APPENDIX

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 18-20576

NORTH CYPRESS MEDICAL CENTER OPERATING COMPANY, LIMITED; NORTH CYPRESS MEDICAL CENTER OPERATING COMPANY GP, L.L.C.,
Plaintiffs-Appellants,

v.

CIGNA HEALTHCARE; CONNECTICUT GENERAL LIFE INSURANCE COMPANY; CIGNA HEALTHCARE OF TEXAS, INCORPORATED,
Defendants-Appellees.

Filed: March 19, 2020

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

Before KING, JONES, and DENNIS, Circuit Judges.

OPINION

EDITH H. JONES, Circuit Judge:

North Cypress Medical Center Operating Co., Ltd., and North Cypress Medical Center Operating Co. GP,

L.L.C., appeal the adverse judgment rendered by the district court on ERISA claims assigned by Cigna-insured patients. They contend that substantively and procedurally flawed insurer decisions resulted in underpayment of more than $40 million in benefit claims. Because the district court correctly applied this court's decision in *Connecticut General Life Insurance Co. v. Humble Surgical Hospital, L.L.C.*, which construed an identical provision, 878 F.3d 478, 485 (5th Cir. 2017), North Cypress's arguments cannot be sustained. We AFFIRM.

BACKGROUND

In 2007, the Plaintiff-Appellants (collectively, "North Cypress") opened a general acute care hospital. With the help of a third-party consultant, North Cypress developed a master schedule of fees for each service. When North Cypress provided services covered by a patient's insurance, it reported the scheduled fee for the services to the patient's insurance company. The insurance company was expected to pay most of the fee, while the patient, still nominally responsible for the entire cost, would be billed for a smaller percentage as coinsurance and possibly a deductible.

North Cypress decided to give its patients a break on coinsurance. The hospital offered to limit the patient's coinsurance obligation if the patient paid a certain amount of what he owed within 120 days. To calculate this "Prompt Pay Discount," North Cypress started from Medicare's reimbursement schedule, which provided fees far lower than North Cypress's master schedule for non-Medicare patients. North Cypress multiplied the Medicare fee by 125 percent, and it then applied the patient's in-network coinsurance percentage—even if North Cy-

press was not in-network for the patient's insurance company.[1] The resulting balances significantly reduced out-of-network patients' coinsurance obligations, but they also generated substantial revenue for North Cypress without incurring collection expenses.[2]

The Defendant-Appellees (collectively, "Cigna") administer, and sometimes fund, health insurance plans. All the plans at issue in this case provide Cigna with discretionary authority to interpret the plans, and all "specifically exclude" from coverage:

> Charges for which you are not obligated to pay or for which you are not billed or would not have been

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[1] According to the district court, in-network coinsurance obligations are typically 20% of the covered service, while patients must pay 40% of fees to out-of-network providers.

[2] For example, if the typical ("Chargemaster") cost of care were $10,000:

> When applying the prompt pay discount, rather than billing the patient $4,000 North Cypress would calculate a much lower amount. First, instead of starting with the total Chargemaster cost of care, North Cypress would start with a lower base rate—125% of the Medicare rate for the services provided. For example, instead of $10,000, the base rate might be $2,500. Then instead of multiplying this reduced base rate by 40%, North [Cypress] would multiply it by 20%—the patient's *in-network* coinsurance rate. As a result of the discount, the patient in this example would be billed only $500 rather than $4,000. In contrast, Cigna's responsibility was unchanged; North Cypress would file a claim form reporting its total Chargemaster cost to Cigna and expect the insurer to pay its 60% share—$6,000.

N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare (*North Cypress I*), 781 F.3d 182, 188 (5th Cir. 2015).

> billed except that you were covered under this Agreement.[3]

Cigna interpreted this language as its refusal to countenance a provider's "fee forgiveness," on the ground that such practices desensitize insureds to the higher cost of out-of-network medical care.

Throughout the period relevant to this lawsuit, Cigna insured North Cypress patients at out-of-network rates.[4] In a 2007 letter when it opened for business, North Cypress acknowledged its out-of-network status but noted that Cigna members would still be eligible for its Prompt Pay Discount. North Cypress did not explain how it calculated that discount, and Cigna replied with concern that North Cypress proposed to engage in fee-forgiveness. Cigna emphasized that it would recognize charges only insofar as beneficiaries were legally liable for them, adding that it might delay or deny payment until it had "assurance that the charges shown on claim forms are your actual charges to the patient and that patients will be required to pay amounts such as out-of-network co-insurance and deductibles." North Cypress replied that the Prompt Pay Discount "does not waive any portion of North Cypress's charges for a service." North Cypress

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[3] The district court found that the plans in this case include this provision. On appeal, North Cypress states in a footnote that "Cigna *never* established which plans contained the Exclusion," but North Cypress says nothing more on this point in either brief. "Failure of an appellant to properly argue or present issues in an appellate brief renders those issues abandoned." *United States v. Beaumont*, 972 F.2d 553, 563 (5th Cir. 1992). The district court's factual finding is, therefore, undisputed.

[4] In 2012, North Cypress became an in-network provider for Cigna, ending this controversy.

did not explain to Cigna that the Prompt Pay Discount was based on an entirely different fee schedule, the assumption of an in-network coinsurance rate, and the thus-conditioned waiver of Cigna's usual reimbursement requirements.

Until early November 2008, Cigna accepted claims proffered by North Cypress, paying approximately 80% of the hospital's bill based on its master fee schedule. Prompted by complaints from its insureds about extraordinary out-of-network payments, Cigna became suspicious of fee forgiveness by North Cypress and launched an investigation. It sent 34 survey letters to Cigna plan members and received 19 responses. It received a range of answers and concluded that North Cypress generally collected $100 from a Cigna-insured patient, if anything.

Consequently, Cigna decided to change its payment process for North Cypress claims and notified the hospital of its new "Fee-Forgiving Protocol." Going forward, it would assume that North Cypress charged patients $100, and based on this coinsurance payment, it would calculate the cost of the procedure. Then, it would pay what the patient's plan dictated for a procedure of that cost at an out-of-network hospital. This assumption would be revoked if the beneficiary (or assignee) showed that the amount submitted was actually the amount charged and that the Cigna participant had paid the applicable out-of-network coinsurance amount.

North Cypress protested implementation of the Protocol and, as its patients' assignee, appealed claims in Cigna's multi-level appeals process. Consistently, North Cypress's first appeal would be met with a letter from Cigna conveying that the original decision was based on Cigna's policy of not paying charges that patients are not

legally obliged to pay. The letter would explain the process for a second appeal. According to the letter, appeals were to be decided by a unit separate from the unit involved in the initial decision. The district court found that Cigna adjusted some claims in favor of North Cypress during the appeal process, but North Cypress refused to complete the appeals process for the vast majority of its claims.

In 2009, North Cypress sued in federal court seeking relief for claimed underpayments of insurance by Cigna under state law, RICO, and ERISA. The district court ruled, in relevant part, that North Cypress lacked standing to pursue ERISA claims.[5] On appeal, this court reversed that ruling and remanded for consideration of the ERISA claims. *North Cypress I*, 781 F.3d at 192–95.

After further discovery, the district court responded to cross-motions for summary judgment by dismissing North Cypress's ERISA § 502(a)(3) claims for breach of fiduciary duty, its ERISA § 503 claims for failure to provide a full and fair review of initial benefit decisions, its ERISA § 502(c)(1)(B) claims for refusal to provide requested plan documents, and its state contract law claims. The court also deemed Cigna's affirmative defense of recoupment to be waived and denied North Cypress's request for attorney's fees. Finally, the court narrowed North Cypress's remaining claims for patient benefits

[5] The district court also dismissed appellants' RICO claims, state insurance law claims, and state contract law claims, granted a motion to unseal, and dismissed appellees' ERISA counterclaims. In *North Cypress I*, this court upheld those rulings, except for dismissal of the state contract law claims, which were remanded. 781 F.3d at 197–207.

under ERISA § 502(a)(1)(B) to those for which it had exhausted administrative remedies, ruling that North Cypress lacked a futility excuse for non-exhaustion.

An eight-day bench trial followed. At trial, the court refused to reconsider its ruling on exhaustion. Also, the court dismissed 395 of the exhausted claims that had not been subjected to the challenged Protocol and had therefore been reimbursed satisfactorily. As to the remaining 180 discretionary decisions made by Cigna regarding benefit claims subject to the Protocol,[6] the court found no abuse of discretion and thus no violation of ERISA § 502(a)(1)(B). The court rejected North Cypress's other claims. The hospital timely appealed.

STANDARD OF REVIEW

"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*." *Humble*, 878 F.3d at 483 (alteration in original) (quoting *George v. Reliance Standard Life Ins. Co.*, 776 F.3d 349, 352 (5th Cir. 2015)). In reviewing de novo an administrator's ERISA plan interpretation, we apply the same standard as is appropriate for the district court. *Id.* "[W]hen an administrator has discretionary authority with respect to the decision at issue, the standard of review should be one of abuse of discretion." *Id.* (alteration in original) (quoting *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, 128 S. Ct. 2343 (2008)).

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[6] North Cypress does not dispute that Cigna had discretionary authority to determine eligibility for benefits in this case.

"This court reviews a grant of summary judgment *de novo,* applying the same standards as the district court. We therefore affirm the district court's grant of summary judgment 'if, viewing the evidence in the light most favorable to the non-moving party, there is no genuine dispute [as] to any material fact and the movant is entitled to judgment as a matter of law.'" *LifeCare Mgmt. Servs. L.L.C. v. Ins. Mgmt. Adm'rs Inc.*, 703 F.3d 835, 840–41 (5th Cir. 2013) (alteration in original) (citation omitted) (quoting *U.S. ex. rel. Jamison v. McKesson Corp.*, 649 F.3d 322, 326 (5th Cir. 2011)).

Finally, this court reviews a denial of attorney's fees for abuse of discretion, reviewing factual findings for clear error and legal conclusions de novo. *See Humble*, 878 F.3d at 488; *see also Dean v. Riser*, 240 F.3d 505, 507 (5th Cir. 2001).

DISCUSSION

On appeal, North Cypress raises numerous issues, most of which are connected to the impact of our first appellate decision in this case and intervening case law. Thus, North Cypress contends the district court violated the law of the case by not considering the legal correctness of Cigna's plan interpretation. Second, in contravention of our earlier opinion, the court failed to find that Cigna had conflicts of interest, lacked good faith, and abused its discretion in denying claims under the hospital's Prompt Payment Discount policy. Next, the district court erred in relying on *Connecticut General Life Insurance Co. v. Humble Surgical Hospital, L.L.C.*, the intervening decision of this court that interpreted the same language at issue in Cigna's policy here. Moving on, North Cypress alleges that futility excused its failure to exhaust administrative remedies for the vast majority of

benefit claims at issue and that Cigna failed to provide fair and full review of the challenged benefit claims. Finally, the district court allegedly erred in denying damages and failing to award attorney's fees to North Cypress.

None of these challenges succeeds. As will be explained, the law of the case did not require the district court on remand to determine the legal correctness of Cigna's policy interpretation, and under *Humble*, a court need not reach legal correctness if the insurer's determination was not an abuse of discretion. *Humble* also moots consideration of the conflicts and inferences of bad faith that North Cypress asserts against Cigna. In evaluating Cigna's plan interpretation, the district court correctly applied this court's previous decision in the instant controversy as well as *Humble*. Consequently, North Cypress's exhaustion argument is moot. Moreover, its procedural challenge to Cigna's review fails for lack of substantiating evidence, which leaves the damages issue moot, too. Based on the correctness of the district court's rulings, North Cypress can hardly establish that it had any right to obtain attorney's fees.

I. Law of the Case

Reviewing Cigna's disposition of the challenged benefit claims, the district court "skipped the legal correctness analysis" and proceeded to the "functional equivalent of arbitrary and capricious review." According to North Cypress, this procedure violated the law of the case because, in *North Cypress I*, this court allegedly ordered the trial court on remand to decide whether Cigna's plan interpretation was legally correct. In fact, the law of the case stated no such imperative.

In *North Cypress I*, Cigna requested that this court "affirm the grant of summary judgment against North Cypress's benefit underpayment claims on the merits." 781 F.3d at 195. The panel chose instead to "vacate and remand to allow the district court a full opportunity to consider all of North Cypress's claims for underpayment of benefits and its other closely related ERISA claims with a fully developed record." *Id.* at 197. To explain the remand, the *North Cypress I* panel identified "the many issues Cigna asks us to decide." *Id.* at 196. For this reason, the panel stated,

> Analysis of Cigna's plan interpretation proceeds in two steps. The first question is whether Cigna's reading of the plans is "legally correct." . . . On a finding that the plans, read correctly, do *not* condition coverage on collection of coinsurance, the question would be whether Cigna nevertheless had discretion to absolve itself of responsibility for payment of the greater part of thousands of claims. At this stage of the analysis, the inquiry would include among other factors, whether Cigna had a conflict of interest, as well as the "internal consistency of the plan" and "the factual background of the determination and any inferences of lack of good faith."

Id. at 195–96 (quoting *Threadgill v. Prudential Secs. Grp., Inc.*, 145 F.3d 286, 293 (5th Cir. 1998)).

This general statement of the law, expressed in terms of the facts of the case, is no mandate at all. Nor is it a statement of the whole law regarding review of ERISA benefit decisions. The court's summary omits mention of *Duhon v. Texaco, Inc.,* 15 F.3d 1302, 1307 n.3 (5th Cir. 1994) and *Holland v. International Paper Co. Retirement Plan*, 576 F.3d 240, 246 n.2 (5th Cir. 2009) (cited in

North Cypress I, 781 F.3d at 195 n.57), in which this court established that a party may skip the legal correctness inquiry and proceed to consider whether the plan administrator abused its discretion, as outlined in *North Cypress I*. The *North Cypress I* panel did not deny the authority of *Duhon* or of *Holland* (nor could it).

Accordingly, the district court properly relied on *Holland*, as well as on *Humble*, 878 F.3d at 483–84, in skipping the legal correctness analysis. In so doing, the court did not violate the law of the case and committed no error.

II. Conflicts of Interest and Lack of Good Faith

Law of the case aside, North Cypress contends also that the district court erred in its evaluation of the conflicts of interest and inferences of lack of good faith that North Cypress raised. Under *Humble*, however, the abuse-of-discretion inquiry was obviated by the existence of prior legal authority supporting Cigna's interpretation of identical or nearly identical language concerning insureds' coinsurance obligations. *Humble* explained that "[o]ther courts have held 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." *Humble,* 878 F.3d at 484. Because, as North Cypress itself has acknowledged, the circumstances of this case match those in *Humble*, Cigna's alleged conflicting interests and lack of good faith are immaterial.[7]

[7] The district court applied *Humble*, noting it need not decide the abuse of discretion factors, but it went on to reject, based on record evidence, each of North Cypress's complaints concerning Cigna's alleged conflicts of interest, internal inconsistency in the plan, and lack of good faith. We pretermit further discussion of these findings.

If a benefit claimant (or, as here, assignee) challenges the disposition of a claim, and the court makes no finding of legal correctness to end the inquiry, then it must ordinarily consider whether the plan administrator's interpretation was arbitrary and capricious. *Humble*, 878 F.3d at 483. The inquiry may generally include reviewing whether the plan administrator "had a conflict of interest, as well as the 'internal consistency of the plan' and 'the factual background of the determination and any inferences of lack of good faith.'" *North Cypress I*, 781 F.3d at 195–96 (quoting *Threadgill*, 145 F.3d at 293). Under *Humble*, however, it may not be necessary to review these factors, at least "under the present circumstances," where two other courts "effectively or explicitly concluded that the [insurer's interpretation of the] provision at issue here was legally correct." 878 F.3d at 485.[8]

For some of the benefit decisions in *Humble*, one relevant and longstanding prior case, decided in 1991, was *Kennedy v. Connecticut General Life Insurance Co.*, 924 F.2d 698 (7th Cir. 1991). *Id.* at 485. The *Kennedy* court ruled that Cigna's interpretation of a "nearly-identical" provision as imposing a fee forgiveness restriction was legally correct. *Kennedy,* 924 F.2d at 701. The *Humble* court also relied on the district court's first decision in this case, which although vacated in *North Cypress I,* was controlling during most of the period covering Cigna's dealings with Humble Surgical Hospital and had also ruled Cigna's interpretation to be correct. Thus, as in *Humble*, so it must be here: this court must adhere to the same

[8] The court in *Humble* cautioned that it did not adopt "a bright-line rule because even if a legally incorrect interpretation is supported by prior case law, employing the interpretation could cause a plan administrator to abuse its discretion." 878 F.3d. at 485.

reasoning and result concerning the same policy language. Cigna's interpretation, having relevant legal support, could not in these circumstances be an abuse of discretion.

III. Applying *Humble*

To avoid the dispositive effect of *Humble*, North Cypress proposes four critiques: *Humble* contradicts *North Cypress I* and lacks authority; *Kennedy*, on which *Humble* relied, is inapplicable to this case; Cigna did not rely on *Kennedy* in this case; and various facts render *Humble* distinguishable. These are meritless.

First, it is simply incorrect to claim that "*Humble* came to a different conclusion than did *N. Cypress* finding that Cigna's Exclusion interpretation is 'legally correct.'" *Humble* came to no such conclusion. Instead, the court "skip[ped]" consideration of the issue because "even if [Cigna's] construction of the plans' exclusionary language was legally incorrect, its interpretation still fell within its broad discretion." *Humble*, 878 F.3d at 484. Moreover, *North Cypress I* made no final determination about the legal correctness of Cigna's interpretation, as it merely "suggested (without deciding) that this reading might be legally incorrect."[9] *Id. Humble* remains binding.

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[9] It stated that "[t]here are strong arguments" for that conclusion, declined to rule for Cigna on the merits of North Cypress's ERISA claims, and vacated the district court's summary judgment on North Cypress's state contract law claims, in which the district court had determined that Cigna's interpretation was legally correct. In vacating that holding, the panel characterized it as "filtered through state contract law and based on a much smaller universe of claims" than would be a final decision on the ERISA claims. 781 F.3d at 196–97.

North Cypress contends that here, unlike in *Kennedy*, North Cypress left patients legally responsible for co-payments. True or not, that contention is irrelevant for present purposes. *Humble* relied on *Kennedy*, not to determine whether patients actually were responsible for co-payments, but rather to determine whether Cigna reasonably required that patients be legally responsible for co-payments. *Humble*, 878 F.3d at 484–85. As North Cypress admits, the relevant interpretation in this case is the same as the interpretation in *Humble*. *Kennedy* was reasonably invoked in *Humble* in determining whether Cigna's interpretation was an abuse of discretion, and it is reasonably applicable here.

