APPENDIX

TABLE OF CONTENTS

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 24-10306

ANGELINA EMERGENCY MEDICINE ASSOCIATES PA; ATASCOSA EMERGENCY MEDICINE ASSOCIATES PA; ATHENS EMERGENCY MEDICINE ASSOCIATES PA; BLUFF CREEK EMERGENCY MEDICINE ASSOCIATES, PA; BREWSTER EMERGENCY MEDICINE ASSOCIATES PA, *Et al.*,

Plaintiffs-Appellants,

versus

BLUE CROSS AND BLUE SHIELD OF ALABAMA; USABLE MUTUAL INSURANCE COMPANY, DOING BUSINESS AS ARKANSAS BLUE CROSS AND BLUE SHIELD; ANTHEM BLUE CROSS LIFE AND HEALTH, DOING BUSINESS AS ANTHEM BLUE CROSS; ROCKY MOUNTAIN HOSPITAL AND MEDICAL SERVICES, DOING BUSINESS AS ANTHEM BLUE CROSS AND BLUE SHIELD OF COLORADO; HIGHMARK BCBSD INCORPORATED; BLUE CROSS AND BLUE SHIELD OF GEORGIA, INCORPORATED; BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA INCORPORATED; WELLMARK, INCORPORATED, DOING BUSINESS AS BLUE CROSS AND BLUE SHIELD OF IOWA, DOING BUSINESS AS WELLMARK BLUE CROSS AND BLUE SHIELD; BLUE CROSS AND BLUE SHIELD OF KANSAS CITY; RIGHTCHOICE MANAGED CARE INCORPORATED; HEALTHY ALLIANCE LIFE INSURANCE COMPANY; HMO MISSOURI INCORPORATED; BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, A MUTUAL INSURANCE COMPANY; BLUE CROSS AND BLUE SHIELD OF NEBRASKA, INCORPORATED; BLUE CROSS BLUE SHIELD OF NORTH DAKOTA; EMPIRE HEALTHCHOICE ASSURANCE INCORPORATED; EMPIRE HEALTHCHOICE HMO INCORPORATED; HEALTHNOW NEW YORK INCORPORATED; COMMUNITY INSURANCE COMPANY, DOING BUSINESS AS BLUE CROSS AND BLUE SHIELD OF OHIO; HIGHMARK INCORPORATED; WELLMARK OF SOUTH DAKOTA INCORPORATED; ANTHEM HEALTH PLANS OF VIRGINIA, INCORPORATED; PREMERA BLUE CROSS; BLUE CROSS OF IDAHO HEALTH SERVICE, INCORPORATED, DOING BUSINESS AS BLUE CROSS OF IDAHO,

Defendants-Appellees,

Appeal from United States District Court
for the Northern District of Texas
USDC No. 3:18-CV-425

Before SMITH, HIGGINSON, and DOUGLAS, *Circuit Judges*.

STEPHEN A. HIGGINSON, *Circuit Judge*:

Treating the petition for rehearing en banc as a petition for panel rehearing (5th Cir. R. 40 I.O.P), the petition for rehearing en banc is GRANTED. We withdraw our previous opinion, reported at 150 F.4th 393, and substitute the following:

Plaintiffs-Appellants (the Physician Groups) are fifty-six Texas emergency-medicine physician groups. The Physician Groups sued twenty-four Blue Cross Blue Shield-affiliated plans from outside of Texas (the Blue Plans), alleging that the Blue Plans underpaid the Physician Groups' claims for reimbursement. The Physician Groups alleged that they were owed payments based on patients' assignments of rights under the Blue Plans to the Physician Groups prior to treatment. The district court granted summary judgment on all claims for a variety of independent and overlapping reasons related to the different forms and language of the relevant plans. In so doing, the district court ignored the Physician Groups' arguments about ambiguities in contract language and applied the wrong legal standard in determining whether assignments to the Physician Groups were valid. We AFFIRM

as to the claims where no written assignment was produced. As to the remaining claims, because nearly all of the issues before us require further examination of the evidentiary record, we VACATE summary judgment in part and REMAND for further proceedings consistent with this opinion.

I.

A physician group generally comprises one or more physicians who have formed a limited liability entity to operate their practice in a smaller or more independent manner. Physician groups are an alternative to salaried employment with a hospital or other healthcare organization.

The Physician Groups in this case contract with hospitals to staff emergency departments as facility-based providers. During the relevant period, patients covered under Blue Plans were treated by the Physician Groups at hospital emergency rooms in Texas. The Physician Groups were out-of-network with regard to the Blue Plans and did not have contracts with those Plans for billing and fee agreements. The Blue Plans paid the Physician Groups only part of what the Blue Plans were billed for the care.

Under the federal Emergency Medical Treatment and Active Labor Act, hospitals and emergency physicians must screen and treat patients suffering medical emergencies regardless of their ability to pay and without inquiring into the existence or nature of the patients' insurance coverage. 42 U.S.C. § 1395dd. Patients

experiencing medical emergencies typically go to the nearest emergency room for treatment by whichever physician is available. As a result, many patients are treated in emergency rooms without knowing if that hospital is in-network, or is preferred by their insurance, and many physicians treat patients without knowing how or if their patients can pay for their services. Because of this information gap, it is common practice in emergency care settings for patients to assign their insurance benefits when they arrive at a hospital emergency room. The emergency provider then pursues reimbursement from the insurer, and the patient is billed for any remaining cost of services.

The Physician Groups, as facility-based providers, use the hospital's registration process and staff to obtain assignments from the patients, typically using the hospital's standard form assigning benefits using language like "any practitioner providing care and treatment" to define the assignment to an unspecified, and at the time of assignment, often unknown, treating provider. The Physician Groups then, on behalf of the relevant member physician, submit a claim for reimbursement to Blue Cross Blue Shield of Texas (BCBSTX) as the in-state "host" plan. BCBSTX transmits the claim to the relevant out-of-state Blue Plan to "adjudicate the claim in accordance with the terms of the patient's health benefit plan . . . and transmit back to BCBSTX the claim determination for processing and payment." BCBSTX is then responsible for paying the Physician Group based on the other Blue Plan's

determinations using funds provided by the out-of-state Blue Plan. The parties agree that this process was used for all the claims at issue in this appeal.

The Patient Protection and Affordable Care Act of 2010 (the ACA) governs payment for out-of-network emergency services in all the claims at issue in this case.[1] The ACA provides, in relevant part:

> A group health plan or health insurance issuer complies with the requirements of [the ACA] if it provides benefits with respect to an emergency service in an amount at least equal to the greatest of the three amounts specified[:] . . . (A) The amount negotiated with in-network providers for the emergency service furnished[;] . . . (B) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services[;] . . . [or] (C) The amount that would be paid under Medicare . . . .

45 C.F.R. § 147.138(b)(3)(i). The Physician Groups allege that BCBSTX, acting as the agent of the Blue Plans, refused to pay these greatest-of-three rates, but compliance with the greatest-of-three rule is not at issue in this appeal.

---

[1] The claims in this case all predate the passage of the Consolidated Appropriations Act of 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020), which altered the "greatest-of-three" rule.

After the claims were partially paid, the Physician Groups pursued appeals under the Plans' appeals processes, which are laid out in a document called the BlueCard manual. The providers allege that they properly submitted appeals under the provider appeals process[2] by submitting the appeals to BCBSTX. The Physician Groups allege that BCBSTX did one of three things in response to each of the appeals. First, they occasionally replied with generic statements that did not explain the underpayment or point to provisions justifying the underpayment, stating simply that "[o]ur records indicate that the claim disposition was based on the member's benefit coverage." Second, they physically mailed back the appeal documents with no other response. Or third, they failed to respond at all. The Physician Groups also claim that BCBSTX sometimes directed them to the out-of-state Blue Plan, but those Plans then referred the Groups back to BCBSTX.

The Physician Groups filed suit in February 2018 against BCBSTX and amended the complaint in February 2019 to add the Blue Plans as defendants. The operative complaint alleges underpayment for 290,000 claims, but following a settlement with BCBSTX and other entities, over 75% of the claims were dismissed. The district court ordered the parties to select representative bellwether claims and thereafter granted summary judgment as to all 182 bellwether claims. *Angelina*

[2] In addition to the providers appeal process, the Blue Plans also have a member appeals process requiring appeals directly to the out-of-state Plans. *See infra* Part IV.

Emergency Med. Assocs. P.A. v. Health Care Serv. Corp., No. 3:18-CV-0425-X, 2024 WL 102666 (N.D. Tex. Jan. 9, 2024).

The bellwether claims differed in a variety of ways.[3] Most importantly, the claims differed in the form of assignment, with five major sub-types:

> 1. A group of assignments assigned rights only to a hospital.
>
> 2. A group of assignments assigned rights to the hospital and facility-based physicians.
>
> 3. A group of assignments assigned rights to the hospital and its agents.
>
> 4. A group of assignments assigned rights to the hospital and "any third party designated by the" hospital.
>
> 5. For twenty-nine bellwether claims, the Physicians Groups were unable to produce written evidence of an assignment and relied on a declaration from their Rule 30(b)(6) witness to establish assignment. *Id.* at *8.

