No.

In the Supreme Court of the United States

NORTH CYPRESS MEDICAL CENTER OPERATING COMPANY, LTD., ET AL., PETITIONERS

v.

CIGNA HEALTHCARE, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

J. DOUGLAS SUTTER
SUTTER & KENDRICK, P.C.
3050 Post Oak Blvd., Ste. 200
Houston, TX 77056

DANIEL L. GEYSER
Counsel of Record
ALEXANDER DUBOSE & JEFFERSON LLP
Walnut Glen Tower
8144 Walnut Hill Lane, Ste. 1000
Dallas, TX 75231
(214) 396-0441
dgeyser@adjtlaw.com

QUESTION PRESENTED

This case raises an important and recurring question under the Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (29 U.S.C. 1001 *et seq.*). In reviewing whether an ERISA administrator abused its discretion in denying a benefits claim, this Court has instructed lower courts to apply a "combination-of-factors" analysis. Under that analysis, reviewing courts "must" consider all relevant "case-specific" factors and weigh them together.

In the decision below, the Fifth Circuit abandoned that totality analysis and replaced it with a per se rule: According to the Fifth Circuit, an administrator automatically wins so long as "two other courts," right or wrong, endorsed the administrator's plan interpretation in the past—rendering it "immaterial" whether the administrator's reading was legally correct, infected by conflicts of interest, motivated by bad faith, or applied unevenly to other participants. This mechanical new rule conflicts with the prevailing standard applied by this Court and other circuits—where all factors "must" be considered before deciding if a benefits denial can stand.

The question presented is:

Whether, in reviewing an ERISA administrator's benefits denial, it is automatically dispositive that "two other courts" upheld the administrator's interpretation (as the Fifth Circuit held below, rendering "immaterial" the traditional "abuse-of-discretion inquiry"), or whether a reviewing court must consider all the traditional factors required in this Court's "combination-of-factors" analysis (as required by multiple courts of appeals and this Court).

PARTIES TO THE PROCEEDING BELOW AND RULE 29.6 STATEMENT

Petitioners are North Cypress Medical Center Operating Company, Ltd.; and North Cypress Medical Center Operating Company GP, LLC.

Respondents are Cigna Healthcare; Connecticut General Life Insurance Company; and Cigna Healthcare of Texas, Inc.

North Cypress Medical Center Operating Company, Ltd., and North Cypress Medical Center Operating Company GP, LLC, have no parent corporations, and no publicly held company owns 10% or more of their stock.

RELATED PROCEEDINGS

United States District Court (S.D. Tex.):

North Cypress Med. Ctr. Operating Co., Ltd., et al. v. *Cigna Healthcare, et al.*, Civ. No. 09-2556 (Dec. 12, 2012) (initial final judgment)

North Cypress Med. Ctr. Operating Co., Ltd., et al. v. *Cigna Healthcare, et al.*, Civ. No. 09-2556 (Sept. 3, 2013) (amended final judgment)

North Cypress Med. Ctr. Operating Co., Ltd., et al. v. *Cigna Healthcare, et al.*, Civ. No. 09-2556 (Aug. 16, 2018) (final judgment on remand from the Fifth Circuit in No. 12-20695)

United States Court of Appeals (5th Cir.):

North Cypress Med. Ctr. Operating Co., Ltd., et al. v. *Cigna Healthcare, et al.*, No. 12-20695 (Mar. 10, 2015) (initial appeal)

North Cypress Med. Ctr. Operating Co., Ltd., et al. v. *Cigna Healthcare, et al.*, No. 18-20576 (Mar. 19, 2020)

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases:

Page

Cases—continued:

Page

Cases—continued:

Statutes:

Page

Statutes—continued:

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PETITION FOR A WRIT OF CERTIORARI

North Cypress Medical Center Operating Company, Ltd., and North Cypress Medical Center Operating Company GP, LLC, respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-16a) is reported at 952 F.3d 708. The order of the district court (App., *infra*, 17a-47a) on summary judgment is unreported but available at 2016 WL 9330500. The order of the district court (App., *infra*, 48a-62a) denying reconsideration is unreported but available at 2017 WL 484108. The order of the district court (App., *infra*, 63a-103a) entering findings of fact and conclusions of law is unreported

but available at 2018 WL 3738086. The final judgment of the district court (App., *infra*, 104a-105a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 19, 2020. A petition for rehearing was denied on April 21, 2020 (App., *infra*, 106a-107a). On March 19, 2020, the Court extended the time within which to file a petition for a writ of certiorari due on or after the order's date to 150 days from "the date of the lower court judgment * * * or order denying a timely petition for rehearing"; that order had the effect of extending the deadline to file this petition to September 18, 2020. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

Section 404 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1104(a)(1), provides in pertinent part:

> **Fiduciary duties**
>
> **(a) Prudent man standard of care**
>
> (1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—
>
> (A) for the exclusive purpose of:
>
> (i) providing benefits to participants and their beneficiaries; and
>
> (ii) defraying reasonable expenses of administering the plan;
>
> (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent

> man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; [and]
>
> * * * * *
>
> (D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III.

Section 502 of ERISA, 29 U.S.C. 1132, provides in pertinent part:

> **Civil enforcement**
>
> **(a) Persons empowered to bring a civil action**
>
> A civil action may be brought—
>
> (1) by a participant or beneficiary—
>
> * * * * *
>
> (B) 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 * * * .
>
> * * * * *

INTRODUCTION

This case presents a clear and intractable conflict over an important question under ERISA.