North Cypress counters that, even if *Kennedy* applies to this case, Cigna did not rely on *Kennedy*. Indeed, a series of "facts here not present in *Humble*"[10] constitute Cigna's alleged conflicts of interest and lack of good faith. As previously explained, however, they are immaterial.

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[10] North Cypress alleges that (1) Cigna mobilized a team to pressure North Cypress to join its provider network, (2) this team invented an approach that involved making reduced payment, if any, to North Cypress and convincing plan sponsors to reduce reimbursement of North Cypress, (3) Cigna created the Protocol "exclusively for North Cypress, not relying on *Kennedy*," (4) Cigna repeatedly stated a goal to force North Cypress to the negotiating table to enter an in-network contract, (5) North Cypress reversed its Prompt Pay Discount and billed thousands of patients the full amount of their out-of-network responsibility after the patients failed to pay timely, (6) North Cypress did not commit fraud or provide "kickbacks," and (7) "Cigna used North Cypress as a pretext to plan sponsors for payments based on billed charges from 2007-12 to make millions in additional 'contingency fees.'"

Finally, North Cypress does not adequately brief a challenge to the existence of substantial evidence supporting Cigna's decisions.[11] Even if a plan interpretation is not an abuse of discretion, particular benefit decisions must be supported by substantial evidence. *Humble,* 878 F.3d at 485. With this failure, no grounds remain on which to find that Cigna abused its discretion. North Cypress's ERISA § 502 claims fail.

IV. Remaining Issues

North Cypress also raised the alleged "futility" of exhausting Cigna's appeal process for denied claims, but this process claim is moot because the administrator's decisions were no abuses of discretion. North Cypress's other process argument on appeal—against summary

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[11] In this case, the district court ruled that substantial evidence supported Cigna's conclusion. North Cypress, in its initial brief, notes as a fact in its "Statement of the Case," that "only the original 27 'modest' surveys were Cigna's foundation to adjudicate 9,921 North Cypress claims as 'fee-forgiving' on a patient responsibility of $100." Also, North Cypress (erroneously) faults the district court for failing to consider whether Cigna had substantial evidence for its decision, and, in the course of arguing about the district court's damages rulings, it notes that the district court's ruling "rel[ied] on . . . the erroneous finding of 'substantial evidence' to support Cigna's actions." At no point in its initial brief, however, does North Cypress provide an argument against the district court's finding of substantial evidence.

An argument not included in a statement of issues nor addressed in the body of the brief must be deemed waived. *United States v. Thames*, 214 F.3d 608, 612 (5th Cir. 2000). North Cypress could not undo this waiver by raising the issue in its reply brief. *Depree v. Saunders*, 588 F.3d 282, 290 (5th Cir. 2009) ("This court will not consider a claim raised for the first time in a reply brief."). Thus, North Cypress waived the issue of whether Cigna had substantial evidence for its decision, and the district court's finding of substantial evidence stands undisputed.

dismissal of its ERISA § 503 claims for the absence of a "full and fair hearing" of benefit appeals—fails to establish any error of law or genuine dispute of material fact marring the district court's summary judgment. North Cypress additionally persists in asserting some right to receive damages and attorney's fees. Zero damages is, however, the only appropriate measure for zero substantive success in proving the hospital's case. As for attorney's fees, the fact that North Cypress achieved temporary but fleeting success in reversing the district court's initial legal conclusions is necessary but not sufficient for an award where its claims were later totally rejected after trial. *See Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 255, 130 S. Ct. 2149, 2158 (2010).

CONCLUSION

For the foregoing reasons, the district court's judgment is **AFFIRMED**.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CIVIL ACTION NO. 4:09-CV-2556

NORTH CYPRESS MEDICAL CENTER
OPERATING CO., LTD., et al.,
Plaintiffs,

v.

CIGNA HEALTHCARE, et al.,
Defendants.

Filed: September 28, 2016

MEMORANDUM AND ORDER

Before KEITH P. ELLISON, United States District Judge.

Pending before the Court are the parties' Motions for Summary Judgment (Doc. Nos. 443, 447, and 489). After considering the Motions, the responses thereto, and all applicable law, the Court determines that each Motion should be granted in part and denied in part.

I. BACKGROUND

This case arises out of a dispute over the obligation of an insurer (Defendants, hereinafter "Cigna") to pay a hospital (Plaintiffs, hereinafter "North Cypress") for

medical services provided to insured patients. The facts of the case are familiar to the parties and need not be recited here in full. The central issue remaining in the case is Cigna's interpretation of plan language stating that "payment for the following is specifically excluded: . . . charges for which you [patients] are not obligated to pay or for which you are not billed." *N. Cypress Med. Ctr. Operating Co., Ltd. v. Cigna Healthcare*, 781 F.3d 182, 187 (5th Cir. 2015). Cigna interpreted this language to mean that patients had no insurance coverage for medical procedures for which the patient was not billed. *Id.* at 189. Accordingly, Cigna implemented a Fee-Forgiving Protocol under which it drastically reduced its payment of claims to North Cypress (typically paying $0 or $100) where Cigna believed that North Cypress had waived or reduced patient contribution. *Id.* Remaining in the case are North Cypress's claims under the Employee Retirement Income Security Act ("ERISA") and for breach of contract.

This Court granted summary judgment to Cigna on North Cypress's ERISA and breach of contract claims. (Doc. Nos. 318, 326, 331). On March 10, 2015, the Fifth Circuit vacated the grants of summary judgment with regard to those claims and remanded for further proceedings. *N. Cypress*, 781 F.3d 182. North Cypress and Cigna each subsequently filed Motions for Summary Judgment. (Doc. Nos. 443, 447).

On June 1, 2016, the United States District Court for the Southern District of Texas issued a ruling in a separate case to which Cigna is a party, *Connecticut General Life Insurance Co., et al. v. Humble Surgical Hosp., LLC*, C.A. No. 4:13-cv-3291, 2016 WL 3077405 (S.D. Tex.

Jun. 1, 2016) (hereinafter "*Humble*"). North Cypress argues in a second Motion for Summary Judgment that the *Humble* decision binds this case under the doctrines of *res judicata* and collateral estoppel. (Doc. No. 489.)

At issue in the pending Motions for Summary Judgment are: (1) the preclusive effect, if any of the *Humble* decision; (2) North Cypress's claims under ERISA §§ 502(a)(1)(B), 502(a)(3), 503, and 502(c)(1)(B); and (3) Cigna's affirmative defense of recoupment. *N. Cypress*, 781 F.3d at 195; Doc. Nos. 489, 492, 496, 501.

II. LEGAL STANDARDS

A. Summary Judgment

Summary judgment is proper when there is no genuine dispute as to any material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a). A genuine issue of material fact exists if a reasonable jury could enter a verdict for the non-moving party. *Crawford v. Formosa Plastics Corp.*, 234 F.3d 899, 902 (5th Cir. 2000). The court can consider any evidence in "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any." *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). The Court must view all evidence in the light most favorable to the non-moving party and draw all reasonable inferences in that party's favor. *Crawford*, 234 F.3d at 902.

The party moving for summary judgment bears the burden of demonstrating the absence of a genuine dispute of material fact. *Kee v. City of Rowlett*, 247 F.3d 206, 210 (5th Cir. 2001). If the moving party meets this burden, the non-moving party must go beyond the pleadings to find specific facts showing that a genuine issue of material fact exists for trial. *Little v. Liquid Air Corp.*, 37

F.3d 1069, 1075 (5th Cir. 1994). Summary judgment is appropriate if a party "fails to make a showing sufficient to establish the existence of an element essential to that party's case." *Celotex*, 477 U.S. at 322.

B. *Res judicata* and collateral estoppel

"Claim preclusion, or *res judicata*, bars the litigation of claims that either have been litigated or should have been raised in an earlier suit." *Matter of Swate*, 99 F.3d 1282, 1286 (5th Cir. 1996) (citing *Super Van Inc. v. San Antonio*, 92 F.3d 366, 370 (5th Cir. 1996)). *Res judicata* applies where: "(1) The parties are identical or in privity; (2) the judgment in the prior action was rendered by a court of competent jurisdiction; (3) the prior action was concluded to a final judgment on the merits; and (4) the same claim or cause of action was involved in both actions." *Id.* at 1286.

Collateral estoppel, or issue preclusion, prevents a party from litigating an issue already raised in an earlier action if: (1) the issue at stake is identical to the one involved in the earlier action; (2) the issue was actually litigated in the prior action; and (3) the determination of the issue in the prior action was a necessary part of the judgment in that action. *Petro–Hunt, L.L.C. v. United States,* 365 F.3d 385, 397 (5th Cir. 2004) (footnotes omitted) (citation omitted). Issue preclusion may apply even if the claims and the subject matter of the suits differ. *Next Level Commc'ns LP v. DSC Commc'ns Corp.*, 179 F.3d 244, 250 (5th Cir. 1999) (citation omitted). In addition, "[u]nlike claim preclusion, the doctrine of issue preclusion may not always require complete identity of the parties." *Id.* (citation omitted) (internal quotation marks omitted). But "[w]hile complete identity of all parties is not required, the party against whom the collateral estoppel

would be applied generally must either have been a party, or privy to a party, in the prior litigation." *Vines v. Univ. of La. at Monroe,* 398 F.3d 700, 705 (5th Cir. 2005) (citing *Terrell v. DeConna,* 877 F.2d 1267, 1270 (5th Cir. 1989)).

III. ANALYSIS

A. North Cypress's ERISA § 502(a)(1)(B) claim

i. Legal standard

A benefits plan participant may bring a civil action under ERISA § 502(a)(1)(B) "to recover benefits due him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the plan." 29 U.S.C. § 1132(a)(1)(B). Healthcare providers may bring ERISA suits standing in the shoes of their patients. *N. Cypress*, 781 F.3d at 191. In this case, the Fifth Circuit found that the patients assigned their rights under their insurance contracts to North Cypress, and that North Cypress has standing under ERISA to enforce the contracts. *Id.* at 191-95.

Where a benefits plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or construe the terms of the plan, the administrator's interpretation of the plan is reviewed under an abuse of discretion standard. *Anderson v. Cytec Indus.*, 619 F.3d 505, 512 (5th Cir. 2010). First, the court asks whether the interpretation is "legally correct." *Id.* The most important factor at this stage is whether the contested interpretation is consistent with a fair reading of the plan. *Gosselink v. Am. Tel. & Tel.*, 272 F.3d 722, 727 (5th Cir. 2001). Because ERISA requires that plan descriptions be written in a manner calculated to be understood by the average plan participant, the court must as-

sess whether the administrator's interpretation is consistent with the plan language in its "ordinary and popular sense." 29 U.S.C. § 1022(a); *Stone v. UNOCAL Termination Allowance Plan*, 570 F.3d 252, 260 (5th Cir. 2009). Additional factors in determining whether an administrator's interpretation is legally correct include whether the administrator has given the plan a uniform construction and whether there are any unanticipated costs resulting from different interpretations of the plan. *Crowell*, 541 F.3d at 312.

If the determination was not legally correct, the court proceeds to the second question: whether the interpretation was an abuse of discretion. *Id.* Factors at this stage include, but are not limited to: whether the plan administrator had a conflict of interest, the internal consistency of the plan, the factual background of the determination, and any inferences of lack of good faith. *N. Cypress*, 781 F.3d at 196.

If the determination was legally correct or within Cigna's discretion, the final inquiry is whether the decision to deny benefits was supported by substantial evidence. *Id.* Substantial evidence is "more than a scintilla, less than a preponderance, and [ ] such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Ellis v. Liberty Life Assurance Co. of Boston*, 394 F.3d 262, 273 (5th Cir. 2004).

ERISA claimants are required to exhaust administrative remedies prior to filing a lawsuit. *Denton v. First Nat'l Bank of Waco*, 765 F.2d 1295, 1301 (5th Cir. 1985); *see also Hall v. Nat'l Gypsum Co.*, 105 F.3d 225, 231 (5th Cir. 1997) (the exhaustion requirement "is not one specifically required by ERISA, but has been uniformly imposed by the courts in keeping with Congress's intent in

enacting ERISA"). The exhaustion requirement operates as an affirmative defense rather than a jurisdictional bar. *Crowell v. Shell Oil Co.*, 541 F.3d 295, 308 (5th Cir. 2008). "Exhaustion is to be excused only in the most exceptional circumstances." *Davis v. AIG Life Ins. Co.*, No. 95-60664, 1996 WL 255215, at *2 (5th Cir. Apr. 26, 1996) (citing *Commc'ns Workers of Am. v. AT&T*, 40 F.3d 426, 433 (D.C. Cir. 1994)). A claimant is excused from demonstrating exhaustion if she can show that pursuit of administrative remedies would have been futile. *Bourgeois v. Pension Plan for Employees of Santa Fe Int'l Corps.*, 215 F.3d 475, 479 (5th Cir. 2000). To qualify for the futility exception to the exhaustion requirement, the claimant must show a "*certainty* of an adverse decision." *Id.* (citing *Commc'ns Workers of Am.*, 40 F.3d at 433) (emphasis in original). The claimant is also required to show hostility or bias on the part of the administrative review committee. *McGowin v. ManPower Int'l, Inc.*, 363 F.3d 556, 559 (5th Cir. 2004). In addition to the futility exception, exhaustion is also excused when a plan administrator fails to establish or follow claims procedures consistent with the requirements of ERISA. 29 C.F.R. § 2560.503-1(l). In that case, the claimant is deemed to have exhausted administrative remedies and is entitled to pursue any available remedies under ERISA § 502(a). *Id.*

ii. Effect on *Humble* on North Cypress's § 502(a)(1)(B) claim

The *Humble* decision arises out of the same plan language and interpretation that are at issue here. In each case, the service provider waived or reduced the patient contribution for particular medical services while still billing Cigna for Cigna's portion. Cigna then refused to pay all or part of its obligation to the service provider,

based on Cigna's interpretation of the exclusionary language in its plans. Under Cigna's interpretation, if the member/patient was not obligated to pay all or part of the patient contribution for a particular medical service, then that service was not covered. *Humble*, 2016 WL 3077405, at *6. Therefore, according to Cigna, Cigna was not obligated to make a full payment to the service provider if the service provider waived or reduced the patient contribution. *Id.* In the *Humble* litigation, Cigna sued Humble to recover alleged overpayments for services rendered to members/patients. *Id.* at *1. Humble asserted counterclaims against Cigna for, *inter alia*, nonpayment and underpayment of claims in violation of ERISA § 502(a)(1)(B). *Id.* at *2.

In the first stage of its ERISA analysis, the Court found that Cigna's interpretation of the exclusionary plan language was legally incorrect. *Id.* at *17-18. That is, the average plan participant would not interpret the plan language to mean that Cigna was relieved of its obligation to pay based on a waived or reduced patient contribution. *Id.* In the second stage of the ERISA analysis, the Court found that Cigna abused its discretion by "obstinately denying Humble's claims for benefits in spite of the medical services provided." *Id.* at *17. The Court highlighted the fact that Cigna "admittedly has never used the exclusionary language to reject covered services before and was relentless in engaging in an arbitrary manner with regard to Humble and its claims." *Id.* at *18. The issue presented in Plaintiffs' Motion for Summary Judgment (Doc. No. 489) is whether the decision in *Humble* has preclusive effect in this case.

Res judicata, or claim preclusion, applies only where the parties are identical or in privity. *Matter of Swate*, 99

F.3d at 1286. Although Cigna is a party to both cases at issue here, the remaining parties, North Cypress and Humble, are not identical. Therefore, *res judicata* applies only if the two hospitals are in privity. North Cypress argues that they are in privity because they have identical interests, pointing to various factual similarities between Cigna's treatment of North Cypress and Humble. (Doc. No. 496 at 23-24.) However, this argument mischaracterizes the requirements for privity. As a general matter, privity exists in the following circumstances: (1) a nonparty who has succeeded to a party's interest in property is bound by any prior judgments against that party, (2) a nonparty who controlled the original suit will be bound by the resulting judgment, and (3) a nonparty whose interests were represented adequately by a party in the original suit. *Freeman v. Lester Coggins Trucking, Inc.*, 771 F.2d 860, 864 (5th Cir. 1985). The first two circumstances clearly do not apply to this case. With regard to adequate representation, it is not enough for the parties to have parallel interests. *Id.* Rather, virtual representation "demands the existence of an express or implied legal relationship in which parties to the first suit are accountable to nonparties who file a subsequent suit raising identical issues." *Pollard v. Cockrell*, 578 F.2d 1002, 1008 (5th Cir. 1978). Because North Cypress and Humble have no such express or implied legal relationship, they are not in privity. Therefore, *res judicata* does not apply.

Unlike *res judicata*, collateral estoppel does not require complete identity of the parties. *Next Level Comm'cns LP v. DSC Commc'ns Corp.*, 179 F.3d 244, 250 (5th Cir. 1999). Therefore, collateral estoppel may apply to certain issues in this case even though North Cypress and Humble are not in privity. North Cypress argues that

the holding in *Humble* has preclusive effect with regard to both steps of the ERISA § 502(a)(1)(B) analysis: whether Cigna's interpretation was legally correct and whether it was an abuse of discretion.

Collateral estoppel applies to the issue of whether Cigna's plan interpretation was legally correct. The issue was actually litigated in *Humble*, and the determination of the issue was a necessary part of the judgment on Humble's ERISA § 502(a)(1)(B) counterclaims. *Humble*, 2016 WL 3077405, at *17-18. Moreover, the issue in this case is identical to the issue in Humble. The exclusionary language in the cases was identical, and in both cases, Cigna interpreted the language to mean that if a patient had no obligation to pay, Cigna was also excused from paying. The legal correctness analysis is based on whether the contested interpretation is consistent with how the average plan participant would interpret the language. *Stone v. UNOCAL Termination Allowance Plan*, 570 F.3d 252, 260 (5th Cir. 2009). Therefore, the only relevant facts are the language of the plan and Cigna's interpretation. The factual differences that Cigna raises to challenge collateral estoppel—billing and disclosure practices, time periods, suspected billing policies, evidence, responses from each hospital, and the lack of overlap in individual claims—are irrelevant to the issue of whether Cigna's interpretation of the plan was legally correct. *See* Doc. No. 492 at 4-5. Because the *Humble* decision has preclusive effect on the issue of legal correctness, this Court holds that Cigna's interpretation of the plan language was legally incorrect.[1]

[1] The Court is not persuaded by Cigna's argument that prior inconsistent judgments make collateral estoppel inappropriate in this case.