[3] About 92% of the bellwether claims are ERISA claims, with the remaining 8% of claims falling under breach of contract.

The assignments also varied in what rights they assigned. Some assignments entitled facility-based physicians to pursue payment but did not explicitly provide a right to sue, while other assignments explicitly granted the right to appeal. Finally, some of the bellwether claims' underlying Blue Plans contained anti-assignment provisions either barring a member patient from assigning the right to benefits or allowing Blue Plans to pay a provider directly while prohibiting the assignment of other benefits or legal rights. Though the language varies, a representative example reads:

> You may not assign your legal rights or rights to any payments under this Plan. However, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by you or your dependents, but only as a convenience to you. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) you or your dependents under any circumstances.

The district court found that the Physician Groups did not have standing because these assignments of benefits did not actually transfer any rights to the

Physician Groups for multiple, overlapping reasons including: that some Groups did not provide evidence showing that they or their member physicians were "facility-based physicians;" that the Physician Groups and their member physicians were distinct legal entities; that some assignments did not delegate the right to pursue legal relief; that some assignments could not be produced; and that anti-assignment provisions in some of the Blue Plans barred assignment. *Angelina Emergency Med. Assocs. P.A.*, 2024 WL 102666, at *5-10. The district court also found that almost all of the bellwether claims could be dismissed on the alternative basis of failure to exhaust administrative remedies using the member appeals process rather than the provider appeals process, or due to a time bar. *Id.* at *10-15. For any bellwether claims dismissed "on more than one basis," each basis provided "alternate and independent grounds for dismissal." *Id.* at *7 n.60. The district court then severed the bellwether claims and entered final judgment for the Blue Plans on those claims. The Physician Groups appealed.

II.

A grant of summary judgment is reviewed de novo. *Nickell v. Beau View of Biloxi, LLC*, 636 F.3d 752, 754 (5th Cir. 2011). Summary judgment is proper "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." FED. R. CIV. P. 56(a). "[W]here the non-movant bears the burden of proof at trial, the movant may merely point to an absence

of evidence," which "shift[s] to the non-movant the burden of demonstrating by competent summary judgment proof that there is an issue of material fact warranting trial." *Lindsey v. Sears Roebuck & Co.*, 16 F.3d 616, 618 (5th Cir. 1994) (per curiam). "The nonmovant cannot satisfy this burden merely by denying the allegations in the opponent's pleadings but can do so by tendering depositions, affidavits, and other competent evidence to buttress its claim." *Donaghey v. Ocean Drilling & Expl. Co.*, 974 F.2d 646, 649 (5th Cir. 1992). "When assessing whether a dispute to any material fact exists, we consider all of the evidence in the record but refrain from making credibility determinations or weighing the evidence." *Turner v. Baylor Richardson Med.Ctr.*, 476 F.3d 337, 343 (5th Cir. 2007).

III.

The Employee Retirement Income Security Act of 1974 (ERISA) "is designed 'to protect . . . the interests of participants in employee benefit plans and their beneficiaries' by (1) 'requiring the disclosure and reporting to participants and beneficiaries'; (2) 'establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans'; and (3) 'providing for appropriate remedies, sanctions, and ready access to the Federal courts.'" *Tolbert v. RBC Cap. Mkts. Corp.*, 758 F.3d 619, 621 (5th Cir. 2014) (alteration in original) (quoting 29 U.S.C. § 1001(b)). "ERISA does not supply the provider with a basis for bringing its claim directly against the appellants; instead, the provider's standing to bring this lawsuit must be

derived from the beneficiary and it is subject to any restrictions contained in the plan." *Dialysis Newco, Inc. v. Cmty. Health Sys. Grp. Health Plan*, 938 F.3d 246, 250 (5th Cir. 2019). Federal courts lack jurisdiction to hear providers' ERISA claims where there is a deficient assignment or "a valid and enforceable anti-assignment clause[.]" *Id.*

For nearly all the bellwether claims, the district court concluded that the Physician Groups lacked standing based on one or more of fourassignment-related issues: (1) that the Physician Groups were not named in the assignments, (2) that the assignments did not include a right to sue, (3) that the assignments themselves were not produced, and (4) that the underlying Blue Plans contained valid anti-assignment clauses. We address each of these bases in turn.

A.

The district court held that the Physician Groups lacked standing because most of the assignments were made to "health care providers" rather than the physician groups themselves. *Angelina Emergency Med. Assocs. P.A.*, 2024 WL 102666, at *5.[4]

[4] The district court also raised, sua sponte, that "the plaintiffs have not proffered any evidence that a member of their association was a 'facility-based physician' at the time a patient received their health care services," *Angelina Emergency Med. Assocs. P.A.*, 2024 WL 102666, at *5, without providing an opportunity for the Physician Groups to respond or enter such evidence into the record. However, the Blue Plans conceded in their summary judgment motion that it was an "undisputed material fact" that the claims at issue arose "[a]fter treatment by a physician employed by" the Physician Groups. The Physician Groups provided evidence that their doctors

The Physician Groups argue that, although the Groups and their members are distinct legal entities, the Physician Groups are the "providers of treating physicians" and thus "fall well within the scope of the general language of the assignments."[5] Both the district court and the Blue Plans relied on *Innova Hospital San Antonio LP v. Health Care Service Corp.*, No. 3:12-CV-01607, 2019 WL 13177034 (N.D. Tex. Oct. 2, 2019), where a district court found that an assignment of benefits to "Victory Parent Company LLC d/b/a/ 'Victory Medical Center'" could not provide "derivative standing on Plaintiff Victory Medical Southcross," *id.* at *3, because the two were "separate legal entities[,]" *id.* at *4. We need not resolve its correctness because the legal issue presented in Innova Hospital—whether assignment to a specific named entity on an assignment can be attributed to a different entity—is factually distinct from this case. Here, the question is not whether an assignment made to a specific, named doctor also applies to that doctor's physician group; plainly, the two are distinct legal entities. *See Grain Dealers Mut. Ins. Co. v. McKee*, 943 S.W.2d 455, 458

---

received payments on the claims at issue here—that is, evidence that implies they were the treating physician. The district court did not consider this evidence or this undisputed fact at summary judgment. Subject matter jurisdiction can be established by a "plausible set of facts" based on "the complaint supplemented by undisputed facts[.]" *Bank of La. v. FDI*C, 919 F.3d 916, 922 (5th Cir. 2019). The Physician Groups were not obligated to further "prove" undisputed material facts without any direction from the district court that it was disputing those facts sua sponte.

[5] The Physician Groups also argue that the Blue Plans cannot raise this distinction when they previously paid the claims at issue to the Physician Groups. But the pre-litigation payment of the claims cannot waive the jurisdictional requirements for a valid assignment that confers standing. *Coury v. Prot*, 85 F.3d 244, 248 (5th Cir. 1996) ("The parties can never consent to federal subject matter jurisdiction, and lack of such jurisdiction is a defense which cannot be waived.").

(Tex. 1997) (holding that "a corporation is an entity separate from its shareholders" regardless of control and ownership). The question is whether an assignment naming a class of entities, that is, "health care providers" or facility-based providers, encompasses the Physician Groups.

As a threshold matter, the Blue Plans argue that we should not consider extrinsic evidence because the assignments are unambiguous. *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 959 F.2d 569, 573 (5th Cir. 1992), *overruled in part on other grounds by, Access Mediquip, L.L.C. v. UnitedHealthcare Ins. Co.*, 698 F.3d 229 (5th Cir. 2012) (en banc) (per curiam) (holding that in the face of an *un*ambiguous assignment, "[t]he district court erred in . . . considering evidence of the [parties'] intent."). The Physician Groups contend that, at a minimum, the terms used in the assignments are ambiguous in scope. The assignments here are varied, including language such as:

- "I assign all benefits and all interest and rights to Wise Regional Health System and any practitioner providing care and treatment to me[.]"
- "I irrevocably assign to the Hospital and other Healthcare Providers/Practitioners who furnish services to me all benefits payable for services rendered to me[.]"

The Physician Groups argue that these assignments use "plain English for a lay audience," using descriptive "role and conduct" terms to "assign benefits to a readily identifiable class of people: the physicians providing care to those patients."

We can find no court case or contractual language defining the term "provider" in the context of these assignments. Merriam Webster defines "provider" as "one who provides[,]" and contains examples of usage that include companies as providers. *Provider*, MERRIAM-WEBSTER DICTIONARY (11th ed. 2003). An article available on the National Institutes of Health's website from the publication *Federal Practitioner* criticizes the use of the term "provider" and explains that its origins are "in the sense of a contractor being paid for delivering any health-related products and services" and reduces physicians to "dispensers of services rather than [] individuals." Jonathan R. Scarff, *What's in a Name? The Problematic Term "Provider"*, 38 FED. PRAC. 446, 446 (2021). The term "provider" in particular may contemplate both individual doctors and groups of doctors. *See, e.g., Dialysis Newco*, 938 F.3d at 249, 253 (using the term "healthcare provider" to refer to the corporate dialysis institution rather than individual doctors). The terms of the assignment are, therefore, ambiguous. And the mere fact that the hospitals did not "include more precise form-language that explicitly delegates rights to the management entities to which the facility-based physicians belong" does not invalidate the assignment here.