In a series of decisions, this Court outlined the proper standard of review for denied ERISA benefits claims. When a plan administrator is vested with discretionary authority, courts review the administrator's decision for abuse of discretion—and, critically here, this requires courts to assess the administrator's decision "by taking account of several different, often case-specific, factors,

reaching a result by weighing all together." *Metropolitan Life Ins. Co.* v. *Glenn*, 554 U.S. 105, 117 (2008). This Court stated unequivocally that reviewing courts *must* consider certain factors in this "combination-of-factors" analysis, including whether the administrator has impermissible conflicts or acted in bad faith. *Id.* at 116, 118.

In applying this standard, most circuits have understood this Court to mean what it said. These circuits dutifully examine all the relevant factors before deferring to the administrator. And these circuits perform that totality analysis, as required, even when prior case law supports the administrator's reading of the plan.

The Fifth Circuit, however, has disregarded these directives and adopted its own standard. According to the Fifth Circuit, when "two other courts" support the administrator's interpretation, it becomes unnecessary to review any of the "abuse of discretion factors" considered in the traditional totality analysis. App., *infra*, 11a & n.7. As the Fifth Circuit held, those factors become "immaterial," and "the abuse-of-discretion inquiry [i]s obviated by the existence of prior legal authority supporting [the administrator's] interpretation." *Id.* at 11a. In reviewing the $40-million denied claim here, the court accordingly refused to consider any issues of bad faith, conflicts of interest, arbitrary and disparate treatment, or even the fact that the administrator misread the plan—the traditional factors that this Court and other circuits say "must" be included in the analysis. Instead, because at least two courts endorsed the administrator's reading, the Fifth Circuit held that the administrator's decision automatically was not "'an abuse of discretion.'" *Id.* at 11a-13a.

The Fifth Circuit's outlier position creates a direct conflict with decisions of this Court and other circuits. It endorses an approach that will excuse improper administrator actions, and override the totality analysis that is

necessary to root out fiduciary misconduct. Its mechanical standard is also baseless on its own terms: in every analogous area, prior rulings are *not* automatic proxies for reasonableness; lower courts do get things wrong, and decisions are frequently rejected for being objectively unreasonable, clear error, and (of course) an abuse of discretion. Had this case arisen in any other circuit, petitioners would have had an opportunity to expose the flaws and deficiencies in the administrator's decision. It instead lost under the Fifth Circuit's per se rule based on simple headcounting.

This conflict is clear and intolerable. It has obvious significance for both participants and plans, and it distorts the appropriate standard for reviewing plan interpretations, a subject demanding uniform treatment nationwide. Because this case is an ideal vehicle for resolving a question of great legal and practical importance, the petition should be granted.

STATEMENT

A. Statutory Background

1. Congress enacted ERISA "'to promote the interests of employees and their beneficiaries in employee benefit plans,'" and "'to protect contractually defined benefits.'" *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 113 (1989). While employers have no obligation to establish plans, ERISA "ensure[s]" that employees "receive [earned] benefits" when plans are established. *Conkright* v. *Frommert*, 559 U.S. 506, 516 (2010). To that end, ERISA imposes a variety of obligations on plan administrators and fiduciaries (*e.g.*, 29 U.S.C. 1001(b)), while "provid[ing] 'a panoply of remedial devices' for participants and beneficiaries" to enforce those obligations. *Firestone*, 489 U.S. at 108.

Every ERISA plan is "maintained pursuant to a written instrument," which must identify one or more fiduciaries to administer the plan. 29 U.S.C. 1102(a)(1). That fiduciary is required to "discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. 1104(a)(1). In many instances, however, "the entity that administers the plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket"—meaning that every denied claim generates direct savings for the administrator. *Metropolitan Life Ins. Co.* v. *Glenn*, 554 U.S. 105, 108 (2008). This creates the potential for an impermissible conflict of interest. See, *e.g.*, *id.* at 112, 114 (explaining that administrators, including insurance companies acting as administrators, are conflicted when they "both evaluate[] claims for benefits and pay[] benefits claims").

2. a. When disputes arise between administrators and beneficiaries, ERISA authorizes judicial review to recover improperly denied benefits and to establish beneficiaries' rights. 29 U.S.C. 1132(a)(1)(B); see *Glenn*, 554 U.S. at 115.[1] Section 1132(a) entitles 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 to future benefits." 29 U.S.C. 1132(a)(1)(B). This right may be transferred to healthcare providers, who can "obtain standing to sue derivatively to enforce an ERISA plan beneficiary's claim." *Harris*

[1] A plan separately must establish a claims procedure regarding benefit denials. This procedure must "provide adequate notice" of the denial to the participant or beneficiary, "set[] forth the specific reasons for such denial," and allow "a full and fair review." 29 U.S.C. 1133. The full-and-fair-review requirement "underscores the particular importance of accurate claims processing." *Glenn*, 554 U.S. at 115.

Methodist Fort Worth v. *Sales Support Servs. Inc. Employee Health Care Plan*, 426 F.3d 330, 333-334 (5th Cir. 2005); see also, *e.g.*, *N. Jersey Brain & Spine Ctr.* v. *Aetna, Inc.*, 801 F.3d 369, 373 (3d Cir. 2015) (same for "[e]very United States Court of Appeals to have considered this question"). Section 1132(a)'s enforcement scheme "is one of the essential tools for accomplishing the stated purposes of ERISA." *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 52 (1987).

b. Critically here, because ERISA's text does not dictate *how* to review benefit denials, this Court borrowed principles of trust law to fill the gaps. Under this framework, when a plan grants its administrator "discretionary authority to determine eligibility for benefits or to construe the terms of the plan," a court evaluates any benefit denial under an abuse-of-discretion standard. *Firestone*, 489 U.S. at 115. As this Court has long established, that standard requires a totality analysis—courts "must" consider "several different, often case-specific, factors, reaching a result by weighing all together." *Glenn*, 554 U.S. at 116, 118. In devising that standard, the Court explicitly rejected the use of "'rigid and inflexible requirement[s].'" *Conkright*, 559 U.S. at 522. A "combination-of-factors method of review" is necessary because benefit decisions "arise in too many contexts" and "concern too many circumstances" to develop "a one-size-fits-all procedural system that is likely to promote fair and accurate review." *Glenn*, 544 U.S. at 116, 119.