Collateral estoppel does not, however, apply to the issue of abuse of discretion. Compared to the analysis of legal correctness, abuse of discretion is more fact-specific, taking into account factors such as conflict of interest, internal consistency of the plan, the factual background of the determination, and any inferences of lack of good faith. *See N. Cypress*, 781 F.3d at 196. The holdings in *Humble* on abuse of discretion thus turn on facts specific to the relationship between the parties in that case. Therefore, despite many factual similarities between the two cases, the *issue*—whether Cigna abused its discretion in its interpretation of the plan—is not precisely the same. Because the issues in the cases are merely analogous, not identical, collateral estoppel does not apply. *See NLRB v. W.L. Rives Co.*, 328 F.2d 464, 468 n.5 (5th Cir. 1964).

iii. Abuse of discretion under ERISA § 502(a)(1)(B)

In order to determine whether Cigna abused its discretion in interpreting its plan language, the Court must evaluate whether Cigna had a conflict of interest, the internal consistency of the plan, the factual background of the determination, and any inferences of lack of good faith. *See N. Cypress*, 781 F.3d at 196. After considering these factors, the Court finds that Cigna abused its discretion.

See Doc. No. 492 at 6-9. The *Humble* decision addresses precisely the issue in this case: the legal correctness of Cigna's interpretation of the same exclusionary plan language. By contrast, the cases Cigna has cited, all of which come from other circuits, concern analogous factual scenarios rather than the same issue.

Although Cigna did not directly fund most of the plans at issue,[2] North Cypress claims that there was a conflict of interest because Cigna collected contingency fees when it reduced payments to North Cypress. (Doc. No. 443 at 7-10.) As part of its various cost containment programs, Cigna collects a [redacted text] contingency fee of any savings Cigna provides to plan sponsors.[3] *Id.* If Cigna collected contingency fees for North Cypress claims subject to the Fee-Forgiving Protocol (which targeted North Cypress's practice of reducing patient contribution for particular services), then there was a conflict of interest. *See Humble*, 2016 WL 3077405, at *16 (finding a conflict of interest where "Cigna evaluates the claim for benefits, pays benefits and reimburses itself, based on what it 'saved' the plan sponsors"); *see also Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 112 (2008) (finding that a conflict of interest exists where "a plan administrator both evaluates claims for benefits and pays benefits claims").

Cigna does not dispute that it collected contingency fees for North Cypress claims under its cost containment programs. What is in dispute is whether Cigna collected contingency fees for the particular North Cypress claims at issue in this case, those subject to the Fee-Forgiving Protocol. Cigna representative Wendy Sherry testified in a Rule 30(b)(6) deposition on November 10, 2015 that

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[2] The majority of the claims at issue are part of "Administrative Services Only" (ASO) plans. *N. Cypress*, 781 F.3d at 187. ASOs are funded by plan sponsors (typically employers), with Cigna acting only as the plan administrator. *Id.*

[3] Cigna generates Savings by routing claims to third-party vendors. (Doc. No. 461 at 14 n.8.) If the vendor can resolve the claim with the provider for less than what the plan would have paid, then the plan pays fees to the vendor and Cigna. *Id.*

Cigna has discretion about whether to apply cost containment programs to particular claims. (Doc. No. 444-4 at 27-28.) She further testified that fees collected from North Cypress accounts went to Cigna's bottom line. *Id.* at 29. North Cypress alleges that Cigna earned [redacted text] contingency fees from North Cypress claims in the relevant time period, citing a "Summary Spreadsheet" from Cigna. (Doc. No. 443 at 7.)[4] Cigna, however, asserts that these contingency fees came from claims that were not subject to the Fee-Forgiving Protocol and therefore are not at issue in this case. (Doc. No. 461 at 5.) Cigna states that in fact it took active steps to reduce potential bias by removing North Cypress claims from its cost containment programs wherever possible. *See* Doc. No. 461 at 14-15; Doc. No. 447 at 24; *see also Hagen v. Aetna Ins. Co.*, 808 F.3d 1022, 1027 (5th Cir. 2015) (conflicts of interest are less important "where the administrator has taken active steps to reduce potential bias and promote accuracy") (citing *Glenn*, 554 U.S. at 116-17). Finally, Cigna cites Ms. Sherry's 2011 Rule 30(b)(6) deposition testimony, in which Ms. Sherry states that Cigna did not receive any part of the reductions or savings that resulted from the Protocol. (Doc. No. 447-1 at 7.) Given the ambiguity in the record as to whether Cigna collected a [redacted text] contingency fee on North Cypress claims subject to the Fee-Forgiving Protocol, the evidence on

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[4] North Cypress also purports to cite the Rule 30(b)(6) deposition of Wendy Sherry as an admission that some of Cigna's Savings resulted from claims under the Fee-Forgiving Protocol which targeted North Cypress. (Doc. No. 443 at 7, Doc. No. 466 at 13.) However, the document cited is the deposition of Mary Ellen Cisar, a different Cigna representative. Moreover, Ms. Cisar makes no such admission; her testimony is only that Cigna is capable of calculating the percent of savings attributable to North Cypress. (Doc. No. 271-2 at 43.)

conflict of interest is not conclusive. Because there is a genuine fact dispute regarding conflict of interest, the Court disregards this factor for purposes of summary judgment.

In analyzing the internal consistency factor, the Court must determine whether Cigna's interpretation of the plan language conflicts with any other part of the plan. *See Hollis v. Lubrizol Corp. Long Term Disability Plan*, Civil Action No. 4:06-cv-3691, 2008 WL 7950030, at *5 (S.D. Tex. Feb. 14, 2008). North Cypress has not presented any evidence that it does. Instead, North Cypress argues that the plan language does not specifically authorize or require Cigna's interpretation. (Doc. No. 443 at 14-15, Doc. No. 466 at 11-12, Doc. No. 457 at 29-30.) The lack of specific authorizing language, however, does not make the plan language inconsistent. Second, North Cypress argues that Cigna interpreted the plan language inconsistently across customers. (Doc. No. 457 at 29.) This argument, however, does not go to *internal* inconsistency, that is, conflict between Cigna's interpretation of the plan and the plan language. Finally, North Cypress argues that Cigna's interpretation is inconsistent with the following plan language: "the provider *may* bill you for the difference between the provider's normal charge and the maximum reimbursable charge, in addition to applicable deductibles, co-payments and co-insurance." (Doc. No. 466 at 11.) According to this argument, Cigna's interpretation converts the "may" language to "shall" language. *Id.* In other words, whereas the plan language seems to allow latitude for the provider to charge some amount in patient contribution or not, the interpretation *requires* the provider to charge it. This argument, however, extrapolates too much from the plan language;

there is no clear inconsistency between the two statements. Because North Cypress fails to produce evidence of internal inconsistency, this factor weighs in Cigna's favor.

The next factor is the factual background of the determination and any inference of lack of good faith. Cigna claims that it acted in good faith to try to curtail North Cypress's fee-forgiving practices, relying on *Kennedy v. Connecticut General Life Ins. Co.*, 924 F.2d 698 (7th Cir. 1991). (Doc. Nos. 461 at 12-13, 473 at 8-9). In *Kennedy*, Judge Easterbrook highlighted the benefits of requiring patients to pay for part of their medical care, even when insured: "Co-payments sensitize employees to the cost of health care, leading them not only to use less but also to seek out providers with lower fees. The combination of less use and lower charges . . . makes medical insurance less expensive and enables employers to furnish broader coverage (or to pay higher wages coupled with the same level of coverage)." 924 F.2d at 699. Accordingly, the Seventh Circuit found that Cigna was entitled to withhold payment where a healthcare provider had intentionally collected its entire fee from Cigna by waiving patient contribution. *Id.*

However, there is a great deal of evidence that Cigna's primary motivation was not to root out fee forgiveness, but instead to pressure North Cypress into negotiating an in-network contract. Prior to North Cypress's 2007 opening, North Cypress and Cigna negotiated for an in-network contract but were unsuccessful. *N. Cypress*, 781 F.3d at 188. On October 24, 2007, a director of client management at Cigna expressed a great deal of interest upon learning that North Cypress had terminated its contract with another insurance company:

"Very interesting. So they won't have a contract with anybody. They must be fat and happy—for now." (Doc. No. 267-4 at 11.) By July 2008, Cigna had developed an action plan for northwest Houston that specifically targeted North Cypress Medical Center. (Doc. Nos. 267-6 at 17, 267-7 at 2.) That plan included the Fee-Forgiving Protocol. *Id.* Cigna's medical director Dr. James Nadler wrote in an email about the Fee-Forgiving Protocol, "Recommended reduction in payment ASAP. Goal is to bring hospital to the table." *Id.* The file attached to Dr. Nadler's email states that the goal of the action plan is to "bring the desirable providers into the network at market rates." (Doc. No. 267-6 at 33.) A week later, Dr. Nadler wrote in another email, "[W]e should be implementing [the Fee-Forgiving Protocol] surgically on facilities with aggressive fee forgiving practices with hopes that we'll drive a contract discussion or stop the behavior." (Doc. No. 267-7 at 10.) In an August 6, 2008 email, in response to a question about reasons North Cypress may have to negotiate an in-network contract, another Cigna employee wrote, "our non-payment will hit them hardest." (Doc. No. 270-1 at 3.) By November 12, 2008, Cigna saw signs that its plan was working. Albert Ramirez wrote to Dr. Nadler and others, "FYI—Perhaps the SIU fee-forgiving letter has already had an impact. [Another Cigna employee] tells me the hospital CEO has already sent word (through CIGNA account management for CyFair ISD) of negotiating a possible Cigna contract." *Id.* at 78-79. Cigna employees contemplated delaying the negotiation of the contract because they were "enjoying" North Cypress's response. *Id.* at 109. Subsequent emails by Cigna employees reinforce the idea that Cigna's goal was to pressure North Cypress to negotiate an in-network

contract. *See Id.* at 85, Doc. No. 270-2 at 91. These statements from Cigna employees suggest that Cigna's true motivation for the Fee-Forgiving Protocol was to negotiate an in-network contract, not to prevent harmful externalities in the insurance market. Cigna's arguments in response—that it paid North Cypress's claims for two years prior to the Fee-Forgiving Protocol and that North Cypress did not always deal in good faith—do not overcome that showing. Therefore, this factor weighs heavily in favor of North Cypress, since there are strong inferences that Cigna did not act in good faith.

Based on the evidence on the record, the Court finds that Cigna abused its discretion. Although there is no undisputed evidence of a conflict of interest or a lack of internal consistency, there is strong evidence in the record that Cigna acted in bad faith. Cigna claims to have been concerned about eradicating fee forgiveness, relying on a Seventh Circuit decision from 1991. In fact, the evidence suggests that Cigna deliberately targeted North Cypress with its Fee-Forgiving Protocol in order to pressure it to negotiate an in-network contract. Given the strong evidence of bad faith, the Court finds that Cigna abused its discretion in violation of ERISA § 502(a)(1)(B). As a result, there is no need to reach the question of whether Cigna's actions were based on substantial evidence.

iv. Exhaustion of administrative remedies[5]

In order to pursue a claim under ERISA § 502(a)(1)(B), a plaintiff must either exhaust administrative remedies or show that pursuit of administrative remedies would have been futile. North Cypress does not dispute that it failed to exhaust administrative remedies for the vast majority of the benefit claims at issue prior to filing this suit. Instead, North Cypress argues that any attempt to pursue administrative remedies would have been futile.

North Cypress's futility argument fails because North Cypress cannot show a "*certainty* of an adverse decision" on appeal. *Bourgeois v. Pension Plan for Employees of Santa Fe Int'l Corps.*, 215 F.3d 475, 479 (5th Cir. 2000) (citing *Commc'ns Workers of Am.*, 40 F.3d at 433) (emphasis in original). In fact, of the 24 appeals presented in the cross-motions for summary judgment, three were *completely reversed* on appeal. (Doc. Nos. 278-1, 462-9, 462-10.) That is, although Cigna initially paid North Cypress only the sum calculated under the Fee-

[5] The administrative exhaustion issue is not precluded by the decision in *Humble*. In that case, the court deemed the hospital's claims exhausted because of Cigna's failure to follow claims procedures, citing 29 C.F.R. § 2560.503-1(1). *Humble*, 2016 WL 3077405, at *2 n.1. The court did not elaborate on the particular acts or omissions of Cigna that triggered the application of § 2560.503-1(1). But regardless of what the court meant by Cigna's failure to follow claims procedures, collateral estoppel does not apply because the application of § 2560.503-1(1) is a fact-specific inquiry. The fact that Cigna failed to follow claims procedures with regard to Humble Surgical Hospital does not automatically mean that Cigna failed to follow claims procedures with regard to North Cypress Medical Center. Therefore, even if Cigna's behavior in this case is very similar to its behavior in the *Humble* case, collateral estoppel is not appropriate.

Forgiving Protocol, on appeal, Cigna paid the full requested amount. Three more benefit claims were partially reversed on appeal. (Doc. Nos. 462-11; 278-1 at 12-13, 71-73.) North Cypress argues that the sweeping nature of the Fee-Forgiving Protocol made reversal on appeal unlikely. But no matter how unlikely administrative relief appeared ex ante, the record shows that Cigna was willing to grant it in some cases. As such, despite the considerable evidence of Cigna's hostility and bias toward North Cypress, North Cypress cannot show that appeal would have been futile. Therefore, summary judgment is granted to Cigna for all claims for which North Cypress did not exhaust administrative remedies.

v. Lack of proper assignment

North Cypress is unable to produce written assignments of benefits for some number of its benefits claims.[6] North Cypress alleges that the written assignments for those claims were "misplaced or lost." (Doc. No. 443-12.) In lieu of written assignment forms, North Cypress attempts to prove assignment via the affidavit of Glenda Tankersley, the Business Office Director at North Cypress. *Id.* Ms. Tankersley alleges that each person who receives goods and services at North Cypress must sign

[6] The parties disagree about the exact number of claims lacking a proper assignment. Cigna asserts that 191 claims fall into this category. (Doc. No. 473 at 14.) North Cypress asserts that only 184 claims do. (Doc. No. 466 at 19-20.) The seven in dispute were obtained and scanned into North Cypress's Meditech System but could not be retrieved. *Id.* North Cypress has provided screenshots from the Meditech System evidencing those assignments. *Id.*

a Consent and Assignment, which is reflected on the electronic UB-04 claims form that North Cypress generates. *Id.*

North Cypress argues that Cigna has waived this issue because Cigna failed to raise lack of proper assignment in its denial of claims forms. North Cypress cites only New York state law in support of this proposition, and the Court does not know of any Fifth Circuit law holding the same. Therefore, the Court finds that Cigna has not waived the issue of lack of proper assignment.

Because North Cypress's ERISA standing is based on the assignment of benefits, it is crucial that North Cypress prove assignment for each claim. However, Cigna cannot point to any Fifth Circuit law stating that individual written assignments are the only acceptable proof. Courts in other circuits have found affidavits or other evidence besides written assignment forms sufficient to prove assignment in certain circumstances. *See Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1351 (11th Cir. 2009) (affidavit was sufficient evidence of assignment under a preponderance of the evidence standard); *Am. Medical Ass'n v. United HealthCare Corp.*, No. 00 Civ. 2800 (LMM), 2007 WL 1771498, at *17 (S.D.N.Y. Jun. 18, 2007).

The Court also rejects Cigna's claim that North Cypress has provided no evidence with regard to assignment. On a summary judgment motion, an arguably self-serving affidavit such as Ms. Tankerley's suffices to create a fact issue when it is based on personal knowledge and sets forth facts that would be admissible in evidence. *Dallas/Fort Worth Int'l Airport Bd. v. INet Airport Sys., Inc.*, 819 F.3d 245, 253 n.14 (5th Cir. 2016); *C.R. Pittman*

Constr. Co., Inc. v. Nat'l Fire Ins. Co. of Hartford, 453 F. App'x 439, 443 (5th Cir. 2011).

As such, this issue boils down to a genuine dispute of material fact: whether or not the patients in the claims at issue actually assigned their benefits to North Cypress. North Cypress has put forth evidence that they did, and Cigna disputes the sufficiency of that evidence. Because this fact is in dispute, summary judgment for either side on this issue would be inappropriate and is therefore denied.

vi. MRC-2 claims

There is also a genuine dispute of material fact regarding Cigna's liability for MRC-2[7] claims. The parties do not dispute that the Fee-Forgiving Protocol was applied to MRC-1 claims, which are paid based on North Cypress's billed charges for particular medical services. *See* Doc. No. 443 at viii. By contrast, MRC-2 claims are paid based on a percentage of Medicare charges. *Id.* Cigna asserts that the Fee-Forgiving Protocol was never applied to MRC-2 claims. Two Cigna representatives testified to that effect in Rule 30(b)(6) depositions, and Cigna has provided a Special Investigations Provider Flag Request Form regarding the Protocol with the instructions "Once you have determined the claim is not MRC2 . . ." (Doc. Nos. 447-1 at 79:11-13, 448-12, 448-13 at 32:4-6, 181:17-182:2.) However, North Cypress contends that for some number of MRC-2 claims, Cigna's explanation of benefits letter cites the exclusionary plan language in justifying the amount paid. (Doc. No. 443-12 at 1 (Affidavit

[7] MRC stands for "Maximum Reimbursable Charge." Doc. No. 447 at viii.

of Glenda Tankersley, North Cypress's Business Office Director.)) As with the question of proper assignment, there is a fact dispute here that cannot be resolved at the summary judgment stage. North Cypress and Cigna have different accounts of how MRC-2 claims were paid, and they have produced conflicting evidence. Therefore, neither party can be awarded summary judgment on this issue.

vii. Emergency room claims

North Cypress also asserts damages for emergency room ("E.R.") claims subjected to the Fee-Forgiving Protocol. In its Motion for Summary Judgment, North Cypress inaccurately states that Cigna "claimed that it did not apply the Protocol to [North Cypress's] E.R. claims." (Doc. No. 443 at 26.) In fact, in its opposition brief, Cigna does not deny that the Fee-Forgiving Protocol applied to some E.R. claims. (Doc. No. 461 at 18-19.) Instead, Cigna argues that it had reason to believe that North Cypress was engaging in Fee-Forgiving on E.R. claims. *Id.* Therefore, there is no dispute on this issue, and Cigna is liable (to the extent described *supra*) for violations of ERISA § 502(a)(1)(B) regarding E.R. claims.

viii. Calculating damages

North Cypress, through the report of its Business Office Director Glenda Tankersley, has proposed four possible methods to calculate damages for its § 502(a)(1)(B) claim. (Doc. No. 443 at 28-29.) In response, Cigna cites the report of its expert, Dr. Sean May. (Doc. No. 461 at 25-26.) According to Dr. May, Ms. Tankersley's report contains fundamental flaws. *Id.* Dr. May therefore comes to a different conclusion about the maximum amount of damages available. *Id.* Because the experts disagree, and

in light of this Court's rulings on the § 502(a)(1)(B) claim *supra*, the Court declines to grant summary judgment on the issue of calculation of damages.

