No. 20-378

In the Supreme Court of the United States

NORTH CYPRESS MEDICAL CENTER OPERATING COMPANY, LTD., et al.,

Petitioners,

v.

CIGNA HEALTHCARE, et al.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF IN OPPOSITION

JOSHUA B. SIMON
WARREN HASKEL
DMITRIY TISHYEVICH
McDermott Will & Emery LLP
340 Madison Ave.
New York, NY 10173
(212) 547-5500

MICHAEL B. KIMBERLY
Counsel of Record
PAUL W. HUGHES
MATTHEW A. WARING
McDermott Will & Emery LLP
500 North Capitol St. NW
Washington, DC 20001
(202) 756-8000
mkimberly@mwe.com

Counsel for Respondents

QUESTION PRESENTED

Whether the Fifth Circuit correctly held that Cigna acted reasonably in adopting a particular interpretation of plan language under the totality of the circumstances, including the fact that Cigna's interpretation was supported by longstanding and directly on-point judicial precedent.

RULE 29.6 STATEMENT

Cigna Healthcare of Texas, Inc. is a wholly-owned subsidiary of HealthSource, Inc., which is a wholly-owned subsidiary of Cigna Health Corporation.

Cigna Health Corporation is a wholly-owned subsidiary of Connecticut General Corporation.

Connecticut General Corporation is a wholly owned subsidiary of Cigna Holdings Inc., which is a wholly owned subsidiary of Cigna Holding Company, which is a wholly owned subsidiary of Cigna Corporation, which is publicly traded.

No parent company and no publicly-traded company owns more than 10 percent of Cigna Corporation's stock.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Cases—continued

Statutes

INTRODUCTION

If North Cypress's petition looks familiar, that is because it is a slightly modified version of the same petition that North Cypress's counsel filed, and this Court denied, in *Connecticut General Life Insurance* v. *Humble Surgical Hospital*, 878 F.3d 478 (5th Cir. 2017). The crux of the petition here is the same as it was there: North Cypress asserts that the Fifth Circuit has adopted an impermissible "per se" rule for abuse-of-discretion review in ERISA cases. Under this supposedly "categorical" approach, courts need not engage in a full abuse-of-discretion review if the plan administrator's interpretation of the relevant plan documents is directly supported by judicial precedents.

But that is not a tenable reading of either *Humble* or the decision below. To be sure, in reaching its conclusion that Cigna did not abuse its discretion both here and in *Humble*, the Fifth Circuit placed significant emphasis on the fact that Cigna's interpretation of its plan was based upon "relevant and longstanding" precedent from the Seventh Circuit. Pet. App. 12a. But the court stressed in *Humble* that it was not adopting "a bright-line rule" on that point. 878 F.3d at 485. On the contrary, even when an administrator's "interpretation is supported by prior case law," application of that interpretation can still amount to an "abuse [of] discretion." *Ibid*.

The court's application of *Humble* in this case does not signal a break from *Humble*'s express rejection of a categorical rule. Rather, it reflects an unremarkable application of *stare decisis*—the facts here involve the same plan administrator, interpreting nearly identical plan language, in the same way, based on the same longstanding precedents. *Humble* therefore rightly controls the outcome in these unusually similar circumstances.

Equally untenable is North Cypress's contention that the decision below conflicts with holdings of other circuits. As North Cypress recognizes, the abuse-of-discretion inquiry is fact-intensive, multifactorial, and context-dependent. None of the cases cited in the petition involve plan administrators basing decisions concerning plan language on longstanding judicial precedents. Any differences in outcomes between this case and the cases cited in the petition are thus attributable to differences in case-specific facts, not differences in the legal rules applied to those facts.

Even under North Cypress's misguided view that courts must consider every abuse-of-discretion factor equally in every case, moreover, the outcome here would be the same. The district court held an eight-day bench trial and expressly applied the full range of "traditional abuse of discretion factors" that North Cypress says is required, entirely apart from *Humble*. Pet. App. 98a. It ruled alternatively for Cigna on that basis.