Thus, put simply, wooden and bright-line rules are forbidden, and reviewing courts are required to consider the "many" relevant factors under a "combination-of-factors" analysis. *Glenn*, 554 U.S. at 116, 118. Those factors include things like correctness of the administrator's plan interpretation, bad faith, inconsistent treatment of beneficiaries or providers, and conflicts of interest. See *id.* at 108

(confirming, for example, that when a conflict is present, "a reviewing court should consider that conflict as a factor in determining whether the plan administrator has abused its discretion"). Although not every factor will prove "important" in every case, the reduced weight results from "inherent or case-specific" circumstances, not any categorical rule. *Id.* at 117-118.

B. Facts And Procedural History

1. This case involves a dispute under ERISA for "underpayment of more than $40 million in benefit claims." App., *infra,* 2a. Petitioners operate a "general acute care hospital" in Texas. *Id.* at 65a. After opening, the parties attempted to negotiate an in-network contract, but were unable to reach an agreement. *North Cypress Med. Ctr. Operating Co., Ltd.* v. *Cigna Healthcare*, 781 F.3d 182, 188 (5th Cir. 2015). During the relevant periods here, petitioners instead provided services on an out-of-network basis to members of respondents' ERISA plans. *Id.* at 187-188; see also App., *infra*, 69a.

Petitioners "created a program called the Prompt Pay Discount" for its patients. App., *infra*, 69a. Under the program, patients would receive steep discounts—often roughly approximating in-network rates—by paying coinsurance amounts within 120 days of a charge; if the patient satisfied the charge on time, he or she would not be obligated to pay the full amount. *Id.* at 69a-70a; see also *id.* at 3a n.1 ("in-network coinsurance obligations are typically 20% of the covered service, while patients must pay 40% of fees to out-of-network providers").

Respondents soon objected to petitioners' discount program. Respondents maintained that any discounts amounted to "'fee forgiveness,'" which they asserted fit within a specific exclusion from plan coverage: "'Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you

were covered under this Agreement.'" *Id.* at 3a-4a. Petitioners objected that its "Prompt Pay Discount" did "'not waive any portion of [petitioners'] charges for a service'" (*id.* at 73a), but respondents invoked the exclusion anyway. By "interpret[ing] this language to mean that patients had no insurance coverage for medical procedures for which the patient was not billed," respondents "implemented a Fee-Forgiving Protocol under which it drastically reduced its payment of claims to [petitioners]." *Id.* at 18a.

2. a. As relevant here, petitioners responded by filing suit seeking benefits under ERISA. App., *infra*, 18a. In addition to claiming respondents' plan construction was incorrect, petitioners asserted that respondents adopted that construction in bad faith, applied the plan unevenly to different providers, and were motivated by an inherent conflict of interest—because respondents both administered and paid claims for certain plans, every dollar respondents refused to pay petitioners was a dollar of savings going directly into respondents' pocket. See, *e.g.*, App., *infra*, 27a-28a.[2]

After an initial trip back and forth to the Fifth Circuit, petitioners sought and obtained partial summary judgment on their ERISA claims. App., *infra*, 27a-33a. According to the district court, respondents "abused [their] discretion" in interpreting the plan language. *Id.* at 27a. After recognizing disputed facts on the conflicts-of-interest factor, the court found "strong inferences that [respondents] did not act in good faith." *Id.* at 30a, 31a-33a (citing, for example, "a great deal of evidence that [respondents'] primary motivation was not to root out fee

[2] Petitioners also explained that, even for plans funded by plan sponsors, respondents still "collected contingency fees when it reduced payments to [petitioners]." App., *infra*, 28a.

forgiveness, but instead to pressure [petitioners] into negotiating an in-network contract"). The court ordered further proceedings on certain issues and damages.

b. In response to cross-motions from the parties, the district court later denied reconsideration on certain issues, upholding its findings that (i) respondents' "interpretation of the plan was not legally correct," and (ii) respondents abused their discretion by adopting their position in bad faith. App., *infra*, 51a-54a; see also *id.* at 54a ("The fact that [respondents] had other, legitimate motivations does not change the Court's finding that [respondents] acted in bad faith by attempting to drive contract negotiations through a program ostensibly aimed at curtailing fee-forgiving.").

c. Before the district court could dispose of all the claims, the Fifth Circuit issued its decision in *Connecticut Gen. Life Ins. Co.* v. *Humble Surgical Hosp., LLC*, 878 F.3d 478 (5th Cir. 2017). That case involved effectively the same administrator's construction of the same plan language based on similar activity. In earlier proceedings in *Humble*, the district court ruled that Cigna misread the plan, and was impaired by both conflicts of interest and bad faith. See *Connecticut Gen. Life Ins. Co.* v. *Humble Surgical Hosp., LLC*, No. 13-3291, 2016 WL 3077405, at *24-*25 (S.D. Tex. June 1, 2016). But the Fifth Circuit ultimately reversed.

First, the Fifth Circuit declined to decide whether Cigna's plan interpretation was legally correct. 878 F.3d at 484. It did, however, note that the court "has previously suggested (without deciding) that [Cigna's] reading might be legally incorrect." *Ibid.* (citing *N. Cypress Med. Ctr. Operating Co., Ltd.* v. *Cigna Healthcare*, 781 F.3d 182, 196 (5th Cir. 2015)).