Under Texas law, if a "contract is subject to two or more reasonable interpretations after applying the pertinent rules of construction, the contract is ambiguous, which creates a fact issue on the parties' intent." *King v. Baylor Univ.*, 46 F.4th 344, 362 (5th Cir. 2022) (quoting *Columbia Gas Transmission Corp. v. New Ulm Gas, Ltd.*, 940 S.W.2d 587, 589 (Tex. 1996)). The court should, at a minimum, have allowed the parties to introduce evidence of the intended scope of the assignments in the general practice of business. While the finder of fact may still ultimately find that the Physician Groups were not party to the assignments after this evidence is introduced, the court's grant of summary judgment was improper at this stage.

B.

For thirty-three of the claims, the district court held that the assignments provided only a right to administrative relief rather than the right to seek legal relief. The Physician Groups counter that the plain text of some of these thirty-three assignments goes beyond mere administrative relief, providing several examples:

- "Each person signing … assigns all rights, title, interest and benefits … and authorizes direct payment to the hospital and physicians …. I hereby appoint the hospital, affiliated physicians, and any agent acting on their behalf as my authorized representative to pursue any … legal remedies[.]"

- "I hereby assign and authorize payment … to the Facility, and to any facility-based physician, all insurance benefits …. I consent for the Facility to appeal on my behalf any denial for reimbursement[.]"
- "I assign and authorize payment … to the Facility, and to any Facility-based physician, all insurance benefits …. I consent for the Facility to work on my behalf with my insurance company/companies to get authorization or appeal any denial for reimbursement[.]"

The Blue Plans respond that the Physician Groups cannot rely on this evidence because they failed to cite it before the district court. Before the district court, the Groups advanced several theories related to the issue at hand: they made broad arguments about a right to sue under the assignments, made a specific argument about an assignment example the Blue Plans raised in their brief, and generalized the specific argument to a "subset of the Bellwether Claims." The argument is therefore not waived. *See Bradley v. Allstate Ins. Co.*, 620 F.3d 509, 519 n.5 (5th Cir. 2010) (rejecting the argument that an interpretation of a contract was waived when the district court ruled on the issue, because "[w]e are not bound to overlook the relevant provisions of the policy only because the parties failed to point to them.").

The Blue Plans also argue that these assignments fail because they "do not specifically mention legal rights." This argument is equally unavailing when the assignments assign "all rights" and "all insurance benefits" *in addition to* authorizing direct payment, and mention assigning the right to appeal denials or pursue legal remedies. In *Dialysis Newco*, we explained there was a "degree of distinction between a direct-payment authorization and a full-on assignment of benefits." 938 F.3d at 254. But there is no basis in the law for requiring that an assignment specifically state it provides a right to sue when it assigns "all rights." The district court erred in finding that claims assigning rights or insurance benefits did not assign a right to sue.

C.

The Physician Groups concede that they do not have written assignments for twenty-nine of the bellwether claims. To replace the missing assignments, the Physician Groups instead proffered a declaration from their Rule 30(b)(6) witness, Paul Jordan, the Director of Revenue Assurance with SCP Health. The Physician Groups argued to the district court that an assignment need not be in writing to be effective, citing in support *Encompass Office Solutions, Inc. v. Connecticut General Life Insurance Co.*, No. 3:11-CV-02487, 2017 WL 3268034, at *10 (N.D. Tex. July 31, 2017). The district court followed *Encompass* and held that "witness deposition testimony [i]s, as an evidentiary matter, enough to survive an opposing motion for summary judgment as to whether there was a valid assignment." *Angelina*

Emergency Med. Assocs. P.A., 2024 WL 102666, at *8. But the district court then rejected the Jordan declaration as insufficient under Rule 56 of the Federal Rules of Civil Procedure.

Under Rule 56, "[a]n affidavit or declaration used to support or oppose a motion must be made on personal knowledge, set out facts that would be admissible in evidence, and show that the affiant or declarant is competent to testify on the matters stated." FED. R. CIV. P. 56(c)(4). As the district court correctly pointed out, Jordan's declaration states only that he is employed by SCP Health. He does not provide any basis for having "personal knowledge as to the routines at" the "nearly half-a-hundred physicians associations" or hospitals at issue in the underlying claims. *Angelina Emergency Med. Assocs. P.A.*, 2024 WL 102666, at *8. Even if, as the Physician Groups explain, "SCP Health is the umbrella name for the companies that manage all of the plaintiffs," this cannot explain how a Director of Revenue Assurance at a managerial company could speak to the paperwork practices of hospitals contracting with individual groups.

We credit the district court's factual determination that, at best, "Jordan's declaration . . . creates a fact dispute as to the existence of assignments where he works" but not at the hospitals themselves. *Id.* Because the Physician Groups admit that they do not create, administer, or collect the assignment forms, the district court's dismissal of the claims without a written assignment was reasonable.

D.

In addition to finding issues with specific assignments, the district court held that the underlying health benefit plans for nearly all the claims contained valid anti-assignment clauses prohibiting the assignment of the claims to the Physician Groups. The Physician Groups argue that the Blue Plans are estopped from asserting any anti-assignment clauses because the Blue Plans partially paid the claims and refused to provide the Groups with copies of the health benefit plans that contained the anti-assignment clauses. The Blue Plans claim that the Physician Groups are seeking to assert ERISA estoppel against them. The Physician Groups counter that they are not seeking ERISA estoppel, but instead a separate theory of equitable estoppel laid out in *Hermann*, which predates ERISA estoppel. The Physician Groups have disavowed any reliance on ERISA estoppel. Nevertheless, the district court conflated the estoppel at issue in *Hermann* with ERISA estoppel, and thus improperly applied the ERISA estoppel test to the claims at issue here.

We have recognized ERISA estoppel as a basis for legal relief that lies when a plaintiff shows "(1) a material misrepresentation; (2) reasonable and detrimental reliance upon the representation; and (3) extraordinary circumstances." *Mello v. Sara Lee Corp.*, 431 F.3d 440, 444-45 (5th Cir. 2005).[6] In so doing, we explained that

[6] Prior to 2005, "[t]his circuit ha[d] yet to explicitly adopt ERISA-estoppel as a cognizable legal theory . . . [but] ha[d] considered that the theory could be cognizable given the right set of facts."

"ERISA disfavors generally arguments based on promissory estoppel or on alleged modifications of plan documents that are not made via the plan's internal amendment process." *Id.* at 447 (quoting *Izzarelli v. Rexene Prods. Co.*, 24 F.3d 1506, 1517 (5th Cir. 1994)).

In a separate line of cases predating our adoption of ERISA estoppel, we examined anti-assignment provisions in ERISA cases. First, in *Hermann*, Hermann Hospital sued the insurance company MEBA as an assignee of a patient who was covered by MEBA. *Hermann*, 959 F.2d at 571. Hermann "maintained continuous communication with MEBA, attempting to obtain periodic payments on the claim, but MEBA kept postponing payment, asserting that it was 'investigating' the claim[.]" *Id.* at 574. After Hermann sued, MEBA "for the first time asserted the anti-assignment clause as a basis for its refusal to pay." *Id.* We held that, because "MEBA failed to assert the anti-assignment clause until more than three years after Hermann first requested payment, it is estopped to do so now." *Id.* In particular, we found that "Hermann, which was not privy to the Plan, had no opportunity to review that documentation" containing the anti-assignment clause, and "[i]t was MEBA's responsibility to notify Hermann of that clause if it intended to rely on it to avoid any attempted assignments." *Id.* Although MEBA argued that it was "treat[ing] the

---

Mello, 431 F.3d at 444 (first citing *McCall v. Burlington N./Santa Fe Co.*, 237 F.3d 506, 513 (5th Cir. 2000); and then citing *Weir v. Fed. Asset Disposition Ass'n*, 123 F.3d 281, 290 (5th Cir. 1997)).

assignment document as nothing more than an authorization by [the patient] Mrs. Nicholas for MEBA to pay benefits directly to Hermann" and so did not think the anti-assignment provision was implicated until the suit, we disagreed:

> It had to be clear to MEBA that Hermann, in admitting and providing services to Mrs. Nicholas, was relying on that assignment as its entitlement to recover payment for those Plan benefits that Hermann furnished to Mrs. Nicholas. Thus, it was unreasonable for MEBA to lie behind the log for three years without once asserting the anti-assignment clause, of which Hermann had no knowledge, while duplicitously dragging out the ongoing negotiations to liquidate the claim.

Id.