The other arguments regarding § 502(a)(1)(B) damages can be dispensed with quickly. Cigna argues that North Cypress may not recover damages for claims that were denied or reduced for reasons unrelated to fee-forgiving (for example, because the service was not medically necessary). (Doc. No. 447 at 30.) North Cypress does not contest this argument, stating that "claims that were denied for other than Protocol reasons . . . were not included in [North Cypress's] damage calculations." (Doc. No. 457 at 31.) Cigna also argues that North Cypress may not recover damages for claims for which there is no evidence of underpayment, noting that Ms. Tankersley included several claims in her report with $0 listed in damages. (Doc. No. 447 at 30.) North Cypress has clarified that it is not seeking damages for claims with $0 in damages, so there is no dispute on this issue. (Doc. No. 457 at 31.)

B. North Cypress's ERISA § 502(a)(3) claim

In addition to its ERISA § 502(a)(1)(B) claim, North Cypress also brings a claim of breach of fiduciary duty under § 502(a)(3). Section 502(a)(3) allows a participant, beneficiary, or fiduciary to "obtain other appropriate equitable relief . . . to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a).

A plaintiff may not seek a remedy under § 502(a)(3) that is available under § 502(a)(1)(B). *See, e.g., Musmeci v. Schwegmann Giant Super Mkts.*, 332 F.3d 339, 349 n. 5 (5th Cir. 2003) ("Because we have found a remedy is available at law under Section 502(a)(1)(B), the Plaintiffs are

foreclosed from equitable relief under Section 502(a)(3).") (citing *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002)); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1335 (5th Cir. 1992) ("When a beneficiary simply wants what was supposed to have been distributed under the plan, the appropriate remedy is 502(a)(1)(B)."); *Tolson v. Avondale Indus., Inc.*,141 F.3d 604, 610 (5th Cir. 1998) ("Because Tolson has adequate redress for disavowed claims through his right to bring suit pursuant to Section 1132(a)(1), he has no claim for breach of fiduciary duty under section 1132(a)(3)."). North Cypress's claim clearly falls under § 502(a)(1)(B), as an action "to recover benefits due to [it] under the terms of his plan, to enforce [its] rights under the terms of the plan, or to clarify [its] rights to future benefits under the terms of the plan." North Cypress may not seek identical relief via an allegation of breach of fiduciary duty under § 502(a)(3). Cigna is thus entitled to summary judgment on North Cypress's § 502(a)(3) claim.

C. North Cypress's ERISA § 503 claim

North Cypress further alleges that Cigna violated ERISA § 503 by denying North Cypress a full and fair review of the claims at issue. Section 503 requires an employee benefit plan administrator to:

> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and

> fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133. In order to satisfy § 503, a claim administrator must provide review of the specific ground for an adverse decision. *Robinson v. Aetna Life Ins. Co.*, 443 F.3d 254, 257 (5th Cir. 2005). The standard for a § 503 claim is substantial compliance. *Lacy v. Fulbright & Jaworski*, 405 F.3d 254, 257 (5th Cir. 2005). "Technical noncompliance with ERISA procedures will be excused so long as . . . the beneficiary [receives] an explanation of the denial of benefits that is adequate to ensure meaningful review of that denial." *Sanborn-Alder v. Cigna Group Ins.*, 771 F. Supp. 2d 713, 719 (S.D. Tex. 2011).

North Cypress does not allege any facts suggesting that Cigna failed to provide a full and fair review of the claims at issue. North Cypress points to evidence that Cigna automatically referred North Cypress claims to its Special Investigations Unit (SIU) and that Cigna treated North Cypress claims systematically by subjecting them to the Fee-Forgiving Protocol. Both of these allegations, though, refer to Cigna's *initial* processing of the claims, not to the subsequent review mandated by § 503. In fact, the record shows that Cigna provided clear notice about the specific reason for the denial of claims under the Protocol. In each of the denial letters reviewed by the Court, Cigna cited its concerns about fee-forgiving and quoted the exclusionary plan language. *See* Doc. Nos. 278-1, 462-9, 462-10, 462-11. Moreover, Cigna maintained an administrative review process that resulted in at least a handful of claims being partially or completely reversed. *See supra* § III(A)(iv). As such, the Court finds that summary judgment should be awarded to Cigna on North Cypress's § 503 claim.

D. North Cypress's ERISA § 502(c)(1)(B) claim

North Cypress also alleges that Cigna violated ERISA by refusing to provide requested plan documents. ERISA § 1024(b) requires plan administrators to make plan documents available to participants and beneficiaries upon request. 29 U.S.C. § 1024(b). Refusal to comply within 30 days subjects a plan administrator to liability of up to $100 per day under § 502(c)(1)(B). 29 U.S.C. § 1132(c)(1)(B). North Cypress alleges that it made numerous requests for information from Cigna for documentation of claims procedures and that Cigna repeatedly failed to provide the requested information.

North Cypress is neither a plan participant nor a beneficiary and therefore is not automatically entitled to review plan documents under § 1024(b). *See Koenig v. Aetna Life Ins. Co.*, Civil Action No. 4:13-CV-00359, 2015 WL 6473351, at *5 (S.D. Tex. Oct. 27, 2015) (citing *Hermann Hosp. v. MEBA Med. & Benefits Plan,* 959 F.2d 569, 576 (5th Cir. 1992), *overruled in part by Access Mediquip, L.L.C. v. UnitedHealthcare Ins. Co.,* 698 F.3d 229, 230 (5th Cir. 2012)). Although North Cypress as an assignee has the right to enforce the contracts between plan participants and Cigna, "[t]he assignment of a right to payment, without more, does not automatically convert North Cypress into a 'beneficiary' for purposes of . . . § 502(c)." *Id.* The record shows that, in those cases where North Cypress presented written authorization from plan participants, Cigna provided the requested plan documents. *See* Doc. Nos. 268-50, 279-4. Because North Cypress was not automatically entitled to review the plan documents by virtue of the assignment of benefits, Cigna had no further obligation to North Cypress under ERISA

§ 1024(b). Therefore, Cigna is entitled to summary judgment on North Cypress's § 502(c)(1)(B) claim.[8]

E. Repricing agreements

Prior to the implementation of the Fee-Forgiving Protocol in 2008, North Cypress and Cigna entered into repricing agreements for hundreds of North Cypress's claims. (Doc. No. 443 at 29.) Once the Protocol was implemented, Cigna refused to honor 337 of those agreements, forming the basis of North Cypress's breach of contract claim. *Id.* Cigna argues that ERISA preempts any claim for breach of contract.[9]

ERISA's preemption clause states that the statute "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Subject to the preemption clause, "if an individual, at some point in time, could have brought his claim under ERISA 502(a)(1)(B), and where there is no

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[8] Cigna also argues that it cannot be liable under § 502(c) because it is not the designated plan administrator. Because North Cypress is not a participant or beneficiary for purposes of § 502(c), the Court does not reach this issue.

[9] This Court previously addressed the issue of preemption in its August 10, 2012 Memorandum and Order. (Doc. No. 331.) At that time, the Court found that North Cypress lacked standing to pursue its ERISA claims. *Id.* Because North Cypress could not pursue remedies under ERISA, the Court found that the breach of contract claim was not preempted. *Id.* The Fifth Circuit reversed this Court's ruling on the ERISA standing issue, thereby "remov[ing] the foundation of the district court's preemption ruling." *N. Cypress Med. Ctr. Operating Co., Ltd. v. Cigna Healthcare*, 781 F.3d 182, 198 (5th Cir. 2015). The Fifth Circuit remanded to this Court the issue of whether ERISA preempts North Cypress's breach of contract claim in light of the Fifth Circuit's ruling on ERISA standing. *Id.* at 197-98.

other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely preempted." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). This provision is "intended to ensure that employee benefit plan regulation would be 'exclusively a federal concern.' " *Id.* at 208. The Supreme Court has commented that ERISA's preemption provision is "deliberately expansive" and "conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987).

As the Fifth Circuit noted, the repricing agreements at issue here "by their terms are subject to the underlying ERISA plans." *N. Cypress*, 781 F.3d at 197. Therefore, the Court finds that North Cypress's breach of contract claim is preempted by ERISA. To the extent that North Cypress seeks relief for the repricing agreements under ERISA § 502(a)(1)(B),[10] damages may be available subject to the Court's findings *supra.*

F. Cigna's affirmative defense of recoupment

Cigna has alleged that, by waiving patient contributions for medical services, North Cypress artificially inflated the cost of the service in the claims submitted to Cigna. (Doc. No. 293 ¶¶ 25-37.) As such, Cigna brought counterclaims under ERISA § 502(a)(3) to recover alleged overpayments to North Cypress prior to the implementation of the Fee-Forgiving Protocol. *Id.* ¶ 49. Alternatively, Cigna sought "a declaration that it may offset from future claim payments to [North Cypress] the amount of these overpayments." *Id.* This Court dismissed

[10] *See* Doc. No. 447 at 29-30 ("there is no need to determine if [North Cypress's] breach of contract claims are pre-empted. . . . These are still ERISA claims").

Cigna's ERISA claims as time-barred, and the Fifth Circuit affirmed. *N. Cypress*, 781 F.3d at 206. In affirming the dismissal of Cigna's ERISA counterclaims, the Fifth Circuit distinguished between a counterclaim and the affirmative defense of recoupment: "[a]s a purely defensive procedure, [recoupment] is available to defendant so long as plaintiff's claim survives—even though an affirmative action by defendant is barred by limitations." *N. Cypress*, 781 F.3d at 206 (citing *Distribution Servs., Ltd. v. Eddie Parker Interests, Inc.*, 897 F.2d 811, 812-13 (5th Cir. 1990)).

Cigna now argues that its claim to recover alleged overpayments should be considered as an affirmative defense—recoupment—to North Cypress's ERISA claims rather than as a counterclaim. (Doc. No. 461 at 27.) Cigna acknowledges that it did not expressly plead recoupment as an affirmative defense, but it argues that it is within this Court's discretion to treat the pleadings as if Cigna had done so. *Id.*

Federal Rule of Civil Procedure 8(c)(1) states that a party "must affirmatively state any avoidance or affirmative defense" in its pleadings. A defendant must plead with "enough specificity or factual particularity to give the plaintiff 'fair notice' of the defense that is being advanced." *Rogers v. McDorman*, 521 F.3d 381, 385-86 (5th Cir. 2008) (quoting *Woodfield v. Bowman*, 193 F.3d 354, 362 (5th Cir. 1999)). Failure to timely plead an affirmative defense may result in waiver and the exclusion of the defense from the case. *Morris v. Homco Int'l, Inc.*, 853 F.2d 337, 342-43 (5th Cir. 1988). A court may, however, treat an affirmative defense as though it were expressly raised in the pleadings if it has been "tried by the parties' express or implied consent." *Steadfast Ins. Co. v. SMX 98,*

Inc., No. Civ.A. H-06-2736, 2008 WL 62199, at *17 (S.D. Tex. Jan. 3, 2008).

The parties here have not expressly or impliedly consented to try Cigna's affirmative defense to recoupment. In *Steadfast*, the case Cigna cites in support of its recoupment defense, the parties had "already thoroughly addressed in cross motions for summary judgment" the affirmative defense at issue. *Id.* By contrast, here North Cypress has stated that it "squarely objects to Cigna's effort to revive a pleading that has long since been dismissed." (Doc. No. 466 at 29 n.14.) Because the parties have not consented to treat Cigna's overpayment allegations as an affirmative defense to North Cypress's ERISA claims, the Court declines to exercise its discretion to consider them as such. Cigna has thus waived the affirmative defense of recoupment by failing to plead it.

G. North Cypress's claim for attorneys' fees

North Cypress has requested attorneys' fees under ERISA's fee-shifting provision, 29 U.S.C. § 1132(g)(1). Because the Court finds that fact questions remain on the issues of lack of proper assignment, the application of the Fee-Forgiving Protocol to MRC-2 claims, and the proper calculation of damages, an award of attorneys' fees would be premature at this stage.

IV. CONCLUSION

For the reasons set forth above, the Court finds that North Cypress's Motions for Summary Judgment (Doc. Nos. 443, 489) are **GRANTED IN PART**. Cigna's Motion for Summary Judgment (Doc. No. 447) is **GRANTED IN PART**.

IT IS SO ORDERED.

SIGNED at Houston, Texas on this the 28th day of September, 2016.

s/ *Keith P. Ellison*
HON. KEITH P. ELLISON
UNITED STATES DISTRICT JUDGE

APPENDIX C

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CIVIL ACTION NO. 4:09-CV-2556

NORTH CYPRESS MEDICAL CENTER
OPERATING CO., LTD., et al.,
Plaintiffs,

v.

CIGNA HEALTHCARE, et al.,
Defendants.

Filed: February 6, 2017

MEMORANDUM AND ORDER

Before KEITH P. ELLISON, United States District Judge.

Pending before the Court are the parties' Motions for Reconsideration of the Court's September 28, 2016 Order (Doc. Nos. 525 and 531). After considering the Motions, the responses thereto, and all applicable law, the Court determines that both Motions should be denied.

I. BACKGROUND

This case arises out of a dispute over the obligation of an insurer (Defendants, hereinafter "Cigna") to pay a hospital (Plaintiffs, hereinafter "North Cypress") for

medical services provided to insured patients. The facts of the case are familiar to the parties and need not be recited here in full. The central issue in the case is Cigna's interpretation of plan language stating that "payment for the following is specifically excluded: . . . charges for which you [patients] are not obligated to pay or for which you are not billed." *N. Cypress Med. Ctr. Operating Co., Ltd. v. Cigna Healthcare*, 781 F.3d 182, 187 (5th Cir. 2015). Cigna interpreted this language to mean that patients had no insurance coverage for medical procedures for which the patient was not billed. *Id.* at 189. Accordingly, Cigna implemented a Fee–Forgiving Protocol under which it drastically reduced its payment of claims to North Cypress (typically paying $0 or $100) where Cigna believed that North Cypress had waived or reduced patient contribution. *Id.* North Cypress brought claims against Cigna under the Employee Retirement Income Security Act ("ERISA") and for breach of contract.

In its September 28, 2016 Order, the Court granted summary judgment on various issues in the case. (Doc. No. 529.) North Cypress and Cigna have both moved for reconsideration of the Court's September 28, 2016 order. (Doc. Nos. 525 and 531.)

II. LEGAL STANDARD

Rule 54(b) allows a court to revise an interlocutory order any time prior to the entry of judgment adjudicating all the claims and all the parties' rights and liabilities. The Federal Rules of Civil Procedure do not, however, specifically provide for motions for reconsideration. *See Shepherd v. Int'l Paper Co.*, 372 F.3d 326, 328 n. 1 (5th Cir. 2004). Motions for reconsideration from interlocutory orders are generally governed by the standards for Rule

59(e) motions. *Hamilton Plaintiffs v. Williams Plaintiffs*, 147 F.3d 367, 371 n. 10 (5th Cir. 1998); *Thakkar v. Balasuriya*, No. H–09–0841, 2009 WL 2996727, at *1 (S.D. Tex. Sept. 9, 2009).[1]

A motion under Rule 59(e) must "clearly establish either a manifest error of law or fact or must present newly discovered evidence." *Ross v. Marshall*, 426 F.3d 745, 763 (5th Cir. 2005) (citing *Simon v. United States*, 891 F.2d 1154, 1159 (5th Cir. 1990)). Relief is also appropriate where there has been an intervening change in the controlling law. *See Schiller v. Physicians Resource Group Inc.*, 342 F.3d 563, 567 (5th Cir. 2003). Motions under Rule 59(e) "cannot be used to raise arguments which could, and should, have been made before the judgment issued." *Id.* In considering a motion for reconsideration, a court "must strike the proper balance between two competing imperatives: (1) finality, and (2) the need to render just decisions on the basis of all the facts." *Edward H. Bohlin Co. v. Banning Co.*, 6 F.3d 350, 355 (5th Cir. 1993). While a district court has "considerable discretion" to grant or deny a motion under Rule 59(e), *id.*, the Fifth Circuit cautions that reconsideration under Rule 59(e) is an extraordinary remedy that courts should use sparingly. *Templet v. HydroChem Inc.,* 367 F.3d 473, 479 (5th Cir. 2004); *see also In re Goff*, No. 13–41148, 2014 WL

[1] North Cypress emphasizes that Rule 54(b) allows a court to reverse a prior ruling on an interlocutory order "for any reason it deems sufficient." *United States v. Renda,* 709 F.3d 472, 479 (5th Cir. 2013) (internal quotation marks and citation omitted). However, the Fifth Circuit has endorsed the use of the Rule 59(e) motion standard on motions for reconsideration. *Hamilton Plaintiffs v. Williams Plaintiffs*, 147 F.3d 367, 371 n. 10 (5th Cir. 1998); *Thakkar v. Balasuriya*, No. H–09–0841, 2009 WL 2996727, at *1 (S.D. Tex. Sept. 9, 2009).

4160444, *4 (5th Cir. 2014) ("A motion for reconsideration should only be granted in extraordinary circumstances").

III. ANALYSIS

A. North Cypress's ERISA § 502(a)(1)(B) claim

The Court found in its September 28, 2016 Memorandum and Order that Cigna had violated ERISA § 502(a)(1)(B), but that North Cypress could not recover for any claims for which North Cypress failed to exhaust administrative remedies. Both North Cypress and Cigna challenge aspects of the Court's ruling on § 502(a)(1)(B).

1. Abuse of discretion

A claim for benefits under ERISA § 502(a)(1)(B) proceeds in stages. First, the court asks whether the plan administrator's interpretation is "legally correct." *Anderson v. Cytec Indus.*, 619 F.3d 505, 512 (5th Cir. 2010). If it is not, the court proceeds to the second question: whether the interpretation was an abuse of discretion. *Id.* Factors at this stage include, but are not limited to: whether the plan administrator had a conflict of interest, the internal consistency of the plan, the factual background of the determination, and any inferences of lack of good faith. *N. Cypress*, 781 F.3d at 196.