It then held that Cigna's interpretation nevertheless "fell within its broad discretion." 878 F.3d at 484. In making that determination, the court expressly refused to consider whether Cigna "'had a conflict of interest,'" "'lack of good faith,'" applied the plan "'consisten[tly],'" or fell short under any other totality factor. *Id.* at 484-485 (declaring "[w]e need not review these factors"). The court instead found a single fact "dispositive": "where an administrator's interpretation is supported by prior case law, it cannot be an abuse of discretion." *Id.* at 485.

According to the Fifth Circuit, "[a]t least two other courts have effectively or explicitly concluded that the provision at issue here was legally correct." 878 F.3d at 485 (citing a 1991 Seventh Circuit decision and the *reversed* district court decision in this case). "In these circumstances," the court held, "'the fact that two courts have found [Cigna's] interpretation of the policy language reasonable itself establishes that the interpretation does not constitute an abuse of discretion.'" *Ibid.* Put simply: "'the fact that [at least] two courts have upheld interpretations similar to that of [Cigna] is dispositive of the issue.'" *Ibid.* The court accordingly upheld Cigna's interpretation without confronting the extensive findings from a nine-day bench trial that Cigna had indeed abused its discretion.

d. After *Humble* was issued, the district court held a bench trial. App., *infra*, 64a. Notwithstanding twice reaching the opposite conclusion (on summary judgment and reconsideration), the district court reversed itself and ruled that respondents had not abused their discretion. *Id.* at 94a-103a.

The court's discussion focused heavily on *Humble*, noting, explicitly, that its conclusion was partly "[i]n the interest of uniformity of decisions." *Id.* at 97a-98a. It followed that conclusion with a single numbered paragraph

(*id.* at 98a-101a) dedicated to "the traditional abuse of discretion factors." *Id.* at 98a.

3. a. The Fifth Circuit affirmed. App., *infra*, 1a-16a.

As relevant here, the Fifth Circuit batted aside petitioners' arguments that "the district court erred in its evaluation of the conflicts of interest and inferences of lack of good faith." App., *infra*, 11a. "Under *Humble*," the court explained, "the abuse-of-discretion inquiry was obviated by the existence of prior legal authority supporting [respondents'] interpretation of identical or nearly identical language concerning insureds' coinsurance obligations." *Ibid.* That necessarily "moot[ed]" and rendered "immaterial" any "alleged conflicting interests and lack of good faith." *Id.* at 9a, 11a. As *Humble* concluded, "'where an administrator's interpretation is supported by prior case law, it cannot be an abuse of discretion—even if the interpretation is legally incorrect.'" *Ibid.* (quoting *Humble*, 878 F.3d at 484).

In sum, the Fifth Circuit held, respondents' "interpretation, having relevant legal support, could not in these circumstances be an abuse of discretion." App., *infra*, 13a. That "pretermit[ted] further discussion" of "the abuse of discretion factors." *Id.* at 11a n.7; see also *id.* at 14a (again declaring that respondents' "alleged conflicts of interest and lack of good faith" were "immaterial").

b. The Fifth Circuit denied a petition for rehearing en banc without any member of the court requesting a vote. App., *infra*, 106a-107a.

REASONS FOR GRANTING THE PETITION

A. The Fifth Circuit's Decision Creates A Clear And Obvious Conflict With Decisions Of This Court And Other Circuits

According to the Fifth Circuit, when "two other courts" support the administrator's interpretation, it becomes unnecessary to review any of the "abuse of discretion factors" considered in the traditional totality analysis. App., *infra*, 11a-12a & n.7. In other words, the totality analysis is "obviated" whenever any two courts, at any level, happen to support the administrator's reading—no matter how wrong or unreasonable those courts might have been, and no matter what evidence exists in the record that the administrator was in fact conflicted or acting in bad faith. *Ibid.* Every factor (including those factors this Court said lower courts "must" consider) becomes "immaterial" because the administrator's view has prior legal support—even if that legal support is wrong. *Id.* at 11a, 14a.

The Fifth Circuit's holding directly conflicts with the decisions of this Court and multiple courts of appeals. Those courts do not find prior case law dispositive, but instead examine *all* relevant factors in reviewing the administrator's interpretation. The Fifth Circuit's departure from settled principles is unsound, and it promises to generate intolerable confusion in an area that demands uniformity. This Court's immediate review is warranted.

1. The Fifth Circuit's truncated analysis is squarely at odds with decisions of this Court. For decades now, this Court has repeatedly required a "combination-of-factors" analysis. *Glenn*, 554 U.S. at 118. It directs "judges to determine lawfulness by taking account of several different, often case-specific factors," and "reaching a result by weighing all together." *Id.* at 117. Contrary to the Fifth Circuit's approach, there is no license to simply set aside

all the usual indications of arbitrary-and-capricious conduct; when the relevant "factors" are present, "a reviewing judge *must* take [them] into account." *Id.* at 116; see also *Firestone*, 489 U.S. at 115. This is strictly inconsistent with the Fifth Circuit's categorical holding below. See App., *infra*, 11a & n.7 (explicitly refusing to address the "abuse of discretion factors," and declaring "alleged conflicting interests and lack of good faith * * * immaterial").

The Fifth Circuit's approach also violates this Court's admonition against creating "special procedural or evidentiary rules." *Conkright*, 559 U.S. at 513. As this Court explained, there are no "formulas that will 'falsif[y] the actual process of judging' or serve as 'instrument[s] of futile casuistry.'" *Glenn*, 554 U.S.at 119. Yet the Fifth Circuit's wooden rule does exactly that. Rather than applying "the abuse-of-discretion inquiry" (App., *infra*, 11a), the Fifth Circuit "'avoid[s] the process of judgment'" (*Glenn*, 554 U.S. at 119) by simply identifying "prior legal authority." App., *infra*, 11a. Under the Fifth Circuit's standard, it makes no difference whether the administrator's reading is legally wrong, a product of bad faith, infected by serious conflicts, or otherwise defective in any way. *Id.* at 9a, 11a, 14a. All that matters is that "prior case law," at any level, adopted the administrator's interpretation—"even if the interpretation is legally incorrect." *Ibid.* This does nothing to address whether the administrator, in a *proper* exercise of discretion, would have made the same determination. See, *e.g.*, *Conkright*, 559 U.S. at 521-522.