Stripped of its cert-stage catchphrases, the petition is nothing more than a bid for error correction. It does not warrant the Court's attention.

STATEMENT

A. Factual background

1. Respondent Cigna offers health, pharmacy, dental, supplemental insurance and Medicare plans to individuals, families, and businesses. Under most healthcare insurance plans—Cigna's included—members typically must pay more when they see out-of-network providers compared to in-network providers. Pet. App. 67a. The point of this arrangement is to "sensitize employees to the costs of health care," which "makes medical insurance less expensive and enables employers to furnish broader coverage." *Kennedy* v. *Connecticut General Life Ins.*, 924 F.2d 698, 699 (7th Cir. 1991).

Sometimes out-of-network providers attempt to eliminate the difference between the in-network and out-of-network costs to patients by engaging in what is called "fee forgiving." Fee forgiving happens when out-of-network providers decline to collect the correct out-of-pocket costs (co-pays or co-insurance) for medical services from insured patients, as required under the terms of the relevant benefit plans. Fee forgiving tampers with plan incentives, and it undercuts Cigna's ability to encourage members to use less-expensive, more efficient providers. To safeguard against this practice, Cigna plans have long included provisions that exclude coverage for "charges which [you, the member are] not obligated to pay." Pet. App. 67a.

Under the plan documents at issue here, Cigna has discretionary authority to interpret plan provisions. Pet. App. 3a. For years, Cigna has used that discretion to interpret its plans "to require an out-of-network healthcare provider to collect the full portion of coinsurance from a patient." Pet. App. 95a. If the out-of-network provider fails to do so and "the member has no obligation to pay, then Cigna has no obligation to pay." *Humble*, 878 F.33d at 484; Pet. App. 12a (noting that the Seventh Circuit ruled in 1991 "that Cigna's interpretation of a 'nearly-identical' provision as imposing a fee forgiveness restriction was legally correct").

2. Petitioner North Cypress Medical Center operated an out-of-network general acute care hospital. Pet. App. 2a. There is no dispute that it engaged in impermissible fee forgiving. In particular, North Cypress "offered to limit the patient's co-insurance obligation if the patient paid a certain amount of what he owed within 120 days." *Ibid*. This prompt payment discount "was based on an entirely different fee schedule," assumed "an in-network coinsurance rate," and effectively granted a "waiver of Cigna's usual [co-insurance] re-

quirements." Pet. App. 5a. At bottom, the discount "significantly reduced out-of-network patients' coinsurance obligations" and "generated substantial revenue for North Cypress without incurring collection expenses." Pet. App. 3a.

Compounding its misconduct, North Cypress was using one set of charges to lower members' cost-share and a far higher set of charges to bill Cigna. North Cypress used "125 percent of Medicare" to bill patients and calculate coinsurance, but it then submitted bills to Cigna based on rates that "exceeded 600% or even 1,000% of the analogous Medicare rates." Pet. App. 74a-76a. Thus, for example, North Cypress billed one Cigna member just $823.84 for gallbladder surgery, but then sought $30,968.70 in reimbursement from Cigna for the service. Pet. App. 76a.

3. Most of Cigna's business is providing administrative services to "self-funded" employer plans. Pet. App. 66a. For those plans, "Cigna administers claims, but an employer, such as a school district, is responsible for paying all of the claims." *Ibid.* Not surprisingly, North Cypress's shady billing practices and inflated charges began to raise red flags. Cigna began investigating after one of Cigna's self-funded clients (a public school district) complained "about increasing out-of-network costs" driven by North Cypress, as a result of which the school district had to "rais[e] premiums on employees." Pet. App. 77a-78a.

To investigate North Cypress's suspicious billing practices, Cigna's Special Investigations Unit sent survey letters to members who had received treatment at North Cypress. Pet. App. 78a. The survey responses confirmed Cigna's suspicions: "[North Cypress] did not bill any of the members the amounts they were required to pay under their plans." Pet. App. 79a.