Later, in a dispute between a provider and an insurer involving an assignment of rights to the provider on the eve of litigation, we validated an anti-assignment clause in an ERISA plan based on the distinction between a "direct-payment authorization and a full-on assignment of benefits." *Dialysis Newco*, 938 F.3d at 254. We factually differentiated *Dialysis Newco* from *Hermann* on the basis that, in *Hermann*, "the benefits plan postponed payments on Hermann's claims for three

years while it investigated the claim. Accordingly, the court held that the plan was estopped from asserting the anti-assignment clause." *Id.* at 255 (citing *Hermann*, 959 F.2d at 573-74). By contrast, in *Dialysis Newco*, the patient assigned the right to sue to the provider four days before the provider brought suit and months after the initial treatment, even though "the plan's plain language, as it would be understood by an average plan participant, unambiguously prohibits the assignment of a beneficiary's legal rights." *Id.* at 255-56. Though estoppel was not at issue in Dialysis Newco because the assignment occurred mere days before litigation, we recognized that Hermann's estoppel was based on three years of "postponed payments," without discussing ERISA estoppel principles. *Id.* Despite the opinion in Mello comprehensively discussing the entire line of ERISA-estoppel cases in this circuit, it did not discuss or even cite *Hermann*, while neither *Hermann* nor *Dialysis Newco* discussed ERISA estoppel.

There is no basis in the case law to suggest that ERISA estoppel and estoppel under *Hermann* are the same legal theories. *See Dwyer v. United Healthcare Ins. Co.*, 115 F.4th 640, 652-53 (5th Cir. 2024) (holding that "[u]nder ERISA, the doctrines of waiver and estoppel can apply" to prevent the plan administrator from invoking defenses under the terms of the policy without applying the specific test of ERISA estoppel). Instead, *Hermann* and ERISA estoppel lay out two distinct types of estoppel. *Hermann*, the earlier-in-time decision, based its estoppel ruling on the

equitable principle that a plan could not wait for years to assert an anti-assignment clause that the third party bearing the assignment had no way of learning about. *Mello* and later ERISA estoppel cases base their rulings on promissory estoppel principles with the added requirement of extraordinary circumstances that would prevent the written plan from controlling. At issue here are plaintiffs that were not parties to the written plans and did not have copies of the plans and were thus not bound by the promissory estoppel principles at issue in *Mello*. The district court erred in assuming the tests for ERISA estoppel under *Mello* and general estoppel in ERISA cases were legally identical and then applying the more stringent, inapplicable ERISA estoppel test.

The critical question is whether the facts of the case and the antiassignment provisions more closely track *Hermann*, estopping the insurers from enforcing the clause, or *Dialysis Newco*, in which estoppel was appropriately not raised because of the timeline of the assignment. Without further evidence about the exact interactions between the parties, *Hermann* seems more applicable. The patients assigned all rights before treatment of emergency conditions, not akin to the second, considered assignment in *Dialysis Newco* where the patient assigned their rights on the eve of litigation. The Physician Groups, who had received partial responsive reimbursement, then attempted to receive full payment from the Blue Plans using

the publicly available manual for provider claims and appeals, and even requested the underlying plan documents, which the Blue Plans did not provide.

The Blue Plans do not address the Physician Groups' allegations, and instead argue that "[i]t is irrelevant whether BCBSTX, a third-party with no responsibility for appeals under any of the healthcare plans at issue, failed to comply with ERISA's requirements." But this is a logical fallacy. As discussed further in Part IV, the Blue Plans essentially argue that the Physician Groups used the incorrect appeals process and therefore were not entitled to the plan documents, *which contained the correct appeals process*. The record does not contain any alternative basis by which the Physician Groups could have learned of the anti-assignment clauses contained within the plans, especially because the Blue Plans did engage in partial payment and discussion with the Groups—just as in *Hermann*. And the Blue Plans do not identify any alternative manner that the Physician Groups should have used to learn of the text of the plans.

The district court committed legal error in applying the incorrect test to determine whether the Blue Plans should be estopped from enforcing the anti-assignment clauses. It is possible that, for some or all claims, the Physician Groups possessed the underlying plans and therefore should have known about the anti-assignment clauses. That is a fact issue that the district court must determine as to each claim.

IV.

The district court held that the Physician Groups failed to exhaust administrative remedies under the applicable plans before filing suit—either through ERISA's requirements for the ERISA claims, or under contract law for the non-ERISA claims—forming an independent basis for dismissal for all but a few of the claims.

ERISA regulations require benefit plans to establish and maintain reasonable claims procedures, including ones governing appeals of adverse benefit determinations. 29 C.F.R. § 2560.503-1(b). "A claimant who is denied benefits under an ERISA plan must exhaust all administrative remedies afforded by the plan before instituting litigation for recovery of benefits." *Lacy v. Fulbright & Jaworski*, 405 F.3d 254, 256 (5th Cir. 2005) (per curiam); *see also Denton v. First Nat'l Bank of Waco*, 765 F.2d 1295, 1300 (5th Cir. 1985) (explaining the purposes of the exhaustion requirement). There are two administrative procedures at issue here. The first is the provider appeals process. Under the BlueCard manual, which was available to the Physician Groups as a publicly available document, the provider was required to submit appeals of unpaid or underpaid claims to the host plan, here BCBSTX. Toni Surratt, the Blue Plans' Rule 30(b)(6) witness, testified that appeals submitted by the provider to the host plan were conveyed to the patient's home plan. The second process is the member appeals process for Blue Plan members to appeal claims decisions. Under the specific terms laid out in the members' plans, members were

required to appeal determinations directly to their home plan and could not appeal to the host plan, BCBSTX. It is undisputed that the Physician Groups exhausted the administrative appeals process for providers and failed to exhaust the appeals process for members. The testimony of the Blue Plans' Rule 30(b)(6) witness shows that, specifically, the BlueCard manual rules were followed:

> Q. You would agree, though, that based on the appeals we just reviewed, providers, the plaintiffs did submit, at least with respect to some of the Bellwethers we looked at, disputes over underpayment amounts to [BCBSTX]; right?
>
> A. I would agree they sent them to Texas.
>
> Q. And under the Blue Card rules, they were required to submit them to Texas, right?
>
> A. That is correct.

Because the Physician Groups were attempting to act on a member assignment, they were required to "take[] all the rights of the assignor, no greater and no less." *Quality Infusion Care, Inc. v. Health Care Serv. Corp.*, 628 F.3d 725, 729 (5th Cir. 2010) (quoting *FDIC v. McFarland*, 243 F.3d 876, 887 n.42 (5th Cir. 2001)). As we have previously explained, "claimants seeking benefits from an ERISA plan" are required to "exhaust available administrative remedies under the plan" before proceeding to court. *Bourgeois v. Pension Plan for Emps. of Santa Fe Int'l Corps.*, 215

F.3d 475, 479 (5th Cir. 2000). Taking Quality Infusion Care and Bourgeois together, in order to claim ERISA benefits as assignees, the Physician Groups must exhaust under the member remedies unless an exception to the exhaustion requirement applies.

ERISA exhaustion is a court-imposed requirement intended to "minimiz[e] the number of frivolous ERISA suits, promot[e] the consistent treatment of benefit claims, provid[e] a nonadversarial dispute resolution process, and decreas[e] the time and cost of claims settlement[,] . . . [as well as] provide a clear record of administrative action if litigation should ensue, and to assure that judicial review is made under the arbitrary and capricious standard, not de novo." *Hall v. Nat'l Gypsum Co.*, 105 F.3d 225, 231 (5th Cir. 1997). However, "a court should not relinquish its jurisdiction because of a failure to exhaust administrative remedies when there was a valid reason for such failure[,]" including the futility or inadequacy of administrative remedies. *Bourgeouis*, 215 F.3d at 481-82 (first citing *Hall*, 105 F.3d at 232; then citing *Zipes v. Trans World Airlines, Inc.*, 455 U.S. 385, 393 (1982) (holding that a failure to exhaust EEOC administrative procedures is not a jurisdictional bar to a federal lawsuit); and then citing *Carl Colteryahn Dairy, Inc. v. W. Pa. Teamsters & Emps. Pension Fund*, 847 F.2d 113, 121 (3d Cir. 1988) (allowing claim under Multiemployer Pension Plan Amendments Act to proceed based on "equitable principles," despite a lack of prior arbitration)).

The Physician Groups raise multiple equitable bases for exemption from ERISA's exhaustion requirements. First, the record reflects multiple attempts by the Physician Groups to request from BCBSTX "[a] description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review." The Physician Groups were entitled to that information as part of the provider appeals process under ERISA regulations, 29 C.F.R. § 2560.503-1(j),[7] but contend they never received this information in response to their appeals. The Physician Groups also allege that BCBSTX sometimes suggested that the appeals be sent to the out-of-state Blue Plans, but that when the Physician Groups sent their appeals out of state, they were referred back to BCBSTX.

The repeated testimony of the Blue Plans' Rule 30(b)(6) witness corroborates that appealing to BCBSTX was the pathway available to the Physician Groups as providers:

> Q: … Sticking with the same example of Texas being the host plan, you have [a Blue Plan] member living and

[7] When a plan "fail[s] . . . [to] follow claims procedures consistent with the requirements" under § 2560.503-1, the "claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies" under ERISA's civil-litigation provision. 29 C.F.R. § 2560.503-1(l)(1). Thus, even if we did not hold that the Physician Groups were exempted from the exhaustion requirement, ERISA regulations would provide a separate basis for finding that the Groups had exhausted their appeals.