2. Contrary to the Fifth Circuit, other circuits correctly apply the proper standard of review: "the court *must consider* numerous case-specific factors, including the administrator's conflict of interest, and reach a decision as to whether discretion has been abused by weighing and balancing those factors together." *Montour* v. *Hartford Life & Accident Ins.*, 588 F.3d 623, 630 (9th Cir.

2009); see also, *e.g.*, *Dragus* v. *Reliance Standard Life Ins. Co.*, 882 F.3d 667, 672-673 (7th Cir. 2018); *Marcin* v. *Reliance Standard Life Ins. Co.*, 861 F.3d 254, 263 (D.C. Cir. 2017); *Roganti* v. *Metro. Life Ins. Co.*, 786 F.3d 201, 217-218 (2d Cir. 2015); *Blankenship* v. *Metro. Life Ins. Co.*, 644 F.3d 1350, 1355 (11th Cir. 2011) (per curiam).

Indeed, unlike the Fifth Circuit, these courts apply the correct rules even when confronted with "prior case law" supporting the administrator's interpretation.

a. In the First Circuit, for example, the court had little trouble understanding or applying this Court's directive. In *Colby* v. *Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan*, 705 F.3d 58 (1st Cir. 2013), an administrator read an ERISA plan to say that, "in the addiction context, a risk of relapse" cannot constitute a "current disability" for long-term disability benefits. See 705 F.3d at 61. In evaluating that interpretation, the court recognized that "the caselaw is mixed," and "the only court of appeals to have considered this precise issue" supported the administrator's construction. *Id.* at 65, 67. The court nevertheless conducted the traditional totality inquiry, analyzing all the relevant "factor[s]"—examining "'the record as a whole,'" "weigh[ing]" an "inherent conflict of interest," and reviewing "the language of the plan." *Id.* at 61-62, 65-67. In light of all the considerations, the court ultimately rejected the administrator's reading—even though it was supported by "the only court of appeals to have considered this precise issue." *Id.* at 65, 67.

The Fifth Circuit's mechanical rule, by contrast, would compel the opposite conclusion. Under its contrary approach, the "prior legal authority" itself "obviate[s]" the need for any "abuse-of-discretion inquiry"—"even if the interpretation is legally incorrect." App., *infra*, 14a. Any "conflicts" become per se "immaterial," and there is no

need to "decide the abuse of discretion factors." *Id.* at 11a, 14a. The prior case law "moots consideration of [any] conflicts and inferences of bad faith," and the administrator's "interpretation, having relevant legal support," is automatically not an abuse of discretion. *Id.* at 9a, 13a. That legal standard is incompatible with settled law in the First Circuit.

b. The Fifth Circuit's (outlier) approach also conflicts with the Eighth Circuit's practice. In *Darvell* v. *Life Ins. Co. of N. Am.*, 597 F.3d 929 (8th Cir. 2010), for example, the dispute turned on the correct interpretation of the phrase "regular occupation" in the plan's definition of "disability." 597 F.3d at 933, 935. Even though "[t]he circuits [were] split" on the issue, the Eighth Circuit, unlike the Fifth Circuit, engaged in a traditional totality review. It expressly acknowledged that an administrator's "conflict of interest * * * *must* be weighed in determining whether there is an abuse of discretion." *Id.* at 934 (emphasis added; citing *Glenn*, *supra*). And it examined the administrator's interpretation for "reasonableness," including analyzing the plan's "clear language," assessing the administrator's "consisten[cy]" in "follow[ing] the interpretation," and asking whether the reading "is consistent with the goals of the plan." *Id.* at 935-936. Although the court ultimately sided with the administrator, it did so after conducting the full "combination-of-factors method of review" (*Glenn*, 554 U.S. at 118)—not the Fifth Circuit's inflexible, "any-prior-case-law-moots-everything" standard (App., *infra*, 9a, 11a).

The Eighth Circuit, in short, conducts the mandatory analysis, while the Fifth Circuit holds that "the abuse-of-discretion inquiry [i]s obviated by the existence of prior legal authority supporting [the administrator's] interpretation." App., *infra*, 11a. Those two approaches cannot be squared with each other.

c. Just like the First and Eighth Circuits, multiple courts of appeals have likewise encountered the same "circumstances" (App., *infra*, 13a) and still examined the traditional "factors," rather than declaring everything "moot[]," "immaterial," and "obviate[d]" (App., *infra*, 9a, 11a, 14a) whenever "'an administrator's interpretation is supported by prior case law'" (*id.* at 11a (quoting *Humble*, 878 F.3d at 484)). Compare, *e.g.*, *Osborne* v. *Hartford Life & Accident Ins.*, 465 F.3d 296, 299-300 (6th Cir. 2006) (analyzing "conflicts" and the plan's meaning, even with prior, unpublished circuit precedent "support[ing]" the administrator); *Ehrensaft* v. *Dimension Works Inc. Long Term Disability Plan*, 33 F. App'x 908, 909-910 (9th Cir. 2002) (examining both "inherent conflict of interest" and the "plain reading of the policy"—even where "circuit-level law in this circuit appears to favor" the administrator); see also *Gallo* v. *Madera*, 136 F.3d 326, 328-331 & n.11 (2d Cir. 1998).