Cigna informed North Cypress by letter that "only expenses which patients are legally obligated to pay are reimbursable" under Cigna's plans, and therefore, "[a]ny 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." Pet. App. 72a-73a. In that same letter, Cigna cited a Seventh Circuit decision, *Kennedy* v. *Connecticut General Life Insurance Co.*, 924 F.2d 698 (7th Cir. 1991), for the proposition that Cigna plans cover only a provider's actual charges and not charges that are waived or later discounted from the patient's bill.

North Cypress continued its fee forgiving despite these warnings. After Cigna completed its investigation, it therefore began applying a fee-forgiving protocol to North Cypress's claims. Pet. App. 5a. Under the protocol, Cigna reimbursed North Cypress based on an assumption that it was charging members $100 per claim, based on evidence Cigna had gathered concerning North Cypress's billing practices. *Ibid*. Cigna would adjust the reimbursement if North Cypress gave proof that "the amount submitted [to Cigna] was actually the amount charged" to the patient. *Ibid.* On the handful of occasions where North Cypress did show that it charged more, "Cigna would 'adjust' a claim" and "reassess its benefits determination." Pet. App. 90a.

B. Procedural background

1. North Cypress sued Cigna, asserting that Cigna had abused its discretion because its actions reflected a conflict of interest, its plan interpretation was incorrect, and it adopted its plan interpretation in bad faith. Pet. App. 6a. Alleging more than 10,000 improper denials of plan benefits on behalf of plan beneficiaries, North Cypress asserted causes of action under state law, RICO, and ERISA. *Ibid*.

Following an initial appeal and extensive fact discovery, the district court dismissed North Cypress's ERISA § 502(a)(3) claims for breach of fiduciary duty, its ERISA § 503 claims for failure to provide adequate review of initial benefit decisions, its ERISA § 502-(c)(1)(B) claims for refusal to provide plan documents, and its state contract law claims. Pet. App. 6a. It also "narrowed North Cypress's remaining claims for patient benefits under ERISA § 502(a)(1)(B) to those for which it had exhausted administrative remedies." Pet. App. 6a-7a. What remained for trial after the district court's ruling was North Cypress's ERISA § 502-(a)(1)(B) claim for improper withholding of benefits with respect to 575 claims. Pet. App. 7a, 88a.

2. Following an eight-day bench trial, the district court rejected North Cypress's remaining claims and entered judgment for Cigna. Pet. App. 63a-103a.

For 395 of the 575 claims at issue, the district court concluded that Cigna's $100 default reimbursement protocol had not been applied and there accordingly was "no longer [any] dispute" with respect to those claims. Pet. App. 93a-94a.

"Th[at] [left] 180 remaining claims." Pet. App. 94a. As to those claims, the court "conclude[d] that Cigna did not abuse its discretion." Pet. App. 98a.

In reaching that conclusion, the court relied principally on *Humble*, in which "Cigna had interpreted" "nearly identical" plan language in "the same way." Pet. App. 95a-96a. There, "[t]he Fifth Circuit held that Cigna's interpretation falls within its 'broad discretion.'" Pet. App. 95a. The decision in *Humble* itself had turned on, among other things, Cigna's reliance on the Seventh Circuit's decision in *Kennedy*. The court of appeals held that Cigna's "interpretation does not constitute an abuse of discretion" when "courts have found

Cigna's interpretation of the policy language reasonable." *Humble*, 878 F.3 at 485 (brackets omitted).

Applying that same rational here, the district court held that "where a plan administrator's interpretation [of a plan document] is supported by prior case law, it cannot be an abuse of discretion—even if the interpretation is legally incorrect." Pet. App. 96a (quoting *Humble*, 878 F.3d at 484). Here, "Cigna explicitly relied on *Kennedy* by citing it in letters that Cigna sent" to North Cypress. Pet. App. 97a. "In the interest of uniformity of decisions, and adhering to the prior case law of *Kennedy*" and *Humble*, the court concluded "that Cigna did not abuse its discretion." Pet. App. 98a (citation omitted).