> working in Texas, receiving healthcare in Texas, where does that Texas provider submit an appeal … if they want to challenge the payment they received?
>
> A: They would send that to Texas.
>
> Q: And … is that a requirement, that they send it to Texas?
>
> A: Yes.
>
> Q: Where is that requirement derived?
>
> A: As part of the licensure agreement that the plans hold with the Blue Cross Blue Shield Association, they're required to educate all providers within their defined service area, and part of that education says to [the providers,] you're required to communicate … only with your host plan.

At bottom, the Physician Groups argue that they made all possible efforts to obtain the underlying plans and understand alternative appeals processes, while still following the publicly available appeals process, but were not given copies of the plan. We have previously held that a claimant's efforts, or lack thereof, to obtain the plan can be a key fact in finding whether the claimant has cleared the hurdle of ERISA exhaustion. *See Meza v. Gen. Battery Corp.*, 908 F.2d 1262, 1278-79 (5th Cir. 1990). For example, we denied an exception to ERISA's exhaustion requirement where

"there [was] no mention in the record that [the claimant] ever requested plan information from Appellees." *Id.* at 1279. We added that our ruling was "not to say . . . that [the claimant] would have no judicial remedy if Appellees' failure to provide him with pension plan information prejudiced him," citing an out-of-circuit decision that held a "plan administrator's refusal to provide plan documents denied [the] claimant meaningful access to administrative remedies and excused claimant from [the] exhaustion requirement." *Id.* (citing *Curry v. Cont. Fabricators Inc. Profit Sharing Plan*, 891 F.2d 842, 846 (11th Cir. 1990), *abrogated in part on other grounds by, Murphy v. Reliance Standard Life Ins. Co.*, 247 F.3d 1313 (11th Cir. 2001)).

In *Bourgeois*, we again reasoned that an exception did not apply because the claimant "admit[ed] he had a copy of the [relevant] Pension Plan and had read it" and, citing *Meza*, the claimant had "a duty to seek the necessary information." 215 F.3d at 480 (citing *Meza*, 908 F.2d at 1279). And still, in *Bourgeois*, we "estop[ped] the defendants from asserting certain defenses" because "the company presented no evidence" that it provided the claimant with documents showing the proper avenues of exhaustion, and because the defendants "engaged [the claimant] in negotiations regarding his benefits without ever referring him to the proper channels[.]" *Id.* at 482. The Physician Groups have shown that they requested the underlying plans—as required under *Meza* and *Bourgeois*—and that BCBSTX and the Blue Plans did not "refer[] [them] to the proper channels" or direct them toward the actual appeals

process. *Id.* The Blue Plans proffer a circular argument. They argue that the Physician Groups should have used the member appeals process contained in the underlying plan, even though the Physician Groups did not have the underlying plan and requested a copy from the Blue Plans using the provider appeals process. But the Blue Plans failed to provide a copy of the underlying plan through the provider appeals process because the Physician Groups should have used the member appeals process contained in the underlying plan.

Without addressing this circular logic, the district court held that the Physician Groups "have not produced evidence that they've exhausted their administrative remedies," and that "filing appeals to the wrong body[] do[es] not satisfy the exhaustion requirement." *Angelina Emergency Med. Assocs. P.A.*, 2024 WL 102666, at *11. We will not credit the Blue Plans' flawed logic. At a minimum, there is a factual dispute as to whether the Physician Groups could have discovered the member appeals process without action by BCBSTX, and whether it would have been reasonable to require the Physician Groups to undertake that separate process when they were already being partially paid by BCBSTX.[8]

* * *

[8] The district court dismissed thirteen of the non-ERISA claims for failure to exhaust administrative remedies by the contractual language of these plans. This dismissal was improper for the same reasons discussed above—there are factual disputes as to whether the Physician Groups knew the contractual language of the plans, let alone the exhaustion procedures contained therein.

We AFFIRM summary judgment as to the claims with no written assignment in evidence and VACATE summary judgment as to the remaining claims. We REMAND the remaining claims to the district court for evidentiary determinations as to the validity of the underlying assignments and exceptions to exhaustion.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 24-10306

ANGELINA EMERGENCY MEDICINE ASSOCIATES PA; ATASCOSA EMERGENCY MEDICINE ASSOCIATES PA; ATHENS EMERGENCY MEDICINE ASSOCIATES PA; BLUFF CREEK EMERGENCY MEDICINE ASSOCIATES, PA; BREWSTER EMERGENCY MEDICINE ASSOCIATES PA, *Et al.*,

Plaintiffs-Appellants,

versus

BLUE CROSS AND BLUE SHIELD OF ALABAMA; USABLE MUTUAL INSURANCE COMPANY, DOING BUSINESS AS ARKANSAS BLUE CROSS AND BLUE SHIELD; ANTHEM BLUE CROSS LIFE AND HEALTH, DOING BUSINESS AS ANTHEM BLUE CROSS; ROCKY MOUNTAIN HOSPITAL AND MEDICAL SERVICES, DOING BUSINESS AS ANTHEM BLUE CROSS AND BLUE SHIELD OF COLORADO; HIGHMARK BCBSD INCORPORATED; BLUE CROSS AND BLUE SHIELD OF GEORGIA, INCORPORATED; BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA INCORPORATED; WELLMARK, INCORPORATED, DOING BUSINESS AS BLUE CROSS AND BLUE SHIELD OF IOWA, DOING BUSINESS AS WELLMARK BLUE CROSS AND BLUE SHIELD; BLUE CROSS AND BLUE SHIELD OF KANSAS CITY; RIGHTCHOICE MANAGED CARE INCORPORATED; HEALTHY ALLIANCE LIFE INSURANCE COMPANY; HMO MISSOURI INCORPORATED; BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, A MUTUAL INSURANCE COMPANY; BLUE CROSS AND BLUE SHIELD OF NEBRASKA, INCORPORATED; BLUE CROSS BLUE SHIELD OF NORTH DAKOTA; EMPIRE HEALTHCHOICE ASSURANCE INCORPORATED; EMPIRE HEALTHCHOICE HMO INCORPORATED; HEALTHNOW NEW YORK INCORPORATED; COMMUNITY INSURANCE COMPANY, DOING BUSINESS AS BLUE CROSS AND BLUE SHIELD OF OHIO; HIGHMARK INCORPORATED; WELLMARK OF SOUTH DAKOTA INCORPORATED; ANTHEM HEALTH PLANS OF VIRGINIA, INCORPORATED; PREMERA BLUE CROSS; BLUE CROSS OF IDAHO HEALTH SERVICE, INCORPORATED, DOING BUSINESS AS BLUE CROSS OF IDAHO,

Defendants-Appellees,

Appeal from United States District Court
for the Northern District of Texas
USDC No. 3:18-CV-425

Before SMITH, HIGGINSON, and DOUGLAS, *Circuit Judges*.

STEPHEN A. HIGGINSON, *Circuit Judge*:

Plaintiffs-Appellants (the Physician Groups) are fifty-six Texas emergency-medicine physician groups. The Physician Groups sued twenty-four Blue Cross Blue Shield-affiliated plans from outside of Texas (the Blue Plans), alleging that the Blue Plans underpaid the Physician Groups' claims for reimbursement. The Physician Groups alleged that they were owed payments based on patients' assignments of rights under the Blue Plans to the Physician Groups prior to treatment. The district court granted summary judgment on all claims for a variety of independent and overlap-ping reasons related to the different forms and language of the relevant plans. In so doing, the district court ignored the Physician Groups' arguments about ambiguities in contract language and applied the wrong legal standard in determining whether assignments to the Physician Groups were valid. We AFFIRM as to the claims where no written assignment was produced. As to the remaining claims, because nearly all of the issues before us require further examination of the evidentiary record, we VACATE summary judgment in part and REMAND for further proceedings consistent with this opinion.

A physician group generally comprises one or more physicians who have formed a limited liability entity to operate their practice in a smaller or more independent manner. Physician groups are an alternative to salaried employment with a hospital or other healthcare organization.

The Physician Groups in this case contract with hospitals to staff emergency departments as facility-based providers. During the relevant period, patients covered under Blue Plans were treated by the Physician Groups at hospital emergency rooms in Texas. The Physician Groups were out-of-network with regard to the Blue Plans and did not have contracts with those Plans for billing and fee agreements. The Blue Plans paid the Physician Groups only part of what the Blue Plans were billed for the care.

Under the federal Emergency Medical Treatment and Active Labor Act, hospitals and emergency physicians must screen and treat patients suffering medical emergencies regardless of their ability to pay and without inquiring into the existence or nature of the patients' insurance coverage. 42 U.S.C. § 1395dd. Patients experiencing medical emergencies typically go to the nearest emergency room for treatment by whichever physician is available. As a result, many patients are treated in emergency rooms without knowing if that hospital is in-network, or is preferred by their insurance, and many physicians treat patients without knowing how or if their patients can pay for their services. Because of this information gap, it is common

practice in emergency care settings for patients to assign their insurance benefits when they arrive at a hospital emergency room. The emergency provider then pursues reimbursement from the insurer, and the patient is billed for any remaining cost of services.