In short, while the Fifth Circuit declares that prior authority "pretermit[s]" (App., *infra*, 11a & n.7) the "combination-of-factors" analysis (*Glenn*, 554 U.S. at 118), other courts faithfully apply this Court's decisions: "[c]ourts reviewing benefits decisions for abuse of discretion cannot avoid the process of evaluating whether an ERISA administrator's interpretation was reasonable, even if other courts have already interpreted similar language." *Creno* v. *Metro. Life Ins.*, No. CV-12-1642, 2014 WL 4053410, at *7, *11 (D. Ariz. Aug. 15, 2014); see also, *e.g.*, *Pettit* v. *UnumProvident Corp.*, 774 F. Supp. 2d 970, 981, 983-984 (S.D. Iowa 2011) (giving conflict of interest "some weight" and conducting full five-factor analysis); *Jones* v. *Allen*, No. 2:11-cv-380, 2013 WL 5728344, at *12 (S.D. Ohio Oct. 22, 2013) (performing review without automatically deferring to past cases); *Clarke* v. *Fed. Ins. Co.*, 823 F. Supp. 2d 1213, 1216-1217, 1219-1221 (W.D. Okla. 2011) (same).

The conflict is stark and entrenched, and it will persist until this Court intervenes.

3. Not only is the Fifth Circuit's approach out of step with other circuits, but its position is both unsupportable and (literally) unsupported. According to the panel below, the circuit's earlier decision in *Humble* identified "'other courts * * * h[olding] that, where an administrator's interpretation is supported by prior case law, it cannot be an abuse of discretion—even if the interpretation is legally incorrect.'" App., *infra*, 11a (quoting *Humble*, 878 F.3d at 484). But those "other courts" held no such thing, and *Humble* misread each case it cited for its rigid standard. See 878 F.3d at 484-485 (citing *Hinkle ex rel. Estate of Hinkle* v. *Assurant, Inc.*, 390 F. App'x 105 (3d Cir. 2010); *McGuffie* v. *Anderson Tully Co.*, No. 3:13-cv-888, 2014 WL 4658971 (S.D. Miss. Sept. 17, 2014); and *Fitzgerald* v. *Colonial Life & Ins. Co.*, No. JFM-12-38, 2012 WL 1030261 (D. Md. Mar. 26, 2012)).

First, the Third Circuit's decision in *Hinkle* cuts the other way. There, the benefits dispute turned on the meaning of "accidental" in an ERISA plan. 390 F. App'x at 106, 108. The issue had divided the circuits, and the district court (not the appellate court) "held that 'where the courts of appeals are in disagreement on an issue, a decision one way or another cannot be regarded as arbitrary or capricious.'" *Id.* at 108. Although the Fifth Circuit attributed that "holding" to the Third Circuit, *Humble*, 878 F.3d at 484, the language was "[t]he district court['s]," and the Third Circuit cautioned it was not necessarily "true," even if "proper[]" in that case. 390 F. App'x at 108. Indeed, far from automatically deferring to prior authority, the Third Circuit conducted a typical multi-factor review, faulted the district court for failing to "acknowledge[] Defendants' conflict of interest in reviewing the decision,"

and agreed with prior cases only after examining their *underlying* "analysis" for reasonableness. *Id.* at 107-108; see also *id.* at 107 (reaffirming that "[c]onflicts" represent "one factor among many that a reviewing judge *must* take into account'") (emphasis in *Hinkle*; quoting *Glenn*, 554 U.S. at 116).

Hinkle's analysis thus conflicts with the Fifth Circuit's approach; it expressly considered "factors" that the Fifth Circuit declared "moot[ed]" and "immaterial," and examined those factors before deciding whether the administrator abused its discretion—despite "prior case law" supporting the administrator's construction, which is per se dispositive in the Fifth Circuit. App., *infra*, 11a, 13a. *Hinkle*, if anything, stands for the *opposite* proposition. See 390 F. App'x at 108.

Second, in *Fitzgerald*, the district court indeed at one point suggested that "the fact that two courts have upheld interpretations similar to that of [the administrator] is dispositive of the issue." 2012 WL 1030261, at *3; see *Humble*, 878 F.3d at 485 (quoting this language). But it earlier held that the administrator's conflict of interest "constitutes *a factor that must be considered*." *Fitzgerald*, 2012 WL 1030261, at *2 (emphasis added). More tellingly, after the court hinted that prior cases "arguably" are "dispositive," it continued that it "was not content, however, to rely upon that fact alone": "Were I to do so, I believe *I would be shirking my responsibility to independently review* the reasonableness of [the administrator's] interpretation of the language of the [plan] in this case." *Id.* at *3 (emphasis added); compare *Humble*, 878 F.3d at 484-485 (not quoting this language). The Fifth Circuit, unlike other courts, refused to conduct that "independent[] review."

Finally, the district court in *McGuffie* in fact noted that "case law supports the Plan's interpretation" (*Humble*, 878 F.3d at 485 (so quoting)), but it also independently found that interpretation "reasonable," declared it "the most logical and pragmatic interpretation," and examined the issue from "a practical and actuarial perspective." 2014 WL 4658971, at *3-*4. The Fifth Circuit, by contrast, "pretermit[s]" any "discussion" of those so-deemed "immaterial" factors. App., *infra*, 11a & n.7; see also *Humble*, 878 F.3d at 485 (declaring "'dispositive'" that "'[a]t least two other courts'" had accepted the administrator's interpretation).