The district court did not stop there, however. It went on to hold that "[a] review of the traditional abuse of discretion factors supports this conclusion." Pet. App. 98a. Reviewing the good-faith bases for Cigna's conduct and its actions to limit conflicts of interest, the court concluded that Cigna had not abused its discretion independent of *Humble*. Pet. App. 98a-101a.

3. The Fifth Circuit unanimously affirmed. Pet. App. 1a-16a. North Cypress challenged virtually every element of the district court's findings and conclusions on appeal: It asserted that the district court had violated the law of the case (Pet. App. 9a-11a); erred in holding that Cigna did not have a conflict of interest and did not act in bad faith (Pet. App. 11a-13a); misapplied *Humble* on the question of Cigna's interpretation of plan documents (Pet. App. 13a-15a); unreasonably held North Cypress to ERISA's exhaustion requirement (Pet. App. 15a-16a); and erred in declining to award damages and attorneys' fees (Pet. App. 16a).

The Fifth Circuit rejected each argument, holding that North Cypress had shown "zero" ground for suc-

cess of the merits of its claims. Pet. App. 16a. As it concerns the issues presented in the petition, the court of appeals reasoned that because this case and *Humble* involved indistinguishable circumstances, the "court must adhere to the same reasoning and result concerning the same policy language" that it had reached in *Humble*. Pet. App. 12a-13a. "As North Cypress admits," the court explained, "the relevant interpretation in this case is the same as the interpretation in *Humble*." Pet. App. 14a. Because "*Kennedy* was reasonably invoked in *Humble*," it "is reasonably applicable here" as a ground for holding that Cigna's interpretation fell within the range of permissible interpretations. *Ibid*.

North Cypress petitioned for rehearing en banc, which was summarily denied. Pet. App. 106a-107a.

REASONS FOR DENYING THE PETITION

The petition mischaracterizes the decision below. Correctly understood, the Fifth Circuit's unanimous opinion is consistent with both common sense and this Court's holdings. It does not conflict with the decision of any other court of appeals. And regardless, this case would be a manifestly unsuitable vehicle for review because the district court engaged in precisely the analysis that North Cypress says is required, and it still ruled for Cigna. The petition should be denied.

A. There is no conflict among the circuits

The crux of the petition is North Cypress's view that "the traditional abuse-of-discretion inquiry" has been categorically "obviated" by the Fifth Circuit when there is "prior legal authority supporting the administrator's interpretation." Pet. 20 (cleaned up). On that basis, North Cypress asserts (Pet. 13) that the decision below "directly conflicts with the decisions of this Court and multiple courts of appeals." But that is simply wrong: The Fifth Circuit has expressly disclaimed the

creation of a categorical rule, and there is no split among the circuits. Rather, the decision below simply followed the Fifth Circuit's own precedent in *Humble*, which involved effectively identical facts. This Court denied review in *Humble*, and it should do so here.

1. The decision below does not establish a categorical rule

a. North Cypress repeatedly asserts that the Fifth Circuit has created an "inflexible" (Pet. 16, 21), "wooden" (Pet. 7, 14, 22), "categorical" (Pet. 8, 14, 20, 21) and "per se" (Pet. 5, 15, 19, 21, 24) rule, according to which relevant legal precedents supporting a plan administrator's decision must be treated as "automatic proxies for reasonableness" (Pet. 5, 22) under the abuse-of-discretion framework. But no amount of repetition alters the fact that the Fifth Circuit has expressly disavowed any such bright-line rule.

The starting point is *Humble*. There, the Fifth Circuit 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." 878 F.3d at 484. Although that language is broad, the court clarified in the very next sentence that it was "not adopt[ing] this reasoning as a bright-line rule" and that, "even if a legally incorrect interpretation is supported by prior case law, employing the interpretation could cause a plan administrator to abuse its discretion." *Id*. at 485. The court therefore explicitly limited its "conclu[sion that] Cigna did not abuse its discretion" to the unique "circumstances" of that case, including its observation that the prior cases relied upon by Cigna involved a "nearly-identical exclusionary provision." *Ibid*.

This case and *Humble* are of a piece: They involve the same plan administrator, applying the same inter-

pretation, of the same plan language, in light of the same judicial precedents, to the same basic conduct. As the Fifth Circuit succinctly put it, "the circumstances of this case match those in *Humble*." Pet. App. 11a. Accord Pet. 10 (*Humble* "involved effectively the same administrator's construction of the same plan language based on similar activity").

The court of appeals thus understandably applied its earlier holding in *Humble* to resolve this case. See Pet. App. 12a-13a ("[T]his court must adhere to the same reasoning and result concerning the same policy language" that it had reached in *Humble*); Pet App. 13a ("*Humble* [is] binding."). And in doing so, the court continued with the same qualification that it expressed in *Humble* itself: "Cigna's interpretation, having relevant legal support, could not *in these circumstances* be an abuse of discretion." Pet. App. 13a (emphasis added). This is not a *sub silencio* overruling of *Humble*'s disavowal of a per se rule. It is, instead, a simple application of *stare decisis*.

In a footnote buried late in the petition (at 20 n.3), North Cypress admits that the Fifth Circuit expressly disclaimed a per se rule in *Humble*. But it insists that "the panel below has now confirmed the [true] categorical nature of *Humble*'s holding" by applying it in this case. *Ibid*. That ignores that the facts here and the facts in *Humble* are identical in every relevant respect, and that to have ruled differently here would have required overruling *Humble* and subjecting Cigna to inconsistent legal duties in analytically identical cases. North Cypress does not (and cannot) seriously say that the decision in this case overruled *Humble*.

b. Considered in this broader context, the petition unravels. As North Cypress rightly admits (Pet. 8), "not every factor" in the abuse-of-discretion inquiry "will prove 'important' in every case," and the relative

"weight" that each factor receives depends upon "'case-specific' circumstances."

That explains the decision below. Because Cigna reasonably based its interpretation on two longstanding judicial decisions, and because the Fifth Circuit, just two years earlier, held that Cigna's interpretation of the same plan terms in the same way for the same reasons was not an abuse of discretion, *Humble* controlled the outcome. Pet. App. 12a-14a. Fulsome reconsideration of each individual abuse-of-discretion factor was not necessary under these unique "'case-specific' circumstances" (Pet. 8). And it would not be a worthwhile use of this Court's resources to review such a fact-bound decision.

2. No other case cited in the petition involved an administrator's reliance on directly relevant judicial precedent

a. North Cypress asserts (Pet. 15-17) that the decision below conflicts with binding decisions of the First and Eighth Circuits, among others. That is wrong first and foremost because, as we have just shown, the court below did not hold that an administrator's reliance on judicial precedent is, in every case, "automatically dispositive" of the abuse-of-discretion inquiry. Pet. i. But beyond that, none of the cited cases appears to have considered the question presented in the petition, much less concluded that reliance on precedent can never alone support a finding of reasonableness.

Take first *Colby* v. *Union Security Insurance*, 705 F.3d 58 (1st Cir. 2013), cited at page 15 of the petition. There, the First Circuit held that the plan administrator's interpretation of certain plan language was "unreasonable" "in this case." 705 F.3d at 65. It reached that conclusion despite that there was recent case law supporting the "viability" of the adminis-

trator's position. *Ibid*. But the administrator's decision predated the relevant case law, and thus the administrator could not have relied upon it to support the denial of benefits. *Colby* accordingly did not present the question whether it is reasonable for a plan administrator to rely on longstanding, on-point case law as a basis for interpreting plan language in a particular way, nor how any such reliance factors into subsequent abuse-of-discretion review.

North Cypress's citation to *Darvell* v. *Life Insurance*, 597 F.3d 929 (8th Cir. 2010), is equally off base. That case involved a plan administrator's interpretation of plan documents concerning disability. At the time that the administrator denied benefits in that case, the circuits were "split" on whether the administrator's interpretation was a reasonable one. 597 F.3d at 935. Without opining on whether it would have been reasonable for the plan administrator to rely on supportive case law, the Eighth Circuit held simply that it would "defer[]" to the administrator's "interpretation of the disputed phrase," because "it is reasonable * * * in this case." *Id*. at 936. In addition, the Eighth Circuit acknowledged that "the administrator [was] also the insurer," introducing the possibility of a "conflict," which the court considered and rejected. *Id*. at 934. That confirms only that cases of this sort typically involve unique combinations of factors calling for appropriately tailored, case-specific analyses. Nothing in *Darvell* indicates that the Eighth Circuit would have decided this case differently.

b. In addition to *Colby* and *Darvell*, the petition cites (at 17) a string of cases for the bare proposition that "multiple courts of appeals * * * examined the traditional 'factors'" despite the presence of judicial precedent supporting the administrator's decision. But, like *Colby* and *Darvell*, none of those cases involved the

question whether it is reasonable for a plan administrator itself to rely on directly relevant case law to reach a decision about the meaning of plan language. The Sixth Circuit's decision in *Osborne* v. *Hartford Life*, 465 F.3d 296 (6th Cir. 2006), merely upheld an unpublished decision that post-dated the administrator's denial of benefits. *Id*. at 299-300. And the Second Circuit's decision in *Gallo* v. *Madera*, 136 F.3d 326 (2d Cir. 1998), merely resolved a conflict between two district courts on a question of plan interpretation. Neither of those cases says a word about how either of those courts would treat an administrator's reliance on prior case law in a case like this one.

North Cypress asserts a further split with unpublished decisions of the Third and Ninth Circuits. Pet. 17-19. Setting aside that neither decision is precedential, each supports Cigna, not North Cypress.

In *Hinkle* v. *Assurant, Inc.*, 390 F. App'x 105 (3d Cir. 2010), the Third Circuit concluded that when there is judicial precedent pointing in two different directions on a particular question of interpretation, generally "a decision one way or another cannot be regarded as arbitrary or capricious." *Id*. at 108. And in *Ehrensaft* v. *Dimension Works*, 33 F. App'x 908 (9th Cir. 2002), the Ninth Circuit held similarly that "because the circuit-level law in this circuit appears to favor" the administrator's reading, its "interpretation does not constitute an abuse of descretion." *Id.* at 910. Those conclusions, which are generally consistent with *Humble* and the decision below, make good sense: The abuse-of-discretion standard asks only whether the administrator acted *reasonably* (*Humble*, 878 F.3d at 483)—and it will ordinarily be reasonable to interpret plan documents in a manner consistent with relevant judicial decisions. Nothing in these unpublished de-

cisions conflict with the Fifth Circuit's approach in this case or in *Humble*.[1]

B. The district court's alternative holding makes this a poor vehicle

Even if all that we had said were mistaken—even supposing that the Fifth Circuit had established a bright-line rule (it did not) and that other courts of appeals had considered and rejected that rule (they have not)—review still would be unwarranted. That is because, after holding an eight-day bench trial, the district court conducted precisely the kind of abuse-of-discretion review that North Cypress says it was required to undertake, independent of its application of *Humble*. See Pet. App. 98a-101a. Under that analysis, it still ruled in Cigna's favor. *Ibid*.

The court began by laying out the full framework for abuse-of-discretion review in ERISA cases, explaining the relevance of "whether the administrator had a conflict of interest," whether the administrator's interpretation is "internal[ly] consisten[t]," and whetherthere are "any inferences of lack of good faith." Pet. App. 87a (brackets omitted). It concluded that, under a "review of the[se] traditional abuse of discretion factors," the outcome would be the same wholly apart from *Humble*. Pet. App. 98a.

First, the court held that Cigna's decision was not tainted by a conflict of interest. A conflict of interest exists when the same entity, typically the employer,

---

[1] The petition asserts (Pet. 19-20) a further conflict with unpublished decisions of the U.S. District Courts for the District of Maryland and the Southern District of Mississippi. Those cases are entirely consistent with the decision below. See *Humble*, 878 F.3d at 485. In any event, conflicts among district courts do not warrant the Court's attention.

"both funds the plan and evaluates the claims," because in that case "every dollar saved" on claims "is a dollar in [the employer's] pocket." *Metropolitan Life Insurance* v. *Glenn*, 554 U.S. 105, 112 (2008) (quotation marks omitted). Here, the district court concluded that Cigna did have a potential conflict of interest because it stood to collect contingency fees when it reduced payments to North Cypress. But, the court found, "Cigna took steps to reduce its conflict [of interest]," by "'turn[ing] off' the cost-containment programs that could result in Cigna collecting savings in some circumstances." Pet. App. 98a. As a result, the court concluded, Cigna in fact made less money under the fee-forgiving protocol than it otherwise would have made. *Ibid*. In such circumstances, the court reasoned, "conflicts of interest are afforded less weight in the abuse of discretion analysis." Pet. App. 99a.

The district court next found that Cigna's interpretation of the fee-forgiveness provisions of the plan documents was consistent with its interpretation of other plan provisions. Pet. App. 99a. Those other provisions include the plans' requirements that members pay higher levels of coinsurance and deductibles for out-of-network services. *Ibid*. Adopting North Cypress's contrary position would have allowed plan members to receive out-of-network services without paying the out-of-network amounts that their plans require, undermining the plans' differential treatment of in-network and out-of-network services.

Finally, the district court concluded that Cigna did not act in bad faith. Pet. App. 100a-101a. The court found that there were "two good faith bases for the Fee-Forgiving Protocol: (1) concerns that the employer sponsors of [self-funded plans] were losing money * * * and would have to raise the price of insurance on all plan members," and "(2) the importance of sensitizing

employees to the cost of health care." Pet. App. 100a-101a (cleaned up).

This independent analysis of the "traditional abuse of discretion factors" (Pet. App. 98a) is exactly what North Cypress complains was missing in this case. But it wasn't missing at all. This Court's review of the question presented therefore could not change the outcome in any event.

Resisting that conclusion, North Cypress notes (again buried in a footnote at the end of the petition, at 26 n.5) that the district court "flip-flopped" on its findings. But as North Cypress admits (*ibid.*), the basis for the district court's change in position was the Fifth Circuit's intervening decision in *Humble*. The issuance of intervening guidance from a court of appeals is hardly a surprising basis for a shift in position. And, having twice denied rehearing in *Humble* and now in this case, there is no indication that the Fifth Circuit itself is likely to "flip-flop."

At bottom, there is no chance that this Court's review would affect the outcome here. Even under North Cypress's inflexible view of the abuse-of-discretion standard, the result would be the same.

C. The decision below is plainly correct

1. The lower court correctly held that Cigna did not abuse its discretion. North Cypress does not dispute that prior case law is at least relevant to the question whether an administrator has abused its discretion. Its real argument, instead, is that even when an administrator's decision is based on longstanding judicial precedent, a court must also expressly, and *always*, consider and weigh each of the remaining factors in this Court's abuse-of-discretion framework. Pet. 21.

That is a misreading of this Court's cases, which do not impose such inflexible requirements. Indeed, *Met-*

ropolitan Life Insurance v. *Glenn*, 554 U.S. 105 (2008), disavowed the kind of rigid framework petitioners demand. The Court explained there that "[b]enefits decisions arise in too many contexts [and] concern too many circumstances" for a "one-size-fits-all" approach to the abuse-of-discretion analysis to make sense. *Id.* at 116. The Court acknowledged that in different ERISA cases, different factors may be more or less relevant depending on those factors' "case-specific importance." *Id.* at 117. North Cypress admits as much. Pet. 8.

One factor that will sometimes assume special importance is the administrator's grounding of its interpretation of the plan on established judicial precedent. When (as here) a plan gives the administrator discretion to interpret its terms, a court's review of the administrator's interpretation is deferential, and the interpretation will be overturned only if it is an abuse of discretion. *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 111 (1989). An abuse of discretion "only occurs where no reasonable person could take the view adopted." *Friends for Am. Free Enter. Ass'n* v. *Wal-Mart Stores, Inc.*, 284 F.3d 575, 578 (5th Cir. 2002) (quotation marks omitted) (review of denial of Rule 11 sanctions); see also, *e.g.*, *Jenkins* v. *Chrysler Motors Corp.*, 316 F.3d 663, 664 (7th Cir. 2002) (applying same standard to review of evidentiary rulings); *Higgins* v. *Apfel*, 222 F.3d 504, 505 (8th Cir. 2000) (same, regarding review of a remand decision).

Decisions from one or more courts adopting a particular position are good evidence that that position is "reasonable," even if it is ultimately held incorrect. Cf. *Davis* v. *United States*, 564 U.S. 229, 239 (2011) (search conducted in "reliance on binding judicial precedent" was "objectively reasonable" and qualified for good-faith exception to exclusionary rule, even though precedent was subsequently overturned); *Valdes* v.

Wal-Mart Stores, Inc., 199 F.3d 290, 293 (5th Cir. 2000) (removal is objectively reasonable, for purposes of attorney's fees under 28 U.S.C. § 1447(c), if the defendant "could conclude from th[e] case law that its position was" justified). Thus, if there is precedent supporting a plan administrator's decision, as there was here, that is strong evidence that the decision was not an abuse of discretion.

Looking to precedent supporting the administrator's reading of the plan is particularly sensible in the ERISA context because it furthers uniformity in plan interpretation. The purpose of ERISA, as the Court has often observed, is to "induc[e] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct." *Conkright* v. *Frommert*, 559 U.S. 506, 517 (2010) (quoting *Rush Prudential HMO, Inc.* v. *Moran,* 536 U.S. 355, 379 (2002)). It is therefore important that similar plan language be interpreted similarly across jurisdictions, rather than varying from circuit-to-circuit: "[A] patchwork of different interpretations" of similar plan language 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.'" *Ibid.* (quoting *Fort Halifax Packing Co.* v. *Coyne,* 482 U.S. 1, 11 (1987)). Accordingly, ERISA should be understood not only to permit but to encourage administrators to rely upon relevant precedent in interpreting plan terms.

2. In light of all these considerations, the court of appeals rightly concluded that, in these particular circumstances, Cigna's reliance on directly relevant judicial precedents to support its interpretation of the plan documents made it unnecessary to engage in a fulsome review of all other abuse-of-discretion factors.

Cigna's determination that charges not actually billed to patients are not covered was supported by decisions of the Seventh Circuit and the Southern District of Texas. "In these circumstances," the existence of those holdings by itself "establishes that the interpretation does not constitute an abuse of discretion." *Humble*, 878 F.3d at 485 (quotation marks omitted). That is not to say that reliance on precedent is always reasonable; sometimes it is not (*ibid.*), including when the precedent is not sufficiently on-point, or perhaps when the relevant case has been overruled at the time of the administrator's decision. But here, the Fifth Circuit rightly concluded that it was reasonable for Cigna to rely on *Kennedy*, just as it had held in *Humble* under identical circumstances. That commonsense conclusion is not the stuff of certiorari review.

The petition thus falters at every turn: There is no bright-line rule, no conflict among the circuits, no chance of a different outcome, and no error in the lower court's reasoning. The petition should be denied.

CONCLUSION

The Court should deny the petition.

Respectfully submitted.

JOSHUA B. SIMON
WARREN HASKEL
DMITRIY TISHYEVICH
McDermott Will & Emery LLP
340 Madison Ave.
New York, NY 10173
(212) 547-5500

MICHAEL B. KIMBERLY
Counsel of Record
PAUL W. HUGHES
MATTHEW A. WARING
McDermott Will & Emery LLP
500 North Capitol St. NW
Washington, DC 20001
(202) 756-8000
mkimberly@mwe.com