The Physician Groups, as facility-based providers, use the hospital's registration process and staff to obtain assignments from the patients, typically using the hospital's standard form assigning benefits using language like "any practitioner providing care and treatment" to define the assignment to an unspecified, and at the time of assignment, often unknown, treating provider. The Physician Groups then, on behalf of the relevant member physician, submit a claim for reimbursement to Blue Cross Blue Shield of Texas (BCBSTX) as the in-state "host" plan. BCBSTX transmits the claim to the relevant out-of-state Blue Plan to "adjudicate the claim in accordance with the terms of the patient's health benefit plan . . . and transmit back to BCBSTX the claim determination for processing and payment." BCBSTX is then responsible for paying the Physician Group based on the other Blue Plan's determinations using funds provided by the out-of-state Blue Plan. The parties agree that this process was used for all the claims at issue in this appeal.

The Patient Protection and Affordable Care Act of 2010 (the ACA) governs payment for out-of-network emergency services in all the claims at issue in this case.[1] The ACA provides, in relevant part:

> A group health plan or health insurance issuer complies with the requirements of [the ACA] if it provides benefits with respect to an emergency service in an amount at least equal to the greatest of the three amounts specified[:] . . . (A) The amount negotiated with in-network providers for the emergency service furnished[;] . . . (B) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services[;] . . . [or] (C) The amount that would be paid under Medicare . . . .

45 C.F.R. § 147.138(b)(3)(i). The Physician Groups allege that BCBSTX, acting as the agent of the Blue Plans, refused to pay these greatest-of-three rates, but compliance with the greatest-of-three rule is not at issue in this appeal.

After the claims were partially paid, the Physician Groups pursued appeals under the Plans' appeals processes, which are laid out in a document called the

[1] The claims in this case all predate the passage of the Consolidated Appropriations Act of 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020), which altered the "greatest-of-three" rule.

BlueCard manual. The providers allege that they properly submitted appeals under the provider appeals process[2] by submitting the appeals to BCBSTX. The Physician Groups allege that BCBSTX did one of three things in response to each of the appeals. First, they occasionally replied with generic statements that did not explain the underpayment or point to provisions justifying the underpayment, stating simply that "[o]ur records indicate that the claim disposition was based on the member's benefit coverage." Second, they physically mailed back the appeal documents with no other response. Or third, they failed to respond at all. The Physician Groups also claim that BCBSTX sometimes directed them to the out-of-state Blue Plan, but those Plans then referred the Groups back to BCBSTX.

The Physician Groups filed suit in February 2018 against BCBSTX and amended the complaint in February 2019 to add the Blue Plans as defendants. The operative complaint alleges underpayment for 290,000 claims, but following a settlement with BCBSTX and other entities, over 75% of the claims were dismissed. The district court ordered the parties to select representative bellwether claims and thereafter granted summary judgment as to all 182 bellwether claims. *Angelina Emergency Med. Assocs. P.A. v. Health Care Serv. Corp.*, No. 3:18-CV-0425-X, 2024 WL 102666 (N.D. Tex. Jan. 9, 2024).

[2] In addition to the providers appeal process, the Blue Plans also have a member appeals process requiring appeals directly to the out-of-state Plans. *See infra* Part IV.

The bellwether claims differed in a variety of ways.[3] Most importantly, the claims differed in the form of assignment, with five major sub-types:

> 1. A group of assignments assigned rights only to a hospital.
>
> 2. A group of assignments assigned rights to the hospital and facility-based physicians.
>
> 3. A group of assignments assigned rights to the hospital and its agents.
>
> 4. A group of assignments assigned rights to the hospital and "any third party designated by the" hospital.
>
> 5. For twenty-nine bellwether claims, the Physicians Groups were unable to produce written evidence of an assignment and relied on a declaration from their Rule 30(b)(6) witness to establish assignment. *Id.* at *8.

The assignments also varied in what rights they assigned. Some assignments entitled facility-based physicians to pursue payment but did not explicitly provide a right to sue, while other assignments explicitly granted the right to appeal. Finally,

[3] About 92% of the bellwether claims are ERISA claims, with the remaining 8% of claims falling under breach of contract.

some of the bellwether claims' underlying Blue Plans contained anti-assignment provisions either barring a member patient from assigning the right to benefits or allowing Blue Plans to pay a provider directly while prohibiting the assignment of other benefits or legal rights. Though the language varies, a representative example reads:

> You may not assign your legal rights or rights to any payments under this Plan. However, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by you or your dependents, but only as a convenience to you. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) you or your dependents under any circumstances.

The district court found that the Physician Groups did not have standing because these assignments of benefits did not actually transfer any rights to the Physician Groups for multiple, overlapping reasons including: that some Groups did not provide evidence showing that they or their member physicians were "facility-based physicians;" that the Physician Groups and their member physicians were

distinct legal entities; that some assignments did not delegate the right to pursue legal relief; that some assignments could not be produced; and that anti-assignment provisions in some of the Blue Plans barred assignment. *Angelina Emergency Med. Assocs. P.A.*, 2024 WL 102666, at *5-10. The district court also found that almost all of the bellwether claims could be dismissed on the alternative basis of failure to exhaust administrative remedies using the member appeals process rather than the provider appeals process, or due to a time bar. *Id.* at *10-15. For any bellwether claims dismissed "on more than one basis," each basis provided "alternate and independent grounds for dismissal." *Id.* at *7 n.60. The district court then severed the bellwether claims and entered final judgment for the Blue Plans on those claims. The Physician Groups appealed.

II.

A grant of summary judgment is reviewed de novo. *Nickell v. Beau View of Biloxi, LLC*, 636 F.3d 752, 754 (5th Cir. 2011). Summary judgment is proper "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." FED. R. CIV. P. 56(a). " [W]here the non-movant bears the burden of proof at trial, the movant may merely point to an absence of evidence," which "shift[s] to the non-movant the burden of demonstrating by competent summary judgment proof that there is an issue of material fact warranting trial." *Lindsey v. Sears Roebuck & Co.*, 16 F.3d 616, 618 (5th Cir. 1994) (per curiam).

"The nonmovant cannot satisfy this burden merely by denying the allegations in the opponent's pleadings but can do so by tendering depositions, affidavits, and other competent evidence to buttress its claim." *Donaghey v. Ocean Drilling & Expl. Co.*, 974 F.2d 646, 649 (5th Cir. 1992). "When assessing whether a dispute to any material fact exists, we consider all of the evidence in the record but refrain from making credibility determinations or weighing the evidence." *Turner v. Baylor Richardson Med. Ctr.*, 476 F.3d 337, 343 (5th Cir. 2007).

III.

The Employee Retirement Income Security Act of 1974 (ERISA) "is designed 'to protect . . . the interests of participants in employee benefit plans and their beneficiaries' by (1) 'requiring the disclosure and reporting to participants and beneficiaries'; (2) 'establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans'; and (3) 'providing for appropriate remedies, sanctions, and ready access to the Federal courts.'" *Tolbert v. RBC Cap. Mkts. Corp.*, 758 F.3d 619, 621 (5th Cir. 2014) (alteration in original) (quoting 29 U.S.C. § 1001(b)). "ERISA does not supply the provider with a basis for bringing its claim directly against the appellants; instead, the provider's standing to bring this lawsuit must be derived from the beneficiary and it is subject to any restrictions contained in the plan." *Dialysis Newco, Inc. v. Cmty. Health Sys. Grp. Health Plan*, 938 F.3d 246, 250 (5th Cir. 2019). Federal courts lack jurisdiction to hear providers' ERISA claims

where there is a deficient assignment or "a valid and enforceable anti-assignment clause[.]" *Id.*

For nearly all the bellwether claims, the district court concluded that the Physician Groups lacked standing based on one or more of four assignment-related issues: (1) that the Physician Groups were not named in the assignments, (2) that the assignments did not include a right to sue, (3) that the assignments themselves were not produced, and (4) that the underlying Blue Plans contained valid anti-assignment clauses. We address each of these bases in turn.

A.

The district court held that the Physician Groups lacked standing because most of the assignments were made to "health care providers" rather than the physician groups themselves. *Angelina Emergency Med. Assocs. P.A.*, 2024 WL 102666, at *5.[4]

[4] The district court also raised, sua sponte, that "the plaintiffs have not proffered any evidence that a member of their association was a `facility-based physician' at the time a patient received their health care services," *Angelina Emergency Med. Assocs. P.A.*, 2024 WL 102666, at *5, without providing an opportunity for the Physician Groups to respond or enter such evidence into the record. However, the Blue Plans conceded in their summary judgment motion that it was an "undisputed material fact" that the claims at issue arose "[a]fter treatment by a physician employed by" the Physician Groups. The Physician Groups provided evidence that their doctors received payments on the claims at issue here—that is, evidence that implies they were the treating physician. The district court did not consider this evidence or this undisputed fact at summary judgment. Subject matter jurisdiction can be established by a "plausible set of facts" based on "the complaint supplemented by undisputed facts[.]" *Bank of La. v. FDIC*, 919 F.3d 916, 922 (5th Cir. 2019). The Physician Groups were not obligated to further "prove" undisputed

The Physician Groups argue that, although the Groups and their members are distinct legal entities, the Physician Groups are the "providers of treating physicians" and thus "fall well within the scope of the general language of the assignments."[5] Both the district court and the Blue Plans relied on *Innova Hospital San Antonio LP v. Health Care Service Corp.*, No. 3:12-CV-01607, 2019 WL 13177034 (N.D. Tex. Oct. 2, 2019), where a district court found that an assignment of benefits to "Victory Parent Company LLC d/b/a/ `Victory Medical Center" could not provide "derivative standing on Plaintiff Victory Medical Southcross," *id.* at *3, because the two were "separate legal entities[,]" *id.* at *4. We need not resolve its correctness because the legal issue presented in *Innova Hospital*—whether assignment to a specific named entity on an assignment can be attributed to a different entity—is factually distinct from this case. Here, the question is *not* whether an assignment made to a specific, named doctor also applies to that doctor's physician group; plainly, the two are distinct legal entities. *See Grain Dealers Mut. Ins. Co. v. McKee*, 943 S.W.2d 455, 458 (Tex. 1997) (holding that "a corporation is an entity separate from its shareholders" regardless of control and ownership). The question is whether an assignment naming

material facts without any direction from the district court that it was disputing those facts sua sponte.

[5] The Physician Groups also argue that the Blue Plans cannot raise this distinction when they previously paid the claims at issue to the Physician Groups. But the pre-litigation payment of the claims cannot waive the jurisdictional requirements for a valid assignment that confers standing. *Coury v. Prot*, 85 F.3d 244, 248 (5th Cir. 1996) ("The parties can never consent to federal subject matter jurisdiction, and lack of such jurisdiction is a defense which cannot be waived.").

a *class* of entities, that is, "health care providers" or facility-based providers, encompasses the Physician Groups.

As a threshold matter, the Blue Plans argue that we should not consider extrinsic evidence because the assignments are unambiguous. *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 959 F.2d 569, 573 (5th Cir. 1992), *overruled in part on other grounds by, Access Mediquip, L.L.C. v. UnitedHealthcare Ins. Co.*, 698 F.3d 229 (5th Cir. 2012) (en banc) (per curiam) (holding that in the face of an unambiguous assignment, "[t]he district court erred in . . . considering evidence of the [parties'] intent."). The Physician Groups contend that, at a minimum, the terms used in the assignments are ambiguous in scope. The assignments here are varied, including language such as:

- "I assign all benefits and all interest and rights to Wise Regional Health System and any practitioner providing care and treatment to me[.]"
- "I irrevocably assign to the Hospital and other Healthcare Providers/Practitioners who furnish services to me all benefits payable for services rendered to me[.]"

The Physician Groups argue that these assignments use "plain English for a lay audience," using descriptive "role and conduct" terms to "assign benefits to a readily identifiable class of people: the physicians providing care to those patients."

We can find no court case or contractual language defining the term "provider" in the context of these assignments. Merriam Webster defines "provider" as "one who provides[,]" and contains examples of usage that include companies as providers. *Provider*, MERRIAM-WEBSTER DICTIONARY (11th ed. 2003). An article available on the National Institutes of Health's website from the publication *Federal Practitioner* criticizes the use of the term "provider" and explains that its origins are "in the sense of a contractor being paid for delivering any health-related products and services" and reduces physicians to "dispensers of services rather than [] individuals." Jonathan R. Scarff, *What's in a Name? The Problematic Term "Provider"*, 38 FED. PRAC. 446, 446 (2021). The term "provider" in particular may contemplate both individual doctors and groups of doctors. *See, e.g., Dialysis Newco*, 938 F.3d at 249, 253 (using the term "healthcare provider" to refer to the corporate dialysis institution rather than individual doctors). The terms of the assignment are, therefore, ambiguous. And the mere fact that the hospitals did not "include more precise form-language that explicitly delegates rights to the management entities to which the facility-based physicians belong" does not invalidate the assignment here.

Under Texas law, if a "contract is subject to two or more reasonable interpretations after applying the pertinent rules of construction, the contract is ambiguous, which creates a fact issue on the parties' intent." *King v. Baylor Univ.*, 46 F.4th 344, 362 (5th Cir. 2022) (quoting *Columbia Gas Transmission Corp. v. New Ulm Gas, Ltd.*, 940 S.W.2d 587, 589 (Tex. 1996)). The court should, at a minimum, have allowed the parties to introduce evidence of the intended scope of the assignments in the general practice of business. While the finder of fact may still ultimately find that the Physician Groups were not party to the assignments after this evidence is introduced, the court's grant of summary judgment was improper at this stage.

B.

For thirty-three of the claims, the district court held that the assignments provided only a right to administrative relief rather than the right to seek legal relief. The Physician Groups counter that the plain text of some of these thirty-three assignments goes beyond mere administrative relief, providing several examples:

- "Each person signing … assigns all rights, title, interest and benefits … and authorizes direct payment to the hospital and physicians …. I hereby appoint the hospital, affiliated physicians, and any agent acting on their behalf as my authorized representative to pursue any … legal remedies[.]"

- "I hereby assign and authorize payment … to the Facility, and to any facility-based physician, all insurance benefits …. I consent for the Facility to appeal on my behalf any denial for reimbursement[.]"
- "I assign and authorize payment … to the Facility, and to any Facility-based physician, all insurance benefits …. I consent for the Facility to work on my behalf with my insurance company/companies to get authorization or appeal any denial for reimbursement[.]"

The Blue Plans respond that the Physician Groups cannot rely on this evidence because they failed to cite it before the district court. Before the district court, the Groups advanced several theories related to the issue at hand: they made broad arguments about a right to sue under the assignments, made a specific argument about an assignment example the Blue Plans raised in their brief, and generalized the specific argument to a "subset of the Bellwether Claims." The argument is therefore not waived. *See Bradley v. Allstate Ins. Co.*, 620 F.3d 509, 519 n.5 (5th Cir. 2010) (rejecting the argument that an interpretation of a contract was waived when the district court ruled on the issue, because "[w]e are not bound to overlook the relevant provisions of the policy only because the parties failed to point to them.").

The Blue Plans also argue that these assignments fail because they "do not specifically mention legal rights." This argument is equally unavailing when the assignments assign "all rights" and "all insurance benefits" *in addition to* authorizing direct payment, and mention assigning the right to appeal denials or pursue legal remedies. In *Dialysis Newco*, we explained there was a "degree of distinction between a direct-payment authorization and a full-on assignment of benefits." 938 F.3d at 254. But there is no basis in the law for requiring that an assignment specifically state it provides a right to sue when it assigns "all rights." The district court erred in finding that claims assigning rights or insurance benefits did not assign a right to sue.

C.

The Physician Groups concede that they do not have written assignments for twenty-nine of the bellwether claims. To replace the missing assignments, the Physician Groups instead proffered a declaration from their Rule 30(b)(6) witness, Paul Jordan, the Director of Revenue Assurance with SCP Health. The Physician Groups argued to the district court that an assignment need not be in writing to be effective, citing in support *Encompass Office Solutions, Inc. v. Connecticut General Life Insurance Co.*, No. 3:11-CV-02487, 2017 WL 3268034, at *10 (N.D. Tex. July 31, 2017). The district court followed *Encompass* and held that "witness deposition testimony [i]s, as an evidentiary matter, enough to survive an opposing motion for summary judgment as to whether there was a valid assignment." *Angelina*

Emergency Med. Assocs. P.A., 2024 WL 102666, at *8. But the district court then rejected the Jordan declaration as insufficient under Rule 56 of the Federal Rules of Civil Procedure.

Under Rule 56, "[a]n affidavit or declaration used to support or oppose a motion must be made on personal knowledge, set out facts that would be admissible in evidence, and show that the affiant or declarant is competent to testify on the matters stated." FED. R. CIV. P. 56(c)(4). As the district court correctly pointed out, Jordan's declaration states only that he is employed by SCP Health. He does not provide any basis for having "personal knowledge as to the routines at" the "nearly half-a-hundred physicians associations" or hospitals at issue in the underlying claims. *Angelina Emergency Med. Assocs. P.A.*, 2024 WL 102666, at *8. Even if, as the Physician Groups explain, "SCP Health is the umbrella name for the companies that manage all of the plaintiffs," this cannot explain how a Director of Revenue Assurance at a managerial company could speak to the paperwork practices of hospitals contracting with individual groups.

We credit the district court's factual determination that, at best, "Jordan's declaration . . . creates a fact dispute as to the existence of assignments where he works" but not at the hospitals themselves. *Id.* Because the Physician Groups admit that they do not create, administer, or collect the assignment forms, the district court's dismissal of the claims without a written assignment was reasonable.

D.

In addition to finding issues with specific assignments, the district court held that the underlying health benefit plans for nearly all the claims contained valid anti-assignment clauses prohibiting the assignment of the claims to the Physician Groups. The Physician Groups argue that the Blue Plans are estopped from asserting any anti-assignment clauses because the Blue Plans partially paid the claims and refused to provide the Groups with copies of the health benefit plans that contained the anti-assignment clauses. The Blue Plans claim that the Physician Groups are seeking to assert ERISA estoppel against them. The Physician Groups counter that they are not seeking ERISA estoppel, but instead a separate theory of equitable estoppel laid out in *Hermann*, which predates ERISA estoppel. The Physician Groups have disavowed any reliance on ERISA estoppel. Nevertheless, the district court conflated the estoppel at issue in *Hermann* with ERISA estoppel, and thus improperly applied the ERISA estoppel test to the claims at issue here.

We have recognized ERISA estoppel as a basis for legal relief that lies when a plaintiff shows "(1) a material misrepresentation; (2) reasonable and detrimental reliance upon the representation; and (3) extraordinary circumstances." *Mello v. Sara Lee Corp.*, 431 F.3d 440, 444-45 (5th Cir. 2005).[6] In so doing, we explained that

[6] Prior to 2005, "[t]his circuit ha[d] yet to explicitly adopt ERISA-estoppel as a cognizable legal theory . . . [but] ha[d] considered that the theory could be cognizable given the right set of facts."

"ERISA disfavors generally arguments based on promissory estoppel or on alleged modifications of plan documents that are not made via the plan's internal amendment process." *Id.* at 447 (quoting *Izzarelli v. Rexene Prods. Co.*, 24 F.3d 1506, 1517 (5th Cir. 1994)).

In a separate line of cases predating our adoption of ERISA estoppel, we examined anti-assignment provisions in ERISA cases. First, in *Hermann*, Hermann Hospital sued the insurance company MEBA as an assignee of a patient who was covered by MEBA. *Hermann*, 959 F.2d at 571. Hermann "maintained continuous communication with MEBA, attempting to obtain periodic payments on the claim, but MEBA kept postponing payment, asserting that it was 'investigating' the claim[.]" *Id.* at 574. After Hermann sued, MEBA "for the first time asserted the anti-assignment clause as a basis for its refusal to pay." *Id.* We held that, because "MEBA failed to assert the anti-assignment clause until more than three years after Hermann first requested payment, it is estopped to do so now." *Id.* In particular, we found that "Hermann, which was not privy to the Plan, had no opportunity to review that documentation" containing the anti-assignment clause, and "[i]t was MEBA's responsibility to notify Hermann of that clause if it intended to rely on it to avoid any attempted assignments." *Id.* Although MEBA argued that it was "treat[ing] the

---

Mello, 431 F.3d at 444 (first citing *McCall v. Burlington N./Santa Fe Co.*, 237 F.3d 506, 513 (5th Cir. 2000); and then citing *Weir v. Fed. Asset Disposition Ass'n*, 123 F.3d 281, 290 (5th Cir. 1997)).

assignment document as nothing more than an authorization by [the patient] Mrs. Nicholas for MEBA to pay benefits directly to Hermann" and so did not think the anti-assignment provision was implicated until the suit, we disagreed:

> It had to be clear to MEBA that Hermann, in admitting and providing services to Mrs. Nicholas, was relying on that assignment as its entitlement to recover payment for those Plan benefits that Hermann furnished to Mrs. Nicholas. Thus, it was unreasonable for MEBA to lie behind the log for three years without once asserting the anti-assignment clause, of which Hermann had no knowledge, while duplicitously dragging out the ongoing negotiations to liquidate the claim.

Id.

Later, in a dispute between a provider and an insurer involving an assignment of rights to the provider on the eve of litigation, we validated an anti-assignment clause in an ERISA plan based on the distinction between a "direct-payment authorization and a full-on assignment of benefits." *Dialysis Newco*, 938 F.3d at 254. We factually differentiated *Dialysis Newco* from *Hermann* on the basis that, in *Hermann*, "the benefits plan postponed payments on Hermann's claims for three

years while it investigated the claim. Accordingly, the court held that the plan was estopped from asserting the anti-assignment clause." *Id.* at 255 (citing *Hermann*, 959 F.2d at 573-74). By contrast, in *Dialysis Newco*, the patient assigned the right to sue to the provider four days before the provider brought suit and months after the initial treatment, even though "the plan's plain language, as it would be understood by an average plan participant, unambiguously prohibits the assignment of a beneficiary's legal rights." *Id.* at 255-56. We recognized that *Hermann*'s estoppel was based on three years of "postponed payments," without mentioning ERISA estoppel principles. *Id.* Despite the opinion in *Mello* comprehensively discussing the entire line of ERISA estoppel cases in this circuit, it did not discuss or even cite *Hermann*, while neither *Hermann* nor *Dialysis Newco* discussed ERISA estoppel.

There is no basis in the case law to suggest that ERISA estoppel and estoppel under *Hermann* are the same legal theories. *See Dwyer v. United Healthcare Ins. Co.*, 115 F.4th 640, 652-53 (5th Cir. 2024) (holding that "[u]nder ERISA, the doctrines of waiver and estoppel can apply" to prevent the plan administrator from invoking defenses under the terms of the policy without applying the specific test of ERISA estoppel). Instead, *Hermann* and ERISA estoppel lay out two distinct types of estoppel. *Hermann*, the earlier-in-time decision, based its estoppel ruling on the equitable principle that a plan could not wait for years to assert an anti-assignment clause that the third party bearing the assignment had no way of learning about.

Mello and later ERISA estoppel cases base their rulings on promissory estoppel principles with the added requirement of extraordinary circumstances that would prevent the written plan from controlling. At issue here are plaintiffs that were not parties to the written plans and did not have copies of the plans and were thus not bound by the promissory estoppel principles at issue in *Mello*. The district court erred in assuming the tests for ERISA estoppel under *Mello* and general estoppel in ERISA cases were legally identical and then applying the more stringent, inapplicable ERISA estoppel test.

The critical question is whether the facts of the case and the anti-assignment provisions more closely track *Hermann*, estopping the insurers from enforcing the clause, or *Dialysis Newco*, rejecting estoppel. Without further evidence about the exact interactions between the parties, *Hermann* seems more applicable. The patients assigned all rights before treatment of emergency conditions, not akin to the second, considered assignment in *Dialysis Newco* where the patient assigned their rights on the eve of litigation. The Physician Groups, who had received partial responsive reimbursement, then attempted to receive full payment from the Blue Plans using the publicly available manual for provider claims and appeals, and even requested the underlying plan documents, which the Blue Plans did not provide.

The Blue Plans do not address the Physician Groups' allegations, and instead argue that "[i]t is irrelevant whether BCBSTX, a third-party with no responsibility

for appeals under any of the healthcare plans at issue, failed to comply with ERISA's requirements." But this is a logical fallacy. As discussed further in Part IV, the Blue Plans essentially argue that the Physician Groups used the incorrect appeals process and therefore were not entitled to the plan documents, *which contained the correct appeals process*. The record does not contain any alternative basis by which the Physician Groups could have learned of the anti-assignment clauses contained within the plans, especially because the Blue Plans did engage in partial payment and discussion with the Groups—just as in *Hermann*. And the Blue Plans do not identify any alternative manner that the Physician Groups should have used to learn of the text of the plans.

The district court committed legal error in applying the incorrect test to determine whether the Blue Plans should be estopped from enforcing the anti-assignment clauses. It is possible that, for some or all claims, the Physician Groups possessed the underlying plans and therefore should have known about the anti-assignment clauses. That is a fact issue that the district court must determine as to each claim.

IV.

The district court held that the Physician Groups failed to exhaust administrative remedies under the applicable plans before filing suit—either through

ERISA's requirements for the ERISA claims, or under contract law for the non-ERISA claims—forming an independent basis for dismissal for all but a few of the claims.

ERISA regulations require benefit plans to establish and maintain reasonable claims procedures, including ones governing appeals of adverse benefit determinations. 29 C.F.R. § 2560.503-1(b). "A claimant who is denied benefits under an ERISA plan must exhaust all administrative remedies afforded by the plan before instituting litigation for recovery of benefits." *Lacy v. Fulbright & Jaworski*, 405 F.3d 254, 256 (5th Cir. 2005) (per curiam); *see also Denton v. First Nat'l Bank of Waco*, 765 F.2d 1295, 1300 (5th Cir. 1985) (explaining the purposes of the exhaustion requirement). There are two administrative procedures at issue here. The first is the provider appeals process. Under the BlueCard manual, which was available to the Physician Groups as a publicly available document, the provider was required to submit appeals of unpaid or underpaid claims to the host plan, here BCBSTX. Toni Surratt, the Blue Plans' Rule 30(b)(6) witness, testified that appeals submitted by the provider to the host plan were conveyed to the patient's home plan. The second process is the member appeals process for Blue Plan members to appeal claims decisions. Under the specific terms laid out in the members' plans, members were required to appeal determinations directly to their home plan and could not appeal to the host plan, BCBSTX. It is undisputed that the Physician Groups exhausted the administrative appeals process for providers and failed to exhaust the appeals

process for members. The testimony of the Blue Plans' Rule 30(b)(6) witness shows that, specifically, the BlueCard manual rules were followed:

> Q. You would agree, though, that based on the appeals we just reviewed, providers, the plaintiffs did submit, at least with respect to some of the Bellwethers we looked at, disputes over underpayment amounts to [BCBSTX]; right?
>
> A. I would agree they sent them to Texas.
>
> Q. And under the Blue Card rules, they were required to submit them to Texas, right?
>
> A. That is correct.

Because the Physician Groups were attempting to act on a member assignment, they were required to "take[] all the rights of the assignor, no greater and