* * *

In sum, the rule in the Fifth Circuit is now clear: the traditional "abuse-of-discretion inquiry" is "immaterial" and "obviated" by "the existence of prior legal authority supporting [the administrator's] interpretation." App., *infra*, 11a.[3] That standard runs headlong into this Court's directives and the settled law overwhelmingly applied in other courts nationwide. Those other courts routinely con-

[3] In *Humble*, the Fifth Circuit stated it was not adopting "a bright-line rule"—while holding that "'the fact that [at least] two courts have upheld interpretations similar to that of [Cigna] is *dispositive* of the issue.'" 878 F.3d at 485 (emphasis added). That is the very definition of a bright-line rule. In any event, the panel below has now confirmed the categorical nature of *Humble*'s holding: "[u]nder *Humble*," "the abuse-of-discretion inquiry [i]s obviated by the existence of prior legal authority supporting Cigna's interpretation of identical or nearly identical language." App., *infra*, 11a; accord, *e.g.*, *id.* at 13a ("Cigna's interpretation, having relevant legal support, could not in these circumstances be an abuse of discretion."); *id.* at 11a n.7 ("pretermit[ting]" any "discussion" of "the abuse of discretion factors"); see also C.A. Resp. Br. 46 ("[U]nder *Humble*, the fact that two courts had upheld Cigna's interpretation was 'dispositive' and the court did not need to consider any other abuse of discretion factors.").

front situations where prior decisions support an administrator's reading, but those courts still engage the traditional "combination-of-factors method of review." *Glenn*, 554 U.S. at 118. The Fifth Circuit, by contrast, opted instead for a forbidden bright-line rule, short-circuiting "'the actual process of judging.'" *Id.* at 119. The disposition of routine ERISA cases will now vary based on the happenstance of where a dispute arises. Certiorari is plainly warranted.

B. The Decision Below Is Incorrect

Review is also warranted because the Fifth Circuit's position is wrong.

First, as explained above, the Fifth Circuit's analysis contravenes this Court's unambiguous legal standard. In multiple decisions, this Court has instructed lower courts to conduct a "combination-of-factors method of review," where courts "must" consider certain factors. *Glenn*, 554 U.S. at 116, 117-118. This command leaves no room for inflexible, per se rules or exceptions. Yet the Fifth Circuit refused to apply factors this Court said *must* be applied, and adopted a categorical rule where this Court explicitly said not to do that in this context—there is no shortcut to "'the actual process of judging.'" *Id.* at 119.

The Fifth Circuit was required to "determine lawfulness by taking account of several different, often case-specific factors, reaching a result by weighing all together." *Glenn*, 554 U.S. at 117. Its decision to "obviate" that traditional inquiry—and to replace it with mechanical head-counting—was mistaken.

Second, the Fifth Circuit's standard fails on its own terms. There is no legal or logical basis for insulating an administrator's (incorrect) plan interpretation simply because the bottom-line decisions from two other courts (no matter how weak or irrational) wrongly excused the ad-

ministrator in the past. Lower-court decisions are not automatic proxies for reasonableness. Indeed, there are multiple doctrinal contexts where positions are later declared unreasonable *despite* being accepted by other courts—including AEDPA ("unreasonable application of[] clearly established law," 28 U.S.C. 2254(d)(1); see also, *e.g.*, *Wiggins* v. *Smith*, 539 U.S. 510, 527 (2003) (declaring the Maryland Court of Appeals' decision "objectively unreasonable")); erroneous transfers (rejected by transferee courts as "implausible," *Xitronix Corp.* v. *KLA-Tencor Corp.*, 916 F.3d 429, 431 (5th Cir. 2019)); "abuse of discretion" review; "clear error" review; etc.

The reality is that lower-court rulings are rejected all the time; the fact that two prior decisions got these issues profoundly wrong does not automatically spare the administrator—lower-court rulings only excuse an administrator if those rulings themselves underscore the administrator's reasonableness, which these plainly did not. There is no room for wooden, mechanical head-counting in a process that necessarily turns on a host of "case-specific[] factors." *Glenn*, 554 U.S. at 117.

Indeed, the dangers of the Fifth Circuit's rule are illustrated perfectly in this setting. Contrary to the panel's contention (App., *infra*, 12a-13a), the Seventh Circuit did *not* clearly endorse respondents' reading of the plan language; it said the provider there fit within the plan's exclusion because it expressly waived its patients' liability for any charges. See, *e.g.*, *Kennedy* v. *Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 701-702 (7th Cir. 1991) ("the district court concluded that the contract excused Myers from paying"; if the provider "wishes to receive payment under a plan that requires co-payments, then he must collect those co-payments—*or at least leave the patient legally responsible for them*") (emphasis added); *Ctr. for Restorative Breast Surgery, L.L.C.* v. *Blue Cross Blue Shield of*

La., No. 11-806, 2016 WL 9439243, at *8 (E.D. La. Sept. 19, 2016) (explaining this distinction). Here, by contrast, petitioners adopted a plan that required patients to accept full financial responsibility but offered significant discounts for prompt payments. App., *infra*, 2a-3a. And while the *district court below* initially endorsed respondents' reading, it was later reversed on an earlier appeal, and the Fifth Circuit identified "strong reasons" to believe the plan interpretation was wrong. *N. Cypress Med. Ctr. Operating Co., Ltd.* v. *Cigna Healthcare*, 781 F.3d 182, 195 (5th Cir. 2015) ("[t]here are strong arguments that Cigna's plan interpretation is not 'legally correct'").