In its September 28, 2016 Memorandum and Order, this Court determined that Cigna's interpretation of the plan was not legally correct. (Doc. No. 529 at 9.) The Court therefore proceeded to the question of abuse of discretion. The Court found that the evidence regarding conflict of interest was inconclusive, and that the evidence regarding internal consistency of the plan weighed in Cigna's favor. *Id.* at 10–12. However, the Court ultimately found that Cigna had abused its discretion based

on the factual background of the determination and any inferences of lack of good faith. *Id.* at 12–15. In particular, the Court found that, although Cigna claimed it was trying to curtail North Cypress's fee-forgiving practices in order to prevent harmful externalities in the insurance market, in fact Cigna's goal was to pressure North Cypress into negotiating an in-network contract. *Id.* The Court cited various statements to that effect made in Cigna's internal emails and presentations. *Id.*

North Cypress challenges the Court's findings with regard to conflict of interest and internal consistency of the plan. These findings, however, ultimately had no bearing on the outcome. Conflict of interest and internal consistency are merely factors in the Court's inquiry regarding abuse of discretion. Because North Cypress prevailed on the ultimate factor—factual background of the determination and any inferences of lack of good faith—it prevailed on the overall question of abuse of discretion. There is therefore no reason for the Court to revisit its findings on the other factors, since the outcome (a finding that Cigna abused its discretion) would remain unchanged. For the same reason, the Court declines to revisit its finding that collateral estoppel does not apply to the issue of abuse of discretion. The Court concluded that Cigna abused its discretion based on the facts of *this* case. The application of collateral estoppel would not change that outcome.

Cigna, meanwhile, challenges the Court's ruling on factual background of the determination and any inferences of lack of good faith. Cigna makes two primary arguments. First, Cigna argues that the statements cited by the Court should be discounted because they were

made by individuals outside Cigna's Special Investigations Unit (SIU). Cigna argues that SIU was responsible for investigating North Cypress's fee-forgiving practices, developing the Fee–Forgiving Protocol, and reviewing North Cypress's appeals. The evidence that Cigna cites, however, does not bear this out. Cigna's evidence establishes that SIU played a role in investigating North Cypress's fee-forgiving practices and notes that "SIU [gave] specific processing instructions for each claim." *See* Doc. Nos. 448–6, 462–12 at 3. This evidence does not establish that SIU had exclusive control over the development and implementation of the Fee–Forgiving Protocol. As such, the Court is not persuaded that the strong statements made by Cigna employees and cited in the September 28, 2016 Memorandum and Order should be disregarded in assessing bad faith on the part of Cigna.

Second, Cigna urges the Court to consider evidence that Cigna had other motivations for implementing the Fee–Forgiving Protocol besides pressuring North Cypress into a contract negotiation. These include curtailing fee-forgiving behavior and saving money for struggling plan sponsors. *See, e.g.*, Doc. Nos. 267–7 (urging implementation of the Fee–Forgiving Protocol "with hopes that we'll drive a contract discussion *or stop the behavior*" (emphasis added)), 270–1 at 85 (expressing concern about the fiscal challenges facing plan sponsor Cy Fair Independent School District). According to Cigna, this evidence shows at least a genuine dispute about Cigna's motivation for implementing the Fee–Forgiving Protocol. However, Cigna offers nothing to dispute the strong evidence showing that the Fee–Forgiving Protocol was designed to pressure North Cypress back to the negotiating table. As such, Cigna's evidence merely suggests *mixed*

motivations. The fact that Cigna had other, legitimate motivations does not change the Court's finding that Cigna acted in bad faith by attempting to drive contract negotiations through a program ostensibly aimed at curtailing fee-forgiving.

2. Failure to exhaust administrative remedies

North Cypress also moves for reconsideration of the Court's summary judgment ruling on all claims for which North Cypress failed to exhaust administrative remedies. North Cypress maintains that it was not required to exhaust administrative remedies, since pursuing administrative remedies would have been futile. To qualify for the futility exception to the exhaustion requirement, the claimant must show a "*certainty* of an adverse decision." *Bourgeois v. Pension Plan for Employees of Santa Fe Int'l Corps.*, 215 F.3d 475, 479 (5th Cir. 2000) (citing *Commc'ns Workers of Am.*, 40 F.3d at 433) (emphasis in original). The claimant is also required to show hostility or bias on the part of the administrative review committee. *McGowin v. ManPower Int'l, Inc.*, 363 F.3d 556, 559 (5th Cir. 2004).

In its Motion for Reconsideration, North Cypress highlights the evidence in the record of Cigna's policy of denying North Cypress's claims. In particular, North Cypress urges the Court to consider a November 10, 2008 letter from Cigna's John W. Matheny and North Cypress's response dated November 14, 2008. (Doc. No. 525 at 3–4.) The Court maintains, however, that the reversal of six out of 24 claim appeals in the record defeats any claim by North Cypress of a "*certainty* of an adverse decision," *see Bourgeois*, 215 F.3d at 479, regardless of any communications between the parties ex ante about how

claims would be handled. North Cypress put forth ample evidence of hostility and bias, both of which are relevant to the issue of futility. However, North Cypress cannot overcome the evidence that six out of the 24 appeals reviewed by the Court resulted in favorable decisions for North Cypress. In light of that evidence, no degree of hostility or bias can establish a *certainty* of adverse decision on appeal. And though North Cypress characterizes *Bourgeois* as a "unique" opinion, *Bourgeois*'s certainty standard remains binding Fifth Circuit law.

In an attempt to minimize the significance of the six favorable administrative appeals decisions in the record, North Cypress argues that the decisions on these claims resulted from external pressure. Specifically, North Cypress contends that the only reason that four of the six claims were reversed in the administrative process was because individual plan participants complained to the Texas Department of Insurance (TDI). (Doc. No. 525 at 15.) North Cypress argues that these reversals therefore resulted, not from a fair evaluation on Cigna's part, but rather from Cigna's desire to avoid scrutiny by a state regulatory agency. *Id.* This argument fails for several reasons. First, North Cypress did not raise this argument in its Motions for Summary Judgment and therefore may not raise it now. *See Schiller v. Physicians Resource Group Inc.*, 342 F.3d 563, 567 (5th Cir. 2003) (motions under Rule 59(e) "cannot be used to raise arguments which could, and should, have been made before the judgment issued"). Second, North Cypress does not provide any explanation for the partial reversal of two of the claims. *See* Doc. No. 278–1 at 12–13, 71–73. This suggests that, at least in some circumstances, favorable decisions on appeal could be obtained without any outside regulatory

pressure. Third, even if the Court were to accept North Cypress's allegation that TDI scrutiny motivated the reversals, the Court is not persuaded that the *motivation* for a favorable decision on appeal factors into the certainty standard. After all, the administrative exhaustion requirement exists in part to provide a non-adversarial method of claim settlement. *See Diaz v. United Agric. Emp. Welfare Benefit Plan & Trust*, 50 F.3d 1478, 1483 (9th Cir. 1995). To that end, it does not matter *why* an administrator reverses a claim on appeal; administrative exhaustion does its work to the extent that it keeps some claims out of the courts. Therefore, since the reason for a favorable decision does not speak to the certainty of an adverse decision on appeal, North Cypress's allegations about the TDI complaints are irrelevant to the question of futility.

The cases that North Cypress discusses—*Bourgeois*; *Commc'ns Workers of Am.* (the D.C. Circuit case that the Fifth Circuit cited for the certainty standard in *Bourgeois*); and *Arapahoe Surgery Center, LLC v. Cigna Healthcare, Inc.*, 171 F. Supp. 3d 1092 (D. Colo. 2016)—do not support applying the futility exception to the facts of this case. Notwithstanding the fact that two of these cases come from outside the Fifth Circuit, all are inapposite because none involved successful administrative appeals on behalf of some claimants. Moreover, even if it were applicable to this case, *Arapahoe*'s language confirms that certainty is required for the futility exception: "plaintiff must establish that it is *certain* that his claim will be denied on appeal, not merely that he doubts that an appeal will result in a different decision." 171 F. Supp. 3d at 1110 (internal quotes omitted) (emphasis added).

Next, North Cypress argues that, in order to establish certainty, it would have had to appeal all 10,000 claims at issue. (Doc. No. 525 at 7.) This argument misunderstands the certainty standard. The purpose of the futility exception is to allow claimants to proceed despite failure to pursue administrative appeals, by showing that an appeal would have served no purpose. Here North Cypress simply cannot show that.

North Cypress further argues that it was not required to exhaust administrative remedies because of Cigna's alleged failure to produce plan documents. North Cypress cites no binding authority suggesting that Cigna's alleged failure to produce plan documents has any effect on the administrative exhaustion requirement. In any event, the Court is not persuaded that Cigna refused to provide plan documents as required by ERISA § 1024(b). *See* Doc. No. 529 at 22–23.

The Court rejects three additional arguments on the basis that North Cypress failed to raise them in its Motions for Summary Judgment: (1) that Cigna failed to meet its obligations under 29 C.F.R. § 2560.503–1(g), as a result of which North Cypress should be deemed to have exhausted administrative remedies,[2] (2) that any claims

[2] The only reference to § 2560.503–1 in North Cypress's motions for summary judgment appears in the context of North Cypress's argument concerning *Connecticut General Life Insurance Co., et al. v. Humble Surgical Hosp., LLC*, C.A. No. 4:13–cv–3291, 2016 WL 3077405 (S.D. Tex. Jun. 1, 2016) (hereinafter "*Humble*"). In that case, the court deemed the hospital's claims exhausted because of Cigna's failure to follow claims procedures, citing 29 C.F.R. § 2560.503–1(1). *Humble*, 2016 WL 3077405, at *2 n.1. In its September 28, 2016 Mem-

filed after August 11, 2009 (the date on which North Cypress filed suit) are not subject to the administrative exhaustion requirement, and (3) that Cigna's present litigation is contrary to the position Cigna would have taken in an administrative appeal. *See Schiller*, 342 F.3d at 567.

Finally, North Cypress repeats (almost word for word) the argument from its Motion for Summary Judgment that the ruling on administrative exhaustion in *Connecticut General Life Insurance Co., et al. v. Humble Surgical Hosp., LLC*, C.A. No. 4:13–cv–3291, 2016 WL 3077405 (S.D. Tex. Jun. 1, 2016) (hereinafter "*Humble*") should be applied to this case. *See* Doc. No. 489 at 9. The Court rejected this argument in its September 28, 2016 Order, and North Cypress has provided no reason for the Court to reconsider its decision.

B. North Cypress's ERISA § 503 claim

ERISA § 503 requires an employee benefit plan administrator to:

> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

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orandum and Order, this Court held that *Humble* did not have preclusive effect on the issue of administrative exhaustion. (Doc. No. 529 at 15 n.5.)

29 U.S.C. § 1133. In order to satisfy § 503, a claim administrator must provide review of the specific ground for an adverse decision. *Robinson v. Aetna Life Ins. Co.*, 443 F.3d 254, 257 (5th Cir. 2005). The standard for a § 503 claim is substantial compliance. *Lacy v. Fulbright & Jaworski*, 405 F.3d 254, 257 (5th Cir. 2005). "Technical noncompliance with ERISA procedures will be excused so long as…the beneficiary [receives] an explanation of the denial of benefits that is adequate to ensure meaningful review of that denial." *Sanborn–Alder v. Cigna Group Ins.*, 771 F. Supp. 2d 713, 719 (S.D. Tex. 2011).

This Court denied North Cypress's § 503 claim on summary judgment. (Doc. No. 529 at 20–22.) The Court noted that the only evidence North Cypress had produced referred to Cigna's *initial* processing of the claims, not to the subsequent review mandated by § 503. *Id.* The Court further noted that, in each of the denial letters reviewed by the Court, Cigna cited its concerns about fee-forgiving and quoted the exclusionary plan language. *See* Doc. Nos. 278-1, 462-9, 462-10, 462-11.

North Cypress now presents evidence suggesting that Cigna tracked appeals of North Cypress claim denials and instructed appeals committee members to affirm the original denials pursuant to the protocol. (Doc. Nos. 526–3, 526–4, 526–14.) This evidence does not warrant a reversal of the Court's grant of summary judgment. Motions under Rule 59(e) "cannot be used to raise arguments which could, and should, have been made before the judgment issued." *See Schiller v. Physicians Resource Group Inc.*, 342 F.3d 563, 567 (5th Cir. 2003). North Cypress does not claim that its evidence is newly discovered, and its earlier arguments regarding the § 503

claim were based on initial denials rather than subsequent review.

North Cypress also argues that a ruling against Cigna on the § 502(a)(1)(B) claim is fundamentally inconsistent with a ruling that Cigna provided full and fair review as required by § 503. The Court disagrees. Once again, the Court points to the distinction between the decisions made at the initial claims processing stage and those made during administrative review. The evidence shows that Cigna provided notice in its denial letters of the reasons for denial, reviewed claims that were administratively appealed, and in some cases, reversed denials on appeal. The Court maintains that, in doing so, Cigna substantially complied with § 503. *See Lacy v. Fulbright & Jaworski*, 405 F.3d 254, 257 (5th Cir. 2005).

C. North Cypress's ERISA § 502(c)(1)(B) claim

This Court granted summary judgment to Cigna on North Cypress's ERISA § 502(c)(1)(B) claim. ERISA § 1024(b) requires plan administrators to make plan documents available to participants and beneficiaries upon request. 29 U.S.C. § 1024(b). Refusal to comply within 30 days subjects a plan administrator to liability of up to $100 per day under § 502(c)(1)(B). 29 U.S.C. § 1132(c)(1)(B). North Cypress alleged that it made numerous requests for information from Cigna for documentation of claims procedures and that Cigna repeatedly failed to provide the requested information. The Court found, however, that North Cypress was not entitled to review plan documents under § 1024(b) because it was neither a plan participant nor a beneficiary. *See Koenig v. Aetna Life Ins. Co.*, Civil Action No. 4:13–CV–00359, 2015 WL 6473351, at *5 (S.D. Tex. Oct. 27, 2015) (citing *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 959 F.2d 569, 576

(5th Cir. 1992), *overruled in part by Access Mediquip, L.L.C. v. UnitedHealthcare Ins. Co.,* 698 F.3d 229, 230 (5th Cir. 2012)).

North Cypress's challenge to the Court's ruling is twofold. First, North Cypress repeats its argument that its status as an assignee of benefits made it a beneficiary for purposes of § 502(c). The Court explained in the September 28, 2016 Memorandum and Order why this is not the case, and North Cypress has not provided any reason to reconsider this ruling. Second, North Cypress notes that the Court did not address the argument that Cigna was the *de facto* plan administrator. It was not necessary to reach this question, however. Regardless of whether Cigna was required to make plan documents available to plan participants and beneficiaries due to its status as a *de facto* plan administrator, Cigna was not required to make those documents available *to North Cypress*, for the reasons explained in the September 28, 2016 Memorandum and Order.

D. North Cypress's claim for attorneys' fees

Finally, North Cypress challenges the Court's denial of attorneys' fees. North Cypress notes that, under ERISA, a court "*in its discretion* may allow a reasonable attorneys' fee and costs of action to either party so long as the party has achieved some degree of success on the merits." *LifeCare Mgmt. Servs. LLC v. Ins. Mgmt. Adm'rs Inc.*, 703 F.3d 835, 846 (5th Cir. 2013) (emphasis added) (internal quotations omitted). For the reasons explained in the September 28, 2016 Memorandum and Order, the Court declines to exercise its discretion to award attorneys' fees at this stage.

IV. CONCLUSION

For the reasons set forth above, the Court finds that the parties' Motions for Reconsideration of the Court's September 28, 2016 Order (Doc. Nos. 525 and 531) are **DENIED**.

IT IS SO ORDERED.

SIGNED at Houston, Texas on this the 6th day of February, 2017.

s/ *Keith P. Ellison*
HON. KEITH P. ELLISON
UNITED STATES DISTRICT JUDGE

APPENDIX D

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CIVIL ACTION NO. 4:09-CV-2556

NORTH CYPRESS MEDICAL CENTER
OPERATING CO., LTD., et al.,
Plaintiffs,

v.

CIGNA HEALTHCARE, et al.,
Defendants.

Filed: August 7, 2018

FINDINGS OF FACT & CONCLUSIONS OF LAW

Before KEITH P. ELLISON, United States District Judge.

The Court submits the following Findings of Fact and Conclusions of Law pursuant to Rule 52(a)(1) of the Federal Rules of Civil Procedure.

I. BACKGROUND

This case centers on the intricacies of healthcare insurance. Before the Court are the procedures by which hospitals can bill patients and submit claims to an insurance company, and, in turn, how that insurance company pays for patients' care.

Plaintiffs North Cypress Medical Center Operating Co., Ltd. and North Cypress Medical Center Operating Company, GP, LLC (collectively "NCMC") filed suit against Defendants Cigna Healthcare and Connecticut General Life Insurance Company (collectively "Cigna") on August 11, 2009, seeking relief under state law and the Employee Retirement Income Security Act ("ERISA"). (Doc. No. 1.)

This Court initially made dispositive rulings several years ago, which both parties appealed. The Fifth Circuit affirmed in part and reversed in part. *N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 781 F.3d 182 (5th Cir. 2015) ("*North Cypress I*"). Of importance here, the Fifth Circuit ruled that NCMC had standing to bring ERISA claims as assignee of the patients. The Fifth Circuit "remand[ed] to allow the district court a full opportunity to consider all of North Cypress's claims for underpayment of benefits and its other closely related ERISA claims with a fully developed record." *Id.* at 197.

On remand, the parties developed a more complete record through discovery and filed cross-motions for summary judgment. (Doc. Nos. 443, 447, 489.) Based on the Court's summary judgment ruling, this case was narrowed to NCMC's ERISA § 502(a)(1)(B) claim and, within that claim, to the 575 benefit claims for which NCMC exhausted its administrative remedies.

On October 10, 2017, this Court commenced a bench trial. Over the course of the eight-day trial, the Court received evidence and heard sworn testimony. Having con-

sidered the evidence, testimony, oral arguments presented during the trial, post-trial filings[1], and the applicable law, the Court sets forth the following Findings of Fact and Conclusions of Law. Additionally, the Court rules on two pending motions filed by NCMC.

II. FINDINGS OF FACT

Parties & Insurance Plans

1. North Cypress Medical Center Operating Company, Ltd. owns a hospital and North Cypress Medical Center Operating Company, GP LLC is the general partner for the limited partnership; collectively they are "NCMC," the Plaintiff hospital in this case. (Tr. 1-94:22-95:2 (Behar).)[2]

2. The hospital is a general acute care hospital with an emergency room. (Tr. 1-77:10-15 (Behar).) It opened on January 4, 2007. (Tr. 1-90:14-15 (Behar).)

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[1] The post-trial filings include the parties' post-trial briefs and proposed findings of fact and conclusions of law, as well as later-filed letters and notices to the Court. (Doc. Nos. 662-68, 672-73, 675-79, 681-83, 689.) The post-trial filings note, in particular, three cases that the Fifth Circuit decided after the conclusion of the instant bench trial: *North Cypress Medical Center Operating Company, Ltd. v. Aetna Life Insurance Company*, No. 16-20674, 2018 WL 3635231 (5th Cir. July 31, 2018); *Ariana M. v. Humana Health Plan of Texas, Inc.*, 884 F.3d 246 (5th Cir. 2018) (en banc); *Connecticut General Life Insurance Company v. Humble Surgical Hospital., L.L.C.*, 878 F.3d 478 (5th Cir. 2017).

[2] Citations to the trial transcript are identified as "Tr. X-Y:Z (Witness)," where X indicates the day of trial, Y and Z identify the page and line number, and the name of the witness is in parentheses.

3. Cigna, the Defendant, is a health services company. (Tr. 4-198:15-19 (Sherry).)

4. Cigna administers insurance plans, the majority of which are self-funded. (Tr. 4-198:20-22 (Sherry); *see* Def. Exh. 1.001-1.186 (collectively, the "plans").) A self-funded insurance plan is an "Administrative Services Only" ("ASO") plan for which Cigna administers claims, but an employer, such as a school district, is responsible for paying all of the claims of its employee population. (Tr. 4-199:2-21 (Sherry); *see e.g.*, Def. Exh. 1.035 at CIG-NCMC0582383.)

5. ASOs explicitly delegate to Cigna "the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plans." (*See, e.g.*, Def. Exh. 1.051 ("Aperio Technologies ASO"); *see also* Doc. No. 677 at 15-16 (NCMC stating, in its own Proposed Findings of Fact, "all of the plans provided Cigna with the discretionary authority to interpret the provisions of the plan").)

6. Cigna has set up a network of healthcare providers who agree to give Cigna a discounted rate off of their billed charges and agree to refer patients within the network. (Tr. 4-197:20-198:11 (Sherry); *see also* Def. Exh. 82 at CIG-NCMC0011985.) Cigna's in-network healthcare providers agree to discounted fees in exchange for receiving access to Cigna's pool of plan members. (Tr. 4-202:25-203:6 (Sherry).)

7. The amount a patient pays is called the "[c]oinsurance," and it is defined in the plans as "the percentage of charges for Covered Expenses that an insured person is required to pay under the plan." (*See e.g.*, Def. Exh. 1.035 at CIG-NCMC0582391.)

8. Typically, a patient's coinsurance is lower when the patient goes to an in-network provider. (Tr. 4-203:18-24 (Sherry).) This is both because in-network providers have agreed to discounted fees and because the insurer will pay a larger share of the fee. For example, if a patient receives in-network care, the plan will pay 80 percent of the fee and the patient will pay 20 percent of the fee; whereas, if a patient receives out-of-network care, the plan will pay 60 percent of the maximum reimbursable charge and the patient will pay 40 percent. (Tr. 4-205:13-206:12 (Sherry); *e.g.*, Def. Exh. 1.035 at CIG-NCMC0582394; *see also* Tr. 4-208:14-19 (Sherry) (this scheme "is absolutely standard").)

9. Payments for "charges which [the patient is] not obligated to pay or for which [the patient is] not billed" are "specifically excluded" from the plans. (*See, e.g.*, *id.* at CIG-NCMC0582421.)

10. The Plans define the amounts to be paid as based on the "Maximum Reimbursable Charge." (*See, e.g.*, Def. Exh. 1.035.) Some claims are covered by Maximum Reimbursable Charge 1 ("MRC-1") and others by Maximum Reimbursable Charge 2 ("MRC-2").

11. MRC-1 is defined as "the lesser of: (1) the provider's normal charge for a similar service or supply; or (2) the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received." (*Id.* at CIG-NCMC0582442; Tr. 4-206:19-22 (Sherry); *see also* Pl. Exh. 87 at CIG-NCMC0094360.)

12. Some Plans include a "note" in the MRC-1 section: "The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance." (Pl. Exh. 87 at CIG-NCMC0094360; Def. Exh. 1.026 at CIG-NCMC0156030; *but see* (Def. Exh. 1.035) (does not include the "may bill" language).)

13. MRC-2 is the lesser of the provider's normal charge or a percentage of a Medicare-based fee schedule adopted by the Plan. (Tr. 4-206:24-207:2 (Sherry).)

14. Emergency and urgent care services are an exception to the differing coinsurance rates for in-network and out-of-network care. For emergency care, physicians are not restricted to in-network referrals and the Plans pay the same amount regardless of whether the provider was in-network. (*See, e.g.*, Def. Exh. 1.060 ("CLARCOR Inc. ASO") at CIG-NCMC0618694; Def. Exh. 82 ("Behar-Cigna Contract") at CIG-NCMC0011985.)

Assignments

15. When NCMC admitted patients to the hospital, the patients assigned their benefits to NCMC. The paperwork that patients signed is called, "Consent to Treatment and Release of Medical Information," and it contains a section called, "Assignment of Benefits." (*See, e.g.*, Pl. Exh. 2.) The Assignment of Benefits section explicitly assigned NCMC "the right to collect any and all unpaid insurance benefits, penalties, attorney's fees, court costs, and all other recoverable damages of any nature from the medical insurance company(ies) that provided coverage." (*Id.*) NCMC's policy is that "[e]very patient" gives their consent and assignment. (Tr. 2-127:2-8, 11 (Jones).)

16. NCMC informed Cigna of each patient's assignment of benefits. When NCMC submitted claims forms to Cigna ("UB-04 claims forms"), NCMC wrote "Benefits Assigned" on the form. (*See, e.g.*, Def. Exh. 84.)

NCMC's Prompt Pay Discount for Out-of-Network Patients

17. When NCMC opened in 2007, it was out-of-network with Cigna and all the major insurance carriers. (Tr. 1-252:13-21 (Behar).) NCMC remained out-of-network with Cigna from January 4, 2007 through July 31, 2012, when it entered into an in-network Hospital Services Agreement with Cigna. (Tr. 5-91:9-14 (Tankersley); Def. Exh. 83.)

18. NCMC created a program called the Prompt Pay Discount (or "Access NCMC") to simulate an in-

network experience for patients. (*See* Def. Exh. 31 ("Access NCMC Program Patient Participation Form"); Def. Exh. 33 ("Access NCMC Script"); Tr. 3-42:7-13, 3-45:7-20 (Jones); Tr. 5-110:8-20 (Tankersley).)

19. NCMC could determine Cigna's in-network and out-of-network coinsurance rates by calling Cigna. (Tr. 3-32:20-23 (Jones).)

20. NCMC calculated the amount to bill a patient through the Prompt Pay Discount "by taking 125 percent of the Medicare fee schedule and multiplying it by the patient's in-network coinsurance rate." (Tr. 5-115:25-116:12 (Tankersley).) NCMC documents sometimes refer to this function as the "NCMC Fee Schedule calculator." (Def. Exh. 30 ("NCMC Decision and Business Office Assistance Manual") at NCMC 8 30069; *see also* Def. Exhs. 101-104 (showing those calculations).) NCMC referred to the amount that resulted from that calculation as the "estimated reasonable and customary in-network allowed amount." (Def. Exh. 31 ("Access NCMC Program Patient Participation Form"); Tr. 3-45:7-20 (Jones).). If the patient paid that amount—125 percent of the Medicare rate multiplied by the in-network coinsurance rate—within 120 days, they would not have to pay anything else. (Tr. 3-53:23-55:1 (Jones); *see also* Tr. 5-117:12-118:11 (Tankersley).)

21. The Prompt Pay Discount was offered to any patient with commercial insurance, with the exception of patients who required emergency services.

(Tr. 3-40:3-5 (Jones); Tr. 5-114:22-115:1 (Tankersley).) The Prompt Pay Discount was not offered to patients with Medicare. (Tr. 5-115:8-9 (Tankersley).)

22. Without the Prompt Pay Discount, patients may not have been able to afford care at NCMC. (Tr. 3-52:5-16 (Jones).)

23. At the same time, the Prompt Pay Discount put the hospital in a better negotiating position with insurance companies, and saved the hospital money in fee collection. (Def. Exh. 37 ("Access NCMC Powerpoint") at NCMC26 0069499-501; Tr. 1-84:1-24 (Behar) (noting how much more money NCMC collected from patients than the typical hospital); Tr. 2-190:13-19 (Jones) (same).)

Initial Communications About Billing Practices

24. When NCMC opened, NCMC and Cigna exchanged letters about billing practices. On January 3, 2007, NCMC sent Cigna a letter titled "Notice of Discount" about its "Prompt Pay Discount." (Pl. Exh. 1 ("Notice of Discount Letters") at CIG-NCMC0083279.) NCMC's letter stated, in part:

> Until such time as we can establish a contractual relationship to serve all of your beneficiaries, NCMC will provide "out-of-network" services to your beneficiaries who request such services. Your beneficiaries will be eligible to participate in the NCMC Prompt Payment

> Out-of-Network Discount Policy on patient responsibility amounts for services and items rendered.

(*Id.*) The letter did not disclose how the Prompt Pay Discount was calculated.

25. Over the course of the next two years, NCMC sent a substantially similar Notice of Discount Letter to Cigna over twenty times via certified mail. (Pl. Exh. 1; *see also* Tr. 1-88:12-14 (Behar).)

26. In response to the first Notice of Discount Letter, Cigna replied, in part:

> [Y]our letter would seem to propose a practice known as 'fee-forgiving,' whereby your organization accepts an insurer's payment as payment and waives any obligation of the patient to pay the amounts not covered by insurance or a benefit plan or otherwise agrees to collect only in-network coinsurance and deductibles rather than the deductible or co-insurance requirements applicable to services obtained from a non-participating provider.
>
> . . .
>
> It is [Cigna's] view that "fee-forgiving" on any particular claim, or any portion thereof, could constitute fraud and subject a provider to civil and criminal liability. . .
>
> Generally our health benefit plans exclude from coverage "charges which the Employee or Dependent is not legally required to pay." In other words, only expenses which patients are legally obligated to pay are reimbursable.

> . . .
> . . . [C]laim forms submitted to CIGNA by North Cypress Medical Center should reflect only the amount which North Cypress Medical Center will accept as payment from the patient. Any portion of a charge which is in any way waived or for which a patient is not personally responsible should not be reflected on a claim form . . . For example, if your facility has agreed to only charge a patient the amount of the in-network copayment (for example, $50.00), then only the $50 charge can be submitted as a claim for reimbursement under the benefit plan. Hence, if the patient has an out-of-network benefit, the payment would be $40.
> . . .
> Accordingly, payment for any claims North Cypress Medical Center submits may be delayed or denied until we have assurance that the charges shown on claim forms are your actual charges to the patient and that patients will be required to pay amounts such as out-of-network co-insurance and deductibles.

(Pl. Exh. 3B ("Morris Letter").)

27. NCMC replied to the Morris Letter by denying Cigna's suspicions: "NCMC's prompt pay policy does not waive any portion of NCMC's charges for a service." (Pl. Exh. 37 at CIG-NCMC0011457.) NCMC wrote that Cigna "confuse[s] the amount that NCMC is willing to accept from a patient that promptly pays the *patient portion of charges* with the amount that NCMC is willing to accept for the *entire charge*." (*Id.* (emphasis in original).) The

letter did not explain how much a patient would be charged by NCMC, what portion of the patient charge would be waived, or how NCMC was calculating those amounts. (Tr. 1-239:24-240:9, 241:22-242:19 (Behar).)

NCMC's Chargemaster and Bills to Cigna

28. When NCMC treated patients covered by the Plans, it submitted claims to Cigna for reimbursement of those services using UB-04 claims forms. (Tr. 3-47:11-14 (Sherry).)

29. The fee calculations used for the Prompt Pay Discount were not used to bill Cigna. (Tr. 3-47:21-48:5 (Jones).)

30. Instead, NCMC used its Chargemaster to bill Cigna—and all other insurers to whom it submitted claims.

31. The Chargemaster is a database that NCMC maintains of all of the charges that NCMC could bill for a service. (Tr. 5-39:8:12-13 (Tankersley).) For example, it has separate prices for individual pharmacy items. (Tr. 5-40:1-7 (Tankersley).) Before the hospital opened, a third-party consultant set the charges in the Chargemaster. (Tr. 5-41:18-42:1 (Tankersley).) After the hospital opened, NCMC increased all Chargemaster prices, with the exception of pharmacy and supply prices, by five percent on an annual basis. (Tr. 5:42:2-12 (Tankersley).)

32. NCMC would bill Cigna the sum of the Chargemaster prices for different products and services provided. (Tr. 3:48:3-5 (Jones); Tr. 1-104:14-18 (Behar).) This means that NCMC calculated charges for patients based on an entirely different set of numbers than the charges for Cigna.[3] (*Compare* Def. Exh. 105 ("Chargemaster") *to* Def. Exhs. 101-104 ("NCMC Fee Calculators," each for a different year); *see also* Tr. 5-149:24-150:8 (Tankersley) (testifying that the amounts on the UB-04 claims forms come from the Chargemaster and the amounts used to calculate patient fees under Prompt Pay Discount do not come from the Chargemaster.).

33. NCMC's Chargemaster rates are higher than Medicare rates. (Tr. 6-20:15-21 (May).) NCMC's Chargemaster rates sometimes exceeded 600% or even 1,000% of the analogous Medicare rates. (Tr. 6-20:15-24 (May).) For example, patient CDH received gall bladder surgery at NCMC (Def. Exh. 84.) Patient CDH was charged $823.84. (*Id.* at NCMC37 141599; Tr. 5-139:19-140:3 (Tankerlsey).) That amount was based on 20 percent—an in-network coinsurance rate—of $4,119.24, the amount calculated via the Prompt Pay Discount, where $4,119.24 was 125 percent of Medicare.

[3] Later, when Cigna and NCMC entered into an in-network Hospital Services Agreement on July 31, 2012, the parties agreed to billing based upon NCMC's Chargemaster. (Def. Exh. 83 at 1.3 (defining "Billed Charges"), III(A) (addressing how Chargemaster charges could increase).)

(Def. Exh. 84; Def. Exh. 103 ("NCMC Fee Calculator 2011") at 66; Tr. 5-136:21-24, 140:12-17 (Tankersley).) Patient CDH paid $823.84 within 30 days and was never going to be charged more. (Tr. 5-140:18-25 (Tankersley).) For that same gall bladder surgery of patient CDH, NCMC billed Cigna $30,968.70. (Def. Exh. 84 at NCMC37 141578; Tr. 5-147:17-148:1 (Tankersley).) The amount that formed the basis of the patient's charges came from Medicare and does not appear on the bill to Cigna; the amount that was billed to Cigna came from NCMC's Chargemaster. (Tr. 5-149:24-150:8 (Tankerlsey).) The Chargemaster amount was more than nine times the Medicare amount and more than seven times the 125 percent of Medicare amount that was used to calculate the patient's fee. (*See* Tr. 5-147:21-24, 149:18-23 (Tankersley).) The claim submission to Cigna for patient CDH noted "Prompt Pay Discount" in the "Remarks" section. (Def. Exh. 84 at NCMC37 141578.) NCMC made that remark on all UB-04 claims forms where it applied the Prompt Pay Discount. (Def. Exh. 33; Tr. 5-51:17-21, 156:25-157:9 (Tankersley).)

34. Cigna witnesses testified that they expected the total amount entered on the UB-04 claims forms to be the amount used to calculate the patient's responsibility, as well as Cigna's responsibility. (Tr. 4-90:10-14, 91:10-12, 99:7-20 (Sherry).) Neither the Notice of Discount letters nor the "Prompt Pay Discount" written into the UB-04 claims forms disclosed the use of Medicare or in-network coinsurance rates. (*See* Tr. 5-156:14-18 (Tankersley).)

35. Notes from an NCMC business meeting indicated that the Business Office "is not to disclose prompt pay amounts to insurance carriers should insurance request such" (Def. Exh. 50 at NCMC26 0075813), and, outside of this litigation, NCMC did not disclose the Prompt Pay Discount amounts or method of calculation to plan administrators.

36. From the time that NCMC opened through November 16, 2008, Cigna paid NCMC for claims using the total amount provided on the UB-04 claims forms, from the Chargemaster, to determine the out-of-network coinsurance amounts. In other words, Cigna would pay NCMC approximately 80 percent of the charges that NCMC submitted. (Tr. 4-18:4-24 (Sherry).) Cigna was using the first part of the MRC-1 definition, not the alternative MRC-1 approach that would have compared to other hospitals. (*Id.*)

Cigna's Investigation Into NCMC's Billing Practices & Response

37. For ASOs, Cigna was administering the payment, but the payment was actually the employer's money. At least one ASO plan sponsor complained about increasing out-of-network costs to both Cigna and NCMC. (Tr. 3-192:20-24 (Sherry) (noting that employers like Cypress Fairbanks School District "were losing a lot of money"); Tr. 2-43:3-7 (Behar) ("the Cypress-Fairbanks School District suffered"); Def. Exh. 62 at NCMC8 29893 (noting that 20 percent of the Cypress Fairbanks School District out-of-network claims were being paid to

NCMC, for a total of $1.3 million dollars, and that this rate and amount were not sustainable for Cypress Fairbanks School District).) Cypress Fairbanks School District informed NCMC that, because of the ASO's increase in out-of-network expenses, "much" of which it attributed to NCMC, it would be raising premiums on employees. (Def. Exh. 62 at NCMC8 29896.)

38. High out-of-network expenses generally made Cigna suspicious of fee-forgiving activities. (Pl. Exh. 108 (Ramirez Testimony from March 17, 2011) at 50-53.)

39. Wendy Sherry, President of Payer Solutions at Cigna, testified that, in response to complaints from employers, Cigna "launched an investigation" that involved people from multiple areas of Cigna. (Tr. 3-90:21-91:17, 192:15-193:3 (Sherry).) Other facilities, including Northwest Surgical Center and Cy-Fair Surgery Center were also investigated. (Tr. 3- 157:14-24 (Sherry).)

40. Cigna's Special Investigations Unit ("SIU") was involved in investigating NCMC. (Tr. 4-216:2-10 (Sherry).) The SIU sent 34 survey letters to Cigna plan members (i.e. patients) about NCMC and received 19 responses. (Def. Exh. 14 at ¶ 4 (Declaration of Katrina Sharrow).) Seven members were billed nothing and paid nothing to NCMC; one member was billed and paid $45.00; four members were billed and paid $100.00; one member was billed and paid $102.00; four members were billed and paid amounts ranging from $320.00 to $575.12;

one member was billed $3,000 by NCMC but paid nothing; and one member could not remember if NCMC had billed her anything. (*Id.* at ¶ 7.) NCMC did not bill any of the members the amounts they were required to pay under their plans. (*Id.* at ¶ 7; *see also* Pl. Exh. 86.)

41. During its investigation, the SIU did not learn that NCMC was calculating patient responsibility based on 125 percent of Medicare. (*See* Tr. 4-222:11-15 (Sherry).)

42. On November 10, 2008, Cigna informed NCMC, by letter, that Cigna believed there was "evidence of a pattern of behavior by NCMC in which NCMC generally collects $100 from the CIGNA Participant, if any amount is collected at all." (Pl. Exh. 39 at 000636-37; Tr. 3-202:20-203:6 (Sherry).) In that letter, Cigna informed NCMC that it would reimburse claims based on the assumption that a patient was only billed $100; therefore, Cigna would imagine that $100 amount to be the patient's coinsurance amount for out-of-network services, and Cigna would pay the plan's corresponding coinsurance amount based on that. (Pl. Exh. 39.) This practice would continue until NCMC presented "clear evidence" that: "(1) the charges shown on the NCMC submitted billing are NCMC's actual charges for the services rendered; and (2) the CIGNA participant has paid their applicable out-of-network coinsurance and/or deductible in accordance with their Cigna benefit plan." (*Id.* at 000636-37.) This letter described, and marked the start of, Cigna's SIU's

"Fee-Forgiving Protocol," which calculated the amount Cigna would pay based on the assumption that the patient's portion of the payment was $100. (*Id.*; *see also* Tr. 4- 217:15-20 (Sherry).)

43. NCMC responded, "NCMC assures you that charges on claim forms submitted to Cigna are NCMC's actual charges. . . Cigna insureds are liable for amounts such as [out-of-network] co-insurance and deductibles, though, as indicated in NCMC's correspondence and bills to CIGNA, the patient portion of charges may be reduced if a patient meets the requirements of NCMC's prompt pay policy." (Pl. Exh. 46.)

44. Ms. Sherry testified that the Fee-Forgiving Protocol applied only to claims covered by MRC-1, and not to claims covered by MRC-2. (Tr. 4-217:21-218:5 (Sherry).)

45. The Fee-Forgiving Protocol resulted in a sharp reduction in how much Cigna paid to NCMC per claim. (*See* Pl. Exh. 64 at CIG-NCMC0082919 ("our spend[ing] at North Cypress Medical Center as [sic] come down from $2Million/month to $200 thousand a month").)

46. One of Cigna's goals in implementing the Fee-Forgiving Protocol was to get NCMC to the negotiating "table" to work toward an in-network agreement. (*See* Pl. Exh. 16 at CIG-NCMC0398827; Pl. Exh. 23; Pl. Exh. 53 (discussing what contract to offer NCMC after implementing the Fee-Forgiving Protocol); Pl. Exh. 108

(Ramirez Testimony from March 17, 2011) at 104-05.)

47. Also when the fee-forgiving protocol began, Cigna stopped applying its cost-containment program to NCMC claims subject to the Fee-Forgiving Protocol. (Tr. 4-44:23-45:4, 151:6-10 (Sherry) (noting, however, that Cigna did continue to collect vendor fees).) Cost-containment programs can result in Cigna collecting savings in some circumstances. Once the cost-containment programs were "turned off" with respect to NCMC claims, the amount of money that Cigna made on NCMC claims decreased. (*Id.*; Pl. Exh. 85B (summary of fees, showing that Cigna made significantly more money from fees on NCMC claims in 2008 before the protocol was in place, than it did for the entirety of 2009 to 2012, though it made money throughout); Pl. Exh. 62 (showing "a large savings" of approximately $621,000 on North Cypress claims from December 2008).)

48. Once Cigna implemented the Fee-Forgiving Protocol, an initial reviewer would determine if the claim submitted by NCMC was an MRC-2 claim, and then all other NCMC claims were flagged and sent to the SIU. (Pl. Exh. 49; Pl. Exh. 50; Pl. Exh. 82 ("continue applying SIU processing rules to ALL claims at this point."); Pl. Exh. 85D at 2 (Ms. Sherry's handwritten notes stating, "[f]lag a provider all claims go to SIU"); Tr. 4-119:22-120:1 (Sherry) (Ms. Sherry confirming the meaning of her handwritten notes).) The SIU would make a

recommendation on the claim. (Pl. Exh. 104 (Remlinger-Sharrow Testimony from Feb. 3, 2017) at 64.) This was a change in practice from how claims were previously processed.

49. Where there were processing errors, the claim processor would not follow the SIU's recommendation. (*Id.* at 66-67.)

50. After the Fee-Forgiving Protocol was implemented, Cigna's SIU sent 29 more survey questionnaires to plan members and received 8 responses. (Def. Exh. 14 at ¶ 9.). The results of the responses were that five members were billed nothing and paid nothing, two members were billed amounts greater than 0 but less than was required, and one member could not remember, but thought NCMC had charged him a "copay" of "several hundred dollars. (*Id.* at ¶ 11.)

NCMC's Appeals of Claims

51. Cigna maintained its position on the Fee-Forgiving Protocol in the months that followed, even as NCMC protested and appealed some claims. (*See* Pl. Exh. 66; Pl. Exh. 70 ("July 31, 2009 Letter").)

52. When NCMC appealed a claim to which the Fee-Forgiving Protocol was applied, Cigna would respond by letter. Letters that upheld the original decision would say that it was based on Cigna's policy of not paying for charges that "patients are not legally obligated to pay." (*See* Pl. Exh. 86B at 1.) The letters would then explain the process for submitting a second appeal. (*See id.* at 2.)

53. As set out in the plans, Cigna has a multi-level appeals procedure. (*See* Def. Exh. 1.014 at CIG-NCMC0114174-5 (describing two levels of appeals and an additional, separate "Independent Review Procedure"); Def. Exh. 1.035 at CIG-NCMC0582434-5 (same).) Appeals of claims are to be "reviewed and the decision made by [someone/a health professional] not involved in the initial decision." (*See* Def. Exh. 1.014 at CIG-NCMC0114174; Def. Exh. 1.035 at CIG-NCMC0582435.)

54. Ms. Sharrow, who worked for the SIU until April 2011 (Def. Exh. 14 at ¶ 2), was involved in the appeals process. (Pl. Exh. 86). Notes indicate that Ms. Sharrow received or handled thousands of appeals and "sent back w/ direction" or "sent back w/ with instruction." (*Id.*) The same notes indicate: "The appeals unit will are [sic] the ones who make the final decision of how claim is going to be handled. SIU can only make recommendations that is why we do not get involved with appeals." (*Id.* at CIG-NCMC0012252.) In a discussion of an NCMC claim on December 1, 2009, Ms. Sharrow's notes say, "We will continue to handle on a claim by claim basis." (*Id.* at CIG-NCMC0012254.) Notes from that same date state, "recd 1 appeal, handled without SIU recommendation." (*Id.*) In a discussion of an NCMC claim on November 4, 2009, Ms. Sharrow writes, "I advised why OON [out-of-network] claim should remain denied and recommended not to enhance since NCMC does not collect member responsibility," but indicates that if

NCMC can show how member is being held responsible for the entire amount, then she would advise differently. (*Id.* at CIG-NCMC0012256.) The SIU sometimes communicated with Cigna's in-house counsel. (*See, e.g.*, Pl. Exh. 86 at CIG-NCMC0012256.)

55. Sometimes the person reviewing the claim would respond to Ms. Sharrow's recommendation to indicate that the appeal would be upheld—and sometimes this affirmation email would be sent the same day that Ms. Sharrow sent her recommendation. (Pl. Exh. 86A at CIG0NCMC0547692.)

III. CONCLUSIONS OF LAW

Legal Standard

1. A benefits plan participant may bring a civil action under ERISA § 502(a)(1)(B) "to recover benefits due him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the plan." 29 U.S.C. § 1132(a)(1)(B). Healthcare providers may bring ERISA suits standing in the shoes of their patients. *N. Cypress I*, 781 F.3d at 191.

2. ERISA claimants are required to exhaust administrative remedies prior to filing a lawsuit. *Denton v. First Nat'l Bank of Waco*, 765 F.2d 1295, 1301 (5th Cir. 1985); *see also Hall v. Nat'l Gypsum Co.*, 105 F.3d 225, 231 (5th Cir. 1997) (the exhaustion requirement "is not one specifically required by ERISA, but has been uniformly imposed by the courts in keeping with Congress's intent in enacting ERISA"). "Exhaustion is to be excused only in

the most exceptional circumstances." *Davis v. AIG Life Ins. Co.*, No. 95-60664, 1996 WL 255215, at *2 (5th Cir. Apr. 26, 1996) (citing *Commc'ns Workers of Am. v. AT&T*, 40 F.3d 426, 433 (D.C. Cir. 1994)). A claimant is excused from demonstrating exhaustion if she can show that pursuit of administrative remedies would have been futile. *Bourgeois v. Pension Plan for Employees of Santa Fe Int'l Corps.*, 215 F.3d 475, 479 (5th Cir. 2000). To qualify for the futility exception to the exhaustion requirement, the claimant must show a "*certainty* of an adverse decision." *Id.* (citing *Commc'ns Workers of Am.*, 40 F.3d at 433) (emphasis in original); *see also Rando v. Standard Ins. Co.*, 182 F.3d 933 (10th Cir. 1999); *Lindemann v. Mobil Oil Corp.*, 79 F.3d 647, 650 (7th Cir. 1996). The claimant is also required to show hostility or bias on the part of the administrative review committee. *McGowin v. ManPower Int'l, Inc.*, 363 F.3d 556, 559 (5th Cir. 2004). The focus of futility is on the bias in the review process, not based on company officials' views. *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.").

3. The Fifth Circuit has adopted a multi-step process for determining whether a plan administrator such as Cigna abused its discretion in construing a plan's terms.

4. "The first question is whether Cigna's reading of the plans is 'legally correct.' " *Conn. Gen. Life Ins. Co. v. Humble Surgical Hosp., L.L.C.*, 878 F.3d 478, 483 (5th Cir. 2017) ("*Humble*") (quoting *North Cypress I*, 781 F.3d at 195). The most important factor at this stage is whether the contested interpretation is consistent with a fair reading of the plan. *Gosselink v. Am. Tel. & Tel.*, 272 F.3d 722, 727 (5th Cir. 2001). Because ERISA requires that plan descriptions be written in a manner calculated to be understood by the average plan participant, the court must assess whether the administrator's interpretation is consistent with the plan language in its "ordinary and popular sense." 29 U.S.C. § 1022(a); *Stone v. UNOCAL Termination Allowance Plan*, 570 F.3d 252, 260 (5th Cir. 2009). Additional factors in determining whether an administrator's interpretation is legally correct include whether the administrator has given the plan a uniform construction and whether there are any unanticipated costs resulting from different interpretations of the plan. *Crowell*, 541 F.3d at 312. If the plan is legally correct, "the inquiry ends and there is no abuse of discretion." *Humble*, 878 F.3d at 483 (quoting *Stone*, 570 F.3d at 257).

5. Second, if the court finds the insurer's interpretation was legally incorrect, the court must then determine whether it was an abuse of discretion. *Id.* This is the "functional equivalent of arbitrary and capricious review." *Id.* (citing *Anderson v. Cytec Indus., Inc.*, 619 F.3d 505, 512 (5th Cir. 2010) (quoting *Meditrust Fin. Servs. Corp. v. Sterling Chems., Inc.*, 168 F.3d 211, 214 (5th Cir. 1999))). "A decision is arbitrary if it is made without a rational connection between the known facts and the decision." *Id.* (citation omitted). "[O]rdinarily," the abuse of discretion factors that courts consider are "whether [the administrator] had a conflict of interest, as well as the internal consistency of the plan and the factual background of the determination and any inferences of lack of good faith." *Id.* at 484 (quotation omitted).

6. In some circumstances, "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." *Id.* (applying the rule that an administrator may interpret plans consistent with prior case law without adopting this as a bright-line rule).

7. Third, the court determines whether the insurer's decision to deny benefits was supported by substantial evidence. *Id.* (citation omitted).

8. Deviation from the three-step test is possible; the court may "skip the first step if it can more readily determine that the decision was not an abuse of

discretion." *Id.* at 483-84 (citing *Holland*, 576 F.3d at 246 n.2).

9. The abuse of discretion standard, however, does not apply to insurance policies that were effective or amended after January 1, 2012; for those policies, courts apply de novo review. *Ariana M. v. Humana Health Plan of Texas, Inc.*, 884 F.3d 246 (5th Cir. 2018).

Reconsideration of Administrative Exhaustion

10. The Court granted summary judgment "to Cigna for all claims for which [NCMC] did not exhaust administrative remedies." (Doc. No. 521 at 15-16.) In 3 of 24 appeals presented in the cross-motions for summary judgment, Cigna reversed its decision and paid the full requested amount, and in 3 other appeals Cigna partially reversed itself. (Doc. No. 521 at 15-16.) The Court adopted Cigna's claim-by-claim exhaustion analysis from summary judgment briefing because NCMC failed to meaningfully address it. (Doc. No. 568.) Thus, 575 claims for benefits remained under ERISA § 502(a)(1)(B).

11. Before trial, NCMC moved, for a second time, for the Court to reconsider its administrative exhaustion ruling. (Doc. No. 577.) At trial, the Court permitted NCMC to present exhaustion-related evidence in the form of an "offer of proof."

12. First, NCMC's present motion for reconsideration is largely based upon two exhibits that were produced in discovery in August 2017 (after the

Court's ruling on exhaustion). (*See* Doc. No. 578 (cover letter to document production, dated August 31, 2017.) The exhibits are the case notes of members of the SIU at Cigna. (*See* Pl. Exh. 86.) NCMC argues that these documents show that the SIU improperly controlled the appeals process, rendering appeals futile.

13. The recently-produced case notes cover a critical time period, but the information in them about how the SIU was involved in appeals was not new. The case notes produced in August 2017 are a continuation of case notes that had been produced several years ago. (Doc. No. 581-4 (Letter from J. Douglas Sutter to Joshua Simon, Aug. 14, 2017).) The previously-produced notes covered the time period of November 8, 2008 through January 14, 2010. (*Id.*) The new notes cover the time period of January 14, 2010 through July 31, 2012. In summary, the case notes show that the SIU received or handled thousands of appeals and "sent back w/ direction" or "sent back w/ with instruction." (Pl. Exh. 86.) They were being sent back to the actual claims administrators. The same "sent back with direction" language appears in the earlier set of case notes; which were available to NCMC years before the summary judgment motions and exhaustion rulings. (*See* Doc. No. 582-5 at CIGNCMC0012251.)

14. The recently-produced case notes do not alter the fact that—as Cigna demonstrated at summary judgment—NCMC could not show certainty of de-

nial because Cigna was willing to grant some appeals and modify some payments. Also, there are occasional instances where the case notes indicate that Cigna would "adjust" a claim based on how much the patient paid the provider, demonstrating that, with more information about the patient's share of the payment, Cigna would reassess its benefits determination. (*See* Doc. No. 578 at CIG NCMC0719000 ("With regards to NCMC your EOB reflects $250 but we will adjust your claim accordingly since you paid the provider $1103.35."), CIG NCMC0719004 ("if the employer has proof of payment from a member showing what the member paid at the time of service such as a credit card receipt, etc. we will adjust claim accordingly possibly allowing an additional payment").)

15. Second, NCMC maintains that the Court was wrong on the law by applying a "certainty of an adverse decision" on appeal standard. This Court maintains that it applied the correct standard. A claimant is excused from demonstrating exhaustion if she can show that pursuit of administrative remedies would have been futile. *Bourgeois*, 215 F.3d at 479. To qualify for the futility exception to the exhaustion requirement, the claimant must show a "*certainty* of an adverse decision." *Id.* (citing *Commc'ns Workers of Am.*, 40 F.3d at 433) (emphasis in original).[4]

[4] NCMC suggests that instead this court follow an approach from another circuit, citing to *Productive MD, LLC v. Aetna Health, Inc.*, 969 F. Supp. 2d 901 (M.D. Tenn.). In *Productive MD*, an out-of-network medical test provider alleged that a health insurer wrongfully failed

16. The cases that NCMC cites are inapposite. First, in *Encompass Office Sols., Inc. v. Conn. Gen. Life Ins. Co.*, 2017 WL 3260834 (N.D. Tex., July 31, 2017), the district court did not reach the question of administrative exhaustion. Second, in *Encompass Office Sols., Inc. v. La. Health Srv. & Indemn. Co.*, 2013 WL 12310676 (N.D. Tex. Sept. 17, 2013), the district court was convinced that the single exhausted claim was evidence that seeking further review of other claims meant they would be denied because the claims were "very similar" and "would merely produce an avalanche of duplicative proceedings." *Id.*, at *15 (quoting *In re Household Int'l Tax Reduction Plan*, 441 F.3d 500, 501-02 (7th Cir. 2006) (holding that unnamed class members are not required to exhaust remedies as a condition to being members of the class)). Later in that case, the district court found a demand letter indicating the insurer's intention to reject any claim for benefits to be a compelling basis for futility. (Findings of Fact and Conclusions of Law at 5, Encompass Office Sols., Inc. v. La. Health Srv. & Indemn. Co., 3:11-cv-01471-M, ECV Doc. No. 601.) Here, in contrast, Cigna explained

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to pay claims in order to coerce it into network contract at unreasonably low reimbursement rates. About 45 claims were exhausted and denied, and the provider argued that exhausting the others (approximately 120 claims) would be futile. The district court agreed that it would have been futile based on the futility factors set out in *Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410 (6th Cir. 1998). The Fifth Circuit has never cited to *Fallick*. *See also Gosselink v. Am. Tel. & Tel., Inc.*, No. CIV.A. H-97-3854, 1999 WL 33737443, at *3 n.3 (S.D. Tex. Aug. 9, 1999).

what information was necessary on appeals and, once again, did sometimes change the amount paid on a claim. Third, in *Arapahoe Surgery Ctr. LLC v. Cigna Healthcare, Inc.*, 2016 WL 1089697 (D. Colo., March 21, 2016), the district court recognized that the Seventh Circuit applies the (same) certainty standard and found that exhaustion was futile because of Cigna's blanket fee-forgiving policy, but the district court did not recognize that any claims were successfully appealed, in contrast to the present circumstances.

17. Third, NCMC objects that Cigna's appeal requirements were not clear and NCMC was not provided the plans. This argument also fails. A plaintiff cannot be excused from exhausting administrative remedies on the basis that he was not provided with plan documents or a summary plan description unless there was no other way for him to know how to appeal. *Gonzalez v. Aztex Advantage*, 547 Fed. Appx. 424, 428 (5th Cir. 2013) (lack of summary plan description was no excuse for failure to exhaust administrative remedies where the notice of denial clearly stated where to address the appeal); *see also Bourgeois*, 215 F.3d at 480-81 (provided limited relief to a plaintiff who was not provided a summary plan description where the only way the plaintiff could have found the address of the appeals committee was in the summary plan description). Here, the denial letters indicated the process for submitting a second-level appeal.

18. NCMC's Motion for Reconsideration is **DENIED**.

Scope of Remaining Claims

19. The Fifth Circuit found that the patients assigned their rights under their insurance contracts to NCMC, and that NCMC has standing under ERISA to enforce the contracts. *N. Cypress I*, 781 F.3d at 191-95. On remand, at the summary judgment stage, NCMC was unable to produce written assignments of benefits for a fraction of the benefits claims. (Doc. No. 521 at 16.) The Court considered whether those patients had actually assigned their benefits to be a disputed issue of material fact. (*Id.* at 17.) Based on reliable trial testimony that all patients actually assigned their benefits, this Court finds that all of the claims at issue were properly assigned to NCMC. *See also Encompass Office Solutions v. Cigna*, 2017 WL 3268034, at *9 (N.D. Tex., July 31, 2017).

20. Of the 575 claims remaining at trial, 395 were MRC-2 claims. Cigna argued at trial that 395 of them were MRC-2 claims to which the Fee-Forgiving Protocol was not applied. Trial testimony demonstrated that the parties no longer dispute the (non-emergency room) MRC-2 claims. Cigna did not apply the Fee-Forgiving Protocol to the MRC-2 and those are no longer within the scope of this case. NCMC's own witness stated that the Fee-Forgiving Protocol "was not intended to be applied against [MRC-2] claims" (Tr. 4-187:9-13 (Sherry)), and NCMC's expert admitted that Cigna generally didn't apply the Fee-Forgiving Protocol to MRC-2 claims (Tr. 5-196:16-18 (Tankersley)). Then, in its post-trial brief, NCMC

writes, "by its own admission, Cigna did not apply the [Fee-Forgiving] Protocol to MRC-2 plan claims." (Doc. No. 662 at 70.) This leaves 180 remaining claims.

21. Trial testimony also indicates that the parties no longer dispute the emergency room claims. Where Cigna applied the Fee-Forgiving Protocol to them, those claims remain within the scope of the dispute.

Reconsideration of Abuse of Discretion

22. All of the 180 claims remaining in this case are subject to self-funded plans or to insurance policies that predate January 1, 2012. Therefore, the abuse of discretion standard applies, and *Ariana M.* has no bearing on this case.

23. Before trial, this Court believed part of its legal analysis on NCMC's ERISA § 502(A)(1)(b) claim was collaterally estopped by the district court decision in *Connecticut General Life Insurance Co., et al. v. Humble Surgical Hosp.*, LLC, C.A. No. 4:13-cv-3291, 2016 WL 3077405 (S.D. Tex. Jun. 1, 2016). (Doc. No. 521 at 8-9 (applying collateral estoppel and holding that Cigna's interpretation of the plan language was legally incorrect).) Shortly after trial in the present case, the Fifth Circuit vacated in part and reversed in part the district court opinion that this Court previously relied upon. *Humble*, 878 F.3d 478. *Humble* concerned Cigna's application of the Fee-Forgiving Protocol, and the Fifth Circuit stated, "even if [Cigna's] construc-

tion of the plans' exclusionary language was legally incorrect, its interpretation still fell within its broad discretion." *Id.* at 484. The Court will therefore reconsider its ruling on NCMC's § 502(A)(1)(b) claim.

24. In two recent cases the Fifth Circuit has skipped the legal correctness analysis. *Humble*, 878 F.3d at 483-84 (citing *Holland*, 576 F.3d at 246 n.2). One of those cases involved Cigna's Fee-Forgiving Protocol, *id*, and the other involved NCMC's Prompt Pay Discount. This Court will do the same.

25. Cigna interpreted the plans to require an out-of-network healthcare provider to collect the full portion of coinsurance from a patient. With the Fee-Forgiving Protocol, Cigna would pay benefits claims amounts to NCMC based on the assumption that what NCMC charged the patient was the correct coinsurance amount, calculated using the coinsurance percentages in the plans. Thus, Cigna would assume that what the patient had paid was 40 percent of the "normal" charge for the service, and Cigna would pay the remaining 60 percent. Cigna invited NCMC to appeal these determinations by providing proof of the amounts that the patient paid. (*See* Pl. Exh. 39.)

26. In *Humble*, Cigna had interpreted plans the same way. The Fifth Circuit held that Cigna's interpretation falls within its "broad discretion." *Humble*, 878 F.3d at 484. Fifth Circuit noted the Supreme Court's explanation that deference to the plan ad-

ministrator's decisions "serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions—a result that 'would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them.' " *Id.* (quoting *Conkright v. Frommert*, 559 U.S. 506, 517 (2010)). The Fifth Circuit dismissed the ordinary abuse of discretion factors in favor of a legal policy that "where a plan administrator's interpretation is supported by prior case law, it cannot be an abuse of discretion—even if the interpretation is legally incorrect." *Id.* (citing *Hinkle ex rel. Estate of Hinkle v. Assurant Inc.*, 390 Fed. Appx. 105, 108 (3d Cir.) (applying the rule that an administrator may interpret plans consistent with prior case law without adopting this as a bright-line rule); *McGuffie v. Anderson Tully Col.*, 2014 WL 4658971, at *3-4 (S.D. Miss. Sept. 17, 2014).

27. The Fifth Circuit concluded that Cigna did not abuse in *Humble* because "[a]t least two other courts have effectively or explicitly concluded that the provision at issue here was legally correct. *Id.* at 485 (citing *Kennedy v. Connecticut General Life Insurance Co.*, 924 F.2d 698, 701 (7th Cir. 1991) (the Seventh Circuit stated a nearly identical provision "means that the patient must be legally responsible for the whole charge."); *N. Cypress I*, 781 F.3d at 196 (this Court's summary judgment ruling, which was vacated on other

grounds, was relevant for most of the relevant period that Cigna was interpreting the disputed plan language here)).

28. One of the courts to which the Fifth Circuit referred had effectively concluded that the provision at issue here was legally correct at the time that Cigna was administering NCMC's claims. In *Kennedy*, Judge Easterbrook had highlighted the benefits of requiring patients to pay for part of their medical care, even when insured: "Co-payments sensitize employees to the cost of health care, leading them not only to use less but also to seek out providers with lower fees. The combination of less use and lower charges . . . makes medical insurance less expensive and enables employers to furnish broader coverage (or to pay higher wages coupled with the same level of coverage)." 924 F.2d at 699. Accordingly, the Seventh Circuit found that Cigna was entitled to withhold payment where a healthcare provider had intentionally collected its entire fee from Cigna by waiving patient contribution. *Id.* The reasoning in *Kennedy* is sound.

29. Cigna explicitly relied on *Kennedy* by citing it in letters that Cigna sent to NCMC. (*See, e.g.*, Pl. Exh. 3B.)

30. Additionally, in a case that the Fifth Circuit recognizes involves "substantially similar facts" as the instant case, the healthcare provider's ERISA claim failed as a matter of law. *North Cypress Medical Center Operating Company, Ltd. v.*

Aetna Life Insurance Company, No. 16-20674, 2018 WL 3635231, at *1 n.1 (5th Cir. July 31, 2018) ("*North Cypress II*"). NCMC was also the plaintiff in *North Cypress II*, and brought an ERISA claim against a different plan administrator for underpayment of benefits. NCMC was also out-of-network with that insurer and offering patients the Prompt Pay Discount. The plan administrator was recognized to have "discretionary authority to determine eligibility for benefits and construe plan terms." *Id.* at * 1.

31. In the interest of uniformity of decisions, *Conkright*, 559 U.S. at 517, and adhering to the prior case law of *Kennedy*, *Humble*, 878 F.3d at 484, this Court concludes that Cigna did not abuse its discretion.

32. A review of the traditional abuse of discretion factors supports this conclusion. First, while Cigna had a conflict of interest, trial testimony that Cigna took steps to reduce its conflict (with respect to the cost-containment plan). (Tr. 4-44:23-45:4, 4-151:6-10 (Sherry).) Cigna "turned off" the cost-containment programs that could result in Cigna collecting savings in some circumstances when it implemented the Fee-Forgiving Protocol. (*Id.*) Also, a trial exhibit showing summaries of fees revealed that Cigna made significantly more money from fees on NCMC claims before the Fee-Forgiving Protocol was in place than in the years in which it was implemented. (*See* Pl. Exh. 85B.) "[W]here the administrator has taken active steps to reduce potential bias and promote accuracy,"

conflicts of interest are afforded less weight in the abuse of discretion analysis. *Hagen v. Aetna Ins. Co.*, 808 F.3d 1022, 1027 (5th Cir. 2015); *see also Arapaho Surgery Center, LLC*, 171 F.Supp.3d at 1113 (even where there is a conflict of interest, a court can conclude that an administrator did not abuse its discretion). Second, Cigna's interpretation of the plans was consistent with other parts of the plans.[5] Third, this Court previously concluded

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[5] The Court's conclusion about consistency of plan language is unchanged since summary judgment. (*See* Doc. No. 521 at 12.) NCMC presented the same arguments then that it does now. First, NCMC argues that the following two parts of the plans are inconsistent: (1) Payment for "charges which [the patient is] not obligated to pay or for which you are not billed" are "specifically excluded" from the plan; and (2) "The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance." (*See* Pl. Exh. 87 at CIG-NCMC0094360; Def. Exh. 1.026 ("TransCore, LP ASO") at CIG-NCMC0156030; Def. Exh. 1.035 ("Cy Fair ISD ASO") at CIG-NCMC0582421.) NCMC argues that Cigna's interpretation converts the "may" language to "shall" language. Those statements are not clearly inconsistent. Rather than reading as if the provider has discretion as to whether to charge a patient their coinsurance amount, it seems to suggest that the provider could charge patients *more* than their coinsurance amount where the provider's normal charge exceeds what reimbursements the plans contemplate.

Second, NCMC argues that Cigna interpreted the plan language inconsistently across providers. This is not the question of *internal* inconsistency that the abuse of discretion factor raises. And, in fact, Cigna has consistently reduced payments to out-of-network providers when it concluded that the out-of-network providers were not collecting the full coinsurance amount. *Humble*, 878 F.3d 478; *Arapaho Surgery Center, LLC*, 171 F.Supp.3d 1092.

Third, NCMC argues that Cigna applied its interpretation of the plans inconsistently between MRC-1 and MRC-2 claims and between in-network and out-of-network providers. (Doc. No. 662 at 79.) Again,

that the factual background and lack of good faith factor weighed "heavily" in NCMC's favor because there were "strong inferences" that Cigna did not act in good faith. (Doc. No. 521 at 14.) The Court's position was based on evidence that Cigna's "true motivation for the Fee-Forgiving Protocol was to negotiate an in-network contract, not to prevent harmful externalities in the insurance market." (*Id.*) Some trial evidence suggests that both the Prompt Pay Discount and the Fee-Forgiving Protocol were implemented to improve each party's respective negotiating position. (*See* Def. Exh. 37 ("Access NCMC Powerpoint") at NCMC26 0069499-501; Pl. Exh. 16 ("Targeted non par facility e-mail and powerpoint") at CIGNCMC0398827; Pl. Exh. 23; Pl. Exh. 53 (discussing what contract to offer NCMC after implementing the Fee-Forgiving Protocol).) At the same time, trial testimony presented two good faith bases for the Fee-Forgiving Protocol: (1) concerns that the employer sponsors of ASOs were losing money while NCMC administered the Prompt Pay Discount and would have to raise the price of insurance on all plan members (Tr. 3-192:20-24 (Sherry); Def. Exh. 62 (E-mail from Jurney to Behar) at NCMC8 29896); and (2) the importance of "sensitiz[ing] employees to the cost

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NCMC's arguments are not based on plan language inconsistencies, but plan application inconsistencies. These arguments are unpersuasive. MRC-1 and MRC-2 are different types of charges. Enforcing coinsurance rates for out-of-network providers and not for in-network providers is consistent with the policy of encouraging patients to seek in-network care to keep health care costs lower for the employers who fund the ASOs.

of health care, leading them . . . to seek out providers with lower fees" and make medical insurance less expensive for all, *Kennedy*, 924 F.2d at 699. *See also SmileCare Dental Grp. v. Delta Dental Plan of Cal., Inc.*, 88 F.3d 780, 783 (9th Cir. 1996) (noting approval of an insurer prohibiting waiver of coinsurance).

33. The Court must also address whether Cigna's interpretation was based on substantial evidence.

34. "Substantial evidence is more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Humble*, 878 F.3d at 485 (quoting *Corry v. Liberty Life Assurance Co. of Bos.*, 499 F.3d 389, 398 (5th Cir. 2007)). In making this inquiry, the Court is "constrained to the evidence before the plan administrator." *Id.* (citing *Killen v. Reliance Standard Life Ins. Co.*, 776 F.3d 303, 312 (5th Cir. 2015)).

35. Where Cigna has reduced benefits payments based on survey responses, that show the healthcare provider forgave out-of-network coinsurance amounts, courts have found Cigna's actions to be supported by substantial evidence. Both in *Humble* and in the present case, Cigna sent surveys to patients who had received treatment at the applicable provider and requested additional information. There, Cigna received 154 responses that supported Cigna's determination that the provider was fee-forgiving, and the Fifth Circuit considered that substantial evidence.

Humble, 878 F.3d at 485-86. Similarly, a district court in Colorado concluded that where, as a result of patient surveys, Cigna concluded that the provider was only charging patients 150 percent of Medicare and then paid the provider accordingly, Cigna's interpretation of the plans was based on substantial; however, where Cigna completely denied coverage, it had abused discretion.[6] *Arapaho Surgery Center, LLC*, 171 F.Supp.3d at 1113.

36. Here, Cigna sent a total of 62 survey letters and received 19 responses before implementing the Fee-Forgiving Protocol, as well as an additional 8 responses after implementing the Fee-Forgiving Protocol. (Def. Exh. 14 at ¶¶ 4, 9 (Declaration of Katrina Sharrow).) NCMC did not bill any of the members the amounts they were required to pay under their plans. (*Id.* at ¶ 13; *see also* Pl. Exh. 86 (SIU Case Notes).) Moreover, NCMC had informed Cigna, in Notice of Discount Letters and on UB-04 claims forms that it offered patients discounts, though NCMC did not explain the discounts. (*See, e.g.*, Pl. Exh. 1; Def. Exh. 84.) Cigna had substantial evidence of that NCMC was discounting or forgiving out-of-network coinsurance.

37. Twelve of the 19 initial respondents said they were billed nothing and paid nothing. (*Id.*) Five of the other initial respondents paid around $100, which is the amount that Cigna believed NCMC was charging patients, as it told NCMC. (*Id.* at ¶ 7.)

[6] It is unclear how many survey responses Cigna received in *Arapahoe*.

Cigna then administered claims based on the assumption that the patients had paid $100 in coinsurance. At no time—when collecting the survey responses or in communications with NCMC prior to this litigation—did Cigna learn that NCMC was calculating patient responsibility based on 125 percent of Medicare. Cigna had "more than a scintilla" of relevant and reasonable evidence that the normal charges for claims produced $100 coinsurance amounts for patients. *Humble*, 878 F.3d at 485.

IV. CONCLUSION

Any Finding of Fact that should be a Conclusion of Law shall be deemed such, and any Conclusion of Law that should be a Finding of Fact shall be deemed such.

Based on the foregoing Findings of Fact and Conclusions of Law, the Court finds and holds for Cigna. Accordingly, NCMC's Motion to Compel Cigna to Adjudicate Claims (Doc. No. 418) is **DENIED** as moot.

IT IS SO ORDERED.

SIGNED at Houston, Texas on this the 7th day of August, 2018.

s/ *Keith P. Ellison*
HON. KEITH P. ELLISON
UNITED STATES DISTRICT JUDGE

APPENDIX E

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CIVIL ACTION NO. 4:09-CV-2556

NORTH CYPRESS MEDICAL CENTER
OPERATING CO., LTD., et al.,
Plaintiffs,

v.

CIGNA HEALTHCARE, et al.,
Defendants.

Filed: August 16, 2018

FINAL JUDGMENT

Before KEITH P. ELLISON, United States District Judge.

Plaintiffs North Cypress Medical Center Operating Co., Ltd. and North Cypress Medical Center Operating Company, GP, LLC (collectively "NCMC") filed suit against Defendants Cigna Healthcare and Connecticut General Life Insurance Company on August 11, 2009, seeking relief under state law and the Employee Retirement Income Security Act ("ERISA"). (Doc. No. 1.). The Court commenced a bench trial on October 10, 2017, and issued its Findings of Fact and Conclusions of Law on August 7, 2018. (Doc. No. 692.)

Pursuant to Federal Rule of Civil Procedure 58(a), and for the reasons set forth in the Court's Findings of Fact and Conclusions of Law, final judgment is hereby **ENTERED** for Defendant Cigna Healthcare and Connecticut General Life Insurance Company.

IT IS SO ORDERED.

SIGNED at Houston, Texas on this the 16th day of August, 2018.

s/ *Keith P. Ellison*
HON. KEITH P. ELLISON
UNITED STATES DISTRICT JUDGE

APPENDIX F

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 18-20576

NORTH CYPRESS MEDICAL CENTER OPERATING COMPANY, LIMITED; NORTH CYPRESS MEDICAL CENTER OPERATING COMPANY GP, L.L.C.,
Plaintiffs-Appellants,

v.

CIGNA HEALTHCARE; CONNECTICUT GENERAL LIFE INSURANCE COMPANY; CIGNA HEALTHCARE OF TEXAS, INCORPORATED,
Defendants-Appellees.

Filed: April 21, 2020

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

ON PETITION FOR REHEARING EN BANC

(Opinion: 3/19/20, 5 Cir., ___, _____ F. 3d. _____)

Before KING, JONES, and DENNIS,
Circuit Judges.

ORDER

PER CURIAM:

(X) Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Panel Rehearing is DENIED. No member of the panel nor judge in regular active service of 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 DENIED.

( ) Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Panel Rehearing is DENIED. 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 DENIED.

ENTERED FOR THE COURT:

s/ *Edith H. Jones*
UNITED STATES CIRCUIT JUDGE