildbur*, 974 F.2d at 638. If Encompass's claims about BCBSLA's practices are true, it makes the policy appear to be based on BCBSLA's bottom line instead of plan terms. One would expect that putting compensation for Encompass's services into a global fee would be reflected in physician's payments; without the increased fee, the plan interpretation begins to appear disjointed, rather than uniform. And the differing treatment between Encompass and other similar providers like hospitals and ASCs seems to be an inconsistent application of the plan terms. The existence of an increased fee for physicians is a material factual issue that

influences whether the Court considers the interpretation legally correct. And because the summary judgment evidence contradicts each other about the issue, the Court cannot grant summary judgment for either party.

While the issue of physicians receiving increased pay is not entirely dispositive of the case, it significantly influences the *Wildbur* analysis. Neither party has put forth so much evidence that

the Court can determine whether BCBSLA's interpretation is legally correct. BCBSLA's actual reimbursement practices and the history of its "global fee" policy are factual issues that must be resolved at trial for the Court to appropriately apply *Wildbur*.

The Court therefore DENIES BCBSLA's Motion as to the merits of the § 502(a) claims and DENIES Encompass's Motion as to the merits of the § 502(a) claims.

**H. Breach of Contract**

In a previous Order, the Court found that any state law claims which relate to ERISA governed plans are preempted by ERISA. (Doc. 200 at 12.) In the motions now before the Court, the parties dispute claims for breach of contract concerning approximately 72 claims which were submitted under a plan that is not governed under the ERISA framework. (Doc. 288-11 at 97 & Doc. 301-3 at 24-50 & Doc. 301-4 at 1-15.) According to BCBSLA, summary judgment should be granted as to any breach of contract claim for these non-ERISA plans "for the reasons set forth above" including the presence of anti-assignment clauses in the plans. (Doc. 321 at 28.) Encompass affirmatively argues that it is entitled to summary judgment as to its breach of contract claims because the services rendered are a "Covered Service" and that BCBSLA failed to pay for those covered services rendered. (Doc. 288-1 at 45-46.)

The plans at issue contain a choice of law provision which identifies Louisiana law as governing. *See e.g.* (Doc. 288-11 at 62) (noting HMO ASO Benefit Plan for City of Baton Rouge Parish of

East Baton Rouge as non-ERISA plan ) & (Doc. 290-20 at 62) ("This benefit Plan will be governed and construed in accordance with the laws and regulations of the state of Louisiana..."). Under Louisiana law, the essential elements of a breach of contract claim are: (1) the existence of a valid contract; (2) a party's breach thereof; and, (3) damages resulting from the breach. *See Favrot v. Favrot*, 68 So.3d 1099, 1109 (La. Ct. App. 2011).

According to the terms of the plans, "Covered Services" under the plans included general anesthesia services "when requested by the operating physician." *See e.g.* (Doc. 290-20 at 27.) Plan language concerning outpatient medical services also includes "home, office, and other outpatient visits for examination, diagnosis, and treatment of an illness or injury." (*Id.*) Neither party has cited to plan language expressly controlling whether payment of a "global fee" to a physician is an acceptable method of payment for the kinds of services which Encompass provides. Under Louisiana law, when the words of a contract are clear and explicit and lead to no absurd consequences, no further interpretation may be made in search of the intent of the parties. La. Civ. Code Ann. art. 2046 (1984). Parol or extrinsic evidence is generally inadmissible to vary the terms of a written contract unless the written expression of the common intention of the parties is ambiguous. La. Civ. Code Ann. art. 1848 (1984); *Ortego v. State, Through the Dep't of Trans. & Develop.*, 689 So.2d 1358, 1363–64 (La. Ct. App. 1997). A contract is considered ambiguous on the issue of intent when it lacks a provision bearing on that issue, the terms of a written contract are

susceptible to more than one interpretation, there is uncertainty or ambiguity as to its provisions, or the intent of the parties cannot be ascertained from the language employed. La. Civ. Code Ann. art. 1848 (1984).

The Court finds the plans' contractual language ambiguous inasmuch as it does not contain a provision outlining whether payment under a global fee is appropriate. Arguing that it has fully performed as required under the plans, BCBSLA claims that it remitted payment for the services rendered directly to the treating physician as part of its "global fee," which it claims is a larger than normal payment intended to cover all overhead expenses, including those provided by Encompass for in-office surgery assistance such as equipment and nursing staff. (Doc. 324 at 16.) In support of this proposition, BCBSLA cites to the affidavit of Thomas Groves, who stated:

> When a physician performs a surgical procedure in his/her office, the physician receives a global fee from BCBSLA. The site of service in office fee is greater than the site of service outpatient fee that a physician receives to compensate the physician for his/her additional office expense associated with performing the procedure in the physician's office. (Doc. 301-5 at 17.)

Katherine Crosby also testified that "for certain things we pay extra if it's done in a physician's office instead of a hospital setting." (Doc. 325 at 41.) Other evidence in the record suggests that

BCBSLA denied all claims submitted by Encompass because the bills submitted for service were duplicative, sending notice which stated that "Reimbursement is considered a portion of another service which has been allowed. Therefore, no payment can be made for this service." *See e.g.* (Doc. 289-6 at 23.) Moreover, Thomas Groves' affidavit notes that "Payment to a physician by BCBSLA for the global fee is inclusive of the physician's overhead. All overhead costs associated with an in-office procedure are embedded in the global fee." (Doc. 301-5 at 17.) Other evidence suggests that the global fee included services similar to those provided by Encompass. (Doc. 329-1 at 22) (equipment, staff are "bundled into the global fee"). Finally, evidence in the record demonstrates that the claims which Encompass submitted to BCBSLA were identical to the claim submitted by the physician as to the date of service and the billing code. *See* (Doc. 301-5 at 6-15.)

In turn, Encompass has submitted evidence that BCBSLA's purported global fee was not any higher for in-office surgeries than for other procedures. (Doc. 288-3 at 8; Doc. 288-4 at 9.) According to evidence submitted by Encompass, BCBSLA did not pay any facility fees as an additional amount to cover the costs associated with the kinds of services performed by Encompass. (Doc. 288-4 at 14.) Moreover, evidence in the record suggests that the billing entries contained a "Technical Component Modifier,"[19] a separate number which "consists of

[19] Encompass has submitted other literature which defines a "Technical component" as "[a] portion of a health care service that identifies the provision of the equipment, supplies, technical personnel, and costs attendant to the performance of

those services beyond the professional services of the physician with regard to surgery." (Doc. 288-3 at 18, 40.)

Surveying the summary judgment record, the Court finds that there is a genuine issue of material fact as to whether Encompass's billing entries were actually duplicative and whether BCBSLA breached the contracts by paying the physician directly instead of paying Encompass. First, the parties have presented contested evidence as to the meaning of a technical component modifier under these circumstances and whether a technical component modifier is properly utilized to cover services provided by Encompass. Also, whether or not BCBSLA actually had a "global fee" policy at the time the claims were submitted remains a disputed questions of fact which can only be answered by a jury, which will necessarily need to determine if BCBSLA actually had a "global fee" and whether the billing entries submitted by Encompass—containing identical billing codes and dates of service—were actually duplicative of other claims. The present record is thus inappropriate for a resolution of the breach of contract claims for the non-ERISA plans. Accordingly, the Court DENIES BCBSLA's motion for summary judgment as to claims for breach of contract associated with non-ERISA governed plans.[20]

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the procedure other than the professional services." (Doc. 288-13 at 17.)

[20] In its Motion for Summary Judgment, BCBSTN claims that all reimbursement claims sought against BCBSTN are brought pursuant to ERISA plans and are therefore preempted. (Doc. 297-1 at 6.) BCBSTN has cited admissible

**I. Quantum Meruit**

Encompass's Fifth Amended Complaint also seeks relief by means of a claim for Quantum Meruit. (Doc. 255 at 20.) Under Louisiana law, unjust enrichment actions, or quantum meruit claims, are subsidiary remedies and are not available if the law provides another remedy. La. Civ. Code Ann. art. 2298 (1984) . "Quantum meruit awards are not dependent on a contract, but, instead, such awards are derived in the absence of a contract." *Love v. E.L. Habetz Builders, Inc.*, 01-1625, 821 So.2d 756, 767 (La. Ct. App. 2002). Where a contract exists and covers the materials or services provided, a claim for quantum meruit must fail. *Dumas and Assocs., Inc. v. Lewis Enters., Inc.*, 704 So.2d 433, 437 (La Ct. App. 1997). The doctrine operates in the absence of a specific contract to imply a promise on behalf of the person to whom the benefit is conferred to pay a reasonable sum for the services or materials furnished. *Brankline v. Capuano*, 656 So.2d 1, 5 (La. Ct. App. 1995).

Here, neither party disputes that a valid contract for the health care services exists as

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summary judgment evidence in support of this assertion. *See* (*Id.* at 7-10.) Encompass did not address this claim in its Response or provide any evidence to rebut the evidence as to whether such plans exist, whether the ERISA safe harbor exemption applies, or whether the plan was established or maintained by an employer intending to benefit employees. The Court therefore finds that Encompass made no opposition to this argument and it is unopposed. *See e.g. Eversley v. MBank Dall.*, 843 F.2d 172, 174 (5th Cir. 1988) (upholding district court decision to accept as undisputed facts listed in motion for summary judgment). Accordingly, the Court GRANTS summary judgment in favor of BCBSTN on all breach of contract claims and claims for quantum meruit, as such claims are preempted by ERISA.

evidenced by the plan language. Although this contract is between BCBSLA and its insureds, Encompass stands in the shoes of the insureds via an assignment of benefits such that a valid contract exists and covers the subject matter of the disputed claim payments. Neither party has argued that the contracts are either void or entirely unenforceable. With an effective contract in place, claims for quantum meruit must be dismissed as a matter of law. Accordingly, the Court GRANTS BCBSLA's Motion as to Encompass's cause of action under quantum meruit.

### J. Defamation, Business Disparagement, and Interference with a Business Relationship

Seeking summary judgment as to its final claim, Encompass argues that its claim for defamation should be granted as a matter of law. (Doc. 288-1 at 48-51.) BCBSLA's Response and a separate Motion for Summary Judgment asks the Court to grant summary judgment Encompass's three remaining tort claims—defamation, business disparagement, and interference with a business relationship—as time-barred under Louisiana law. (Doc. 324 at 16-18; Doc. 378-1 .)

Under Louisiana law, tort actions are subject to a one year limitations period, which begins to run from the day injury or damage is sustained. La. Civ. Code Ann. art. 3492 (1983).[21] As an initial matter, the Court must first resolve whether

[21] The Louisiana Civil Code uses the term "delictual actions" to reference torts, and the term "liberative prescription" for statutes of limitation. *See* Delict, Black's Law Dictionary 492 (9th ed. 2009); Prescription, *id.* 1302.

Louisiana law even applies. BCBSLA claims that it does. (Doc. 324 at 17.) Although Encompass does not expressly concede that Louisiana law applies, its briefing on the defamation issue cites exclusively to Louisiana case law. (Doc. 288-1 at 48-51; Doc. 344 at 18-22.) The Court's choice of law analysis begins by applying the choice of law principles of the forum state. *Cf Levine v. CMP Publ'ns, Inc.,* 738 F.2d 660, 667 (5th Cir. 1984). "Texas has adopted the most-significant-relationship test for determining which state's law applies to a tort action." *Id*. (citing *Gutierrez v. Collins*, 583 S.W.2d 312 (Tex. 1979)). Under the applicable test, courts should consider "the place where the injury occurred, the place where the conduct causing the injury occurred, the domicile, residence, nationality, place of incorporation and place of business of the parties, and the place where the relationship, if any, between the parties is centered." Restatement (Second) of Conflict of Laws § 145(2) (1971).

Here, there is no dispute that the allegedly defamatory letter was mailed to medical providers in Louisiana. (Doc. 288-4 at 1.) Moreover, Encompass has claimed that this letter damaged its business in the state of Louisiana. (Doc. 288-1 at 51; Doc. 288-3 at 72.) The letter itself was sent by Dawn Cantrell, Vice President of Provider Network Administration and lists the return address for a post office box in Baton Rouge, Louisiana, demonstrating the high probability that the letter originated in Louisiana. (Doc. 288-4 at 1.) The only factor which does not suggest that Louisiana law might not apply is Encompass's Texas headquarters. This is insufficient, as the vast

majority of factors identify Louisiana as the state with the most significant relationship to the alleged tort. *See Highland Crusader Offshore Partners, L.P. v. Motient Corp.,* 281 S.W.3d 237, 250 (Tex. Ct. App. 2009) (if any two of the contacts, apart from the defendant's domicile, state of incorporation, or place of business, are located wholly in a single state, this will usually be the state of the applicable law with respect to most issues).

According to BCBSLA, the one-year limitations period should apply to preclude the remaining tort claims because, based on the date it received the allegedly defamatory letter, "Encompass had until August 19, 2011, at the latest to file suit on any tort claims attendant to that letter." *See* (Doc. 378-1 at 11); *see also* (Doc. 324 at 17.) Arguing that the tort claims are not time-barred, Encompass claims that the limitations period should be tolled under the doctrine of *contra non valentem*. (Doc. 344 at 18; Doc. 384-1 at 14.) Specifically, Encompass claims that it did not learn that the contents of the letter were false—that the cited policies in the letter did not even exist—until depositions held in February and March of 2013. (Doc. 344 at 18, 19.)[22]

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[22] Encompass also argues that BCBSLA "does not address Encompass's claim for business disparagement, and thus summary judgment on that claim is inappropriate." (Doc. 384-1 at 26.) But BCBSLA did request summary judgment on each of the tort claims. The title of its motion is "Motion for Summary Judgment on Plaintiff's Three Tort Claims," referring to the three tort claims at issue. (Doc. 378 at 1.) BCBSLA references the tort claims collectively when addressing the statute of limitations argument. See (Doc. 378-1 at 10) ("Louisiana's one year statute of limitations bar's [sic] Encompass' tort claims."); (*id.* at 11) ("Encompass had until August 19, 2011, at the latest, to file suit on any tort claims

Under the doctrine of "*contra non valentem*," a prescription period "does not run when the cause of action is not known or reasonably knowable by plaintiff, even though his ignorance was not induced by defendant." *Eldredge v. Martin Marietta Corp.*, 207 F.3d 737, 743 (5th Cir. 2000) (citations and quotations omitted). However, *contra non valentem* does not suspend prescription when a litigant is perfectly able to bring its claim, but fails or refuses to do so. *Daigle v. McCarthy*, 444 F. Supp. 2d 705, 710 (W.D. La. 2006) (citations omitted). Louisiana courts strictly construe the doctrine of *contra non valentem*, and only extend its benefits up to time that plaintiff has actual or constructive knowledge of the tortious act, which is defined as the time at which plaintiff has information sufficient to excite attention and prompt further inquiry. *Eldredge*, 207 F.3d 737 at 743.

In support of tolling the limitations period, Encompass cites the deposition testimony of Dawn Cantrell, the letter's author and an executive of BCBSLA. (*Id.* at 18.) The relevant deposition testimony indicates that Cantrell had difficulty recalling the specifics of the policies outlined in the purportedly defamatory letter. (Doc. 288-3 at 13.) Encompass has also cited the deposition testimony of Alan Lofton, who did not recall whether the policies in the letter were actual BCBSLA policies at the time the letter was sent. (*Id.* at 39.) Lofton

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attendant to that letter."); (*id.* at 13) ("[C]*ontra non valentum* is unavailable to Encompass, and Encompass' tort claims must be dismissed."). As Encompass requested, the Court incorporates Encompass's arguments regarding *contra non valentum* and the statute of limitations to all of the tort claims at issue. *See* (Doc. 384-1 at 26).

also stated that he was unable to find evidence during his investigation which showed that Encompass was aware of such a policy. (*Id.*) Notwithstanding the arguments of counsel, the evidence presented does not justify tolling the one-year limitations period for the remaining tort actions. *Dominion Exploration & Prod., Inc. v. Waters*, 972 So.2d 350 (La. Ct. App. 2007) (sufficient information existed to bring lawsuit had the company properly availed itself of the discovery process). Once Encompass learned of the letter and its contents, it enjoyed every reasonable opportunity to investigate the statements in the letter and file suit within one year to conduct further discovery on the matter, and no evidence in the record suggests otherwise. *See F.D.I.C. v. Barton*, 96 F.3d 128, 134–45 (5th Cir. 1996) (nothing prevented shareholders from bringing derivative lawsuit before FDIC became receiver, and FDIC did not allege fraud, deceit, misrepresentation or concealment that led to savings and loan's failure to file claim within statutory period.); *Bell v. Kreider*, 858 So.2d 58, 62–63 (La. Ct. App. 2003) (nothing in the record suggested that motorists were prevented from investigating whether commission officer violated proper policies and procedures); *Eastin v. Entergy Corp.*, 865 So.2d 49, 56–57 (La. Ct. App. 2004) (where employees' delay in filing suit could only be attributed to their own inaction; employees were in no way prohibited from filing suit or investigating the circumstances of their terminations to determine if they had a cause of action, yet failed to do so). Accordingly, the Court GRANTS summary judgment in favor of BCBSLA as to Encompass's

claim for defamation, business disparagement, and interference with a business relationship.

Because the Court grants summary judgment on the defamation claim, the Court can also dispose of another motion. BCBSLA filed a motion to exclude the expert testimony of Robert Daniel Gates. (Doc. 379.) Gates was to testify regarding damages suffered as a result of the allegedly defamatory letter. *See* (Doc. 383 at 3-4.) However, because the Court has dismissed the three tort actions, that testimony is no longer relevant. The Court, therefore, DENIES the motion as MOOT.

### K. Recoupment § 502(a)(3) Counterclaims; Money Had and Received

Under section 502(a)(3) of ERISA, a plan administrator such as BCBSLA may bring a civil action "(A) to enjoin any act or practice which violates ... the terms of the plan, or (B) to obtain other appropriate equitable relief...." *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356, 361 (2006). Therefore, the administrator may bring suit to obtain restitution from the beneficiary based solely on "equitable," not legal relief. *Sereboff*, 547 U.S. at 363. An action is equitable if the funds sought are "specifically identifiable" and are "within the possession and control of the beneficiaries." *Sereboff*, 547 U.S. at 362–63; *see also AT&T, Inc. v. Flores*, 322 F. App'x 391, 393 (5th Cir. 2009) (per curiam). According to the Fifth Circuit's three-pronged test, an action is equitable, and therefore proper under section 502(a)(3) of ERISA, if the Plan seeks to recover funds: (1) that are specifically identifiable; (2) that belong in good conscience to the Plan; and (3) that are within the possession and control of the defendant beneficiary. *See Flores*, 322

F. App'x at 393 (citing *Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough*, 354 F.3d 348, 356 (5th Cir. 2003)).

According to Encompass, BCBSLA is not entitled to summary judgment on its ERISA § 502(a) recoupment claim for two reasons. First, Encompass claims that BCBSLA failed to ever identify any plan provision that it is seeking to enforce against Encompass. (Doc. 328 at 57.) Second, Encompass failed to "establish any of the elements necessary to prevail under Section 502(a)(3) as a matter of law. (*Id.*)

Encompass's first proffered argument on the subject is unpersuasive. In support of its argument that BCBSLA must identify specific plan provisions, Encompass cites exclusively to *US Airways, Inc. v. McCutchen*, 133 Sct. 1537 (2013). However, the holding of *McCutchen* stands only for the proposition that certain equitable defenses may not override the clear terms of the plan. *McCutchen*, 133 S.Ct at 1542–43 ("We here consider whether in [a 502(a)(3) suit] a plan participant...may raise certain equitable defenses deriving from principles of unjust enrichment...We hold that neither of those equitable rules can override the clear terms of a plan") *see also id.* at 1544 ("We granted certiorari...to resolve a circuit split on whether equitable defenses can so override an ERISA plan's reimbursement provision"; & "The question in this case concerns the role that equitable defenses alleging unjust enrichment can play in such a suit"). No such equitable defenses have been raised in this case, and the holding of *McCutchen* appears of limited value under the facts of this case. Having fully reviewed all case law

submitted by all parties and pursuant to its own independent research, the Court finds no authority for the proposition that a Section 502(a)(3) claim fails as a matter of law for a fiduciary's failure to cite to plan provisions under which it seeks to recover benefits paid. Instead, the Court relies on the Section 502(a)(3) legal standard articulated in the preceding paragraph as controlling upon the ultimate success of failure of BCBSLA's counterclaim for recoupment. Moreover, plan language in the summary judgment record entitles BCBSLA to recovery "[w]henever any payment for Covered Services has been made...in an amount that exceeds the maximum Benefits available for such services...or whenever payment has been made in error by Us for non-covered services," concluding that "We will have the right to recover such payment from the Member or, if applicable, the Provider." (Doc. 290-17 at 69.) Encompass's arguments as to any lack of plan-based language are therefore unsuccessful.

Even assuming that BCBSLA can show that the funds in question are specifically identifiable, summary judgment in favor of the 502(a)(3) claim or against the 502(a)(3) claim would be improper at this stage of the litigation because there is a genuine issue of material fact concerning whether or not the funds already paid by BCBSLA belong in good conscience to the plan. As noted in Section II(G), both BCBSLA and Encompass hotly contest both the existence of and the propriety of BCBSLA's "global fee," whereby BCBSLA claims to have paid the physicians more for services completed in-office as opposed to a hospital or ambulatory surgical center. Moreover, the parties

have offered competing evidence as to the significance of billing entries submitted by Encompass—namely whether or not the use of a technical component was sufficiently different so as to constitute a separate billing entry from entries submitted by the physician. Accordingly, resolution of the question of whether the funds at issue belong in good conscience to the plan is inappropriate at this time.

Finally, BCBSLA's counterclaim for money had and money received as to non-ERISA plans should be dismissed as a matter of law, as valid contracts govern the subject matter of this suit and the repayment sought. Summary judgment in favor of either party on these claims is therefore inappropriate, and the Court DENIES the parties' motions concerning BCBSLA's ERISA Section 503(a)(3) claim. Furthermore, BCBSLA's claim for money had and money received is dismissed with prejudice.

## III. Conclusion

For the foregoing reasons, the Court DENIES Plaintiff Encompass Office Solutions, Inc.'s Motion for Summary Judgment. The Court also DENIES Plaintiff Encompass Office Solutions, Inc.'s Motion to Strike Evidence in Defendant Bluecross Blueshield of Louisiana's Motion for Summary Judgment. The Court also GRANTS IN PART and DENIES IN PART Defendant Louisiana Health Service & Indemnity Co. d/b/a Bluecross and Blueshield of Louisiana's Motion for Summary Judgment. The Court also GRANTS IN PART and DENIES IN PART Defendant Bluecross Blueshield of Tennessee, Inc.'s Motion for Summary Judgment. The Court also GRANTS IN PART and

DENIES IN PART Defendant Bluecross and Blueshield of Louisiana's Motion *In Limine*. The Court also DENIES as MOOT Defendant Bluecross and Blueshield of Louisiana's Motion to Exclude, and Objection to, Testimony of Robert Daniel Gates as an Expert.

**IT IS SO ORDERED.**

Signed this 17th day of September, 2013.

*/s/ Jorge A. Solis*
JORGE A. SOLIS
UNITED STATES DISTRICT JUDGE