At bottom, the Fifth Circuit expressly refused to consider evidence of bad faith, conflicts, and disparate treatment because a *reversed* district court had accepted the same interpretation and the Seventh Circuit had accepted a distinguishable proposition in a 1991 decision the Fifth Circuit overstated. This underscores the risks and defects of adopting a truncated analysis that fails to incorporate the relevant totality factors.[4]

Finally, the Fifth Circuit's analysis loses the forest for the trees. The entire question is whether the administrator is properly performing its fiduciary role. A wrong decision, made in bad faith, infected by conflicts, and applied unevenly is not a decision adequately discharging one's fiduciary duties in *protecting the beneficiaries' interests*. See *Glenn*, 554 U.S. at 115; 29 U.S.C. 1104(a)(1). The fact that some prior court, at some level, previously *misconstrued* the plan says nothing useful about why the administrator adopted the same reading here. If a party acting

[4] In fact, the Fifth Circuit's position is only one step removed from saying that any district-court decision endorsing a plan's interpretation is effectively unreviewable *because at least one prior court endorsed the plan's position*.

in the best interests of the protected class would have reached the opposite conclusion—even if the plan language was technically susceptible of multiple constructions—the administrator might still abuse its discretion. The proper analysis requires the reviewing court to take "several different considerations" into account. *Glenn*, 554 U.S. at 117. The Fifth Circuit's per se rule is a poor substitute for that process.

C. The Question Presented Is Important And Recurring And Warrants Review In This Case

1. The question presented is of obvious legal and practical importance.

First, this Court often grants review to ensure the application of uniform national standards in the ERISA context. See, *e.g.*, *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 381 (2002); *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 148 (2001). The decision below creates an unprincipled exception to the existing framework for reviewing benefit denials, including potentially giving a free pass to an administrator's incorrect, conflicted, and bad-faith construction of a plan. It conflicts with the established means of reviewing benefits decisions, and it departs from administrable rules this Court has developed over decades. The Fifth Circuit's outlier standard deprives regulated stakeholders of needed stability and uniformity in a context that requires both.

Second, the decision below undermines judicial review as a tool to combat fiduciary misconduct. Congress recognized the vitality of judicial review for securing participant rights under ERISA. Those rights mean little if a plan can operate in bad faith and under a conflict of interest, yet excuse itself so long as two prior cases (arguably) endorsed the plan's "'similar'" view under different circumstances. *Humble*, 878 F.3d at 485; see also App., *infra*, 11a.

This Court's prevailing analysis—which is faithfully applied everywhere outside the Fifth Circuit—ensures that administrators receive meaningful latitude while also ensuring that participants get a fair shake. And that means securing the benefit of the administrator's good-faith exercise of discretion. *Glenn*, 554 U.S. at 111. The very factors that the Fifth Circuit refused to apply are essential to rooting out bad decisions tainted by improper considerations. The Fifth Circuit's contrary rule threatens to frustrate and complicate judicial review in a manner incompatible with Congress's intent.

Finally, this question arises all the time. The factual backdrop of benefits disputes is unsurprising: Many employers operate across state lines, and smaller employers tend to contract with large plan administrators with national practices. Those dynamics regularly lead to similar disputes over similar plan language. A rule in one circuit that replaces meaningful review with simple head-counting—did some other court embrace something like this in the past?—frustrates the system while reducing the accuracy of the process. It leads to distorted plan constructions and excuses administrators who choose an incorrect reading in bad faith to serve their own interests—all because at least two other courts likewise misread the plan in the past.

And since courts outside the Fifth Circuit will continue applying the "combination-of-factors" analysis, that same plan construction will be rejected, properly, in other circuits on the same record—leading to the very disuniformity that ERISA was partly designed to prevent.

2. This case is an ideal vehicle for deciding the question presented. The Fifth Circuit's legal holding was outcome-determinative: it deemed all the traditional factors "immaterial," declared the "abuse-of-discretion inquiry" "obviated" by "prior case law" supporting the administrator,

and expressly found any discussion of "the abuse of discretion factors" "pretermit[ted]" in light of its disposition. App., *infra*, 11a & n.7. The court thus foreclosed any consideration of the key factors that petitioners invoked as central to their argument. See, *e.g.*, *id.* at 11a-13a & n.7, 14a.[5]

In short, the correctness of the Fifth Circuit's analysis is a pure question of law, and there are no obstacles to deciding that question here. The decision below presents a square conflict on a significant question under an important federal scheme, and it cries out for this Court's intervention.

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[5] Although the district court ultimately rejected petitioners' showing, suffice it here to say that the district court in *Humble* looked at the same language in the same plan and found the same administrator engaged in "extraordinary acts of bad faith," had "a conflict of interest," misread the plan, and engaged in other improper conduct. See *Connecticut Gen. Life Ins. Co.* v. *Humble Surgical Hosp., LLC*, No. 13-3291, 2016 WL 3077405, at *25-*26 (S.D. Tex. June 1, 2016); see also C.A. Resp. Br. 44 ("There is no real dispute that the relevant facts in *Humble* and here are the same."). And the district court here flip-flopped on its own findings, ruling for petitioners on summary judgment before landing on a contrary answer (post-*Humble*) that is plausible at best. App., *infra*, 94a-101a. If respondents wish to defend their position under this Court's (proper) totality analysis, they will have every opportunity to do so on remand. But they cannot short-circuit this Court's mandatory inquiry—or the Fifth Circuit's misapplication of it—by *presuming* how petitioners' challenges would be evaluated under the correct legal standard. See, *e.g.*, Pet. Reply Br., *Kisor* v. *Wilkie*, No. 18-15, at 2 (filed Nov. 19, 2018) ("The Court routinely grants certiorari to resolve important questions that controlled the lower court's decision notwithstanding a respondent's assertion that, on remand, it may prevail for a different reason.").

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

J. DOUGLAS SUTTER
SUTTER & KENDRICK, P.C.
3050 Post Oak Blvd., Ste. 200
Houston, TX 77056

DANIEL L. GEYSER
Counsel of Record
ALEXANDER DUBOSE &
JEFFERSON LLP
Walnut Glen Tower
8144 Walnut Hill Lane, Ste. 1000
Dallas, TX 75231
(214) 396-0441
dgeyser@adjtlaw.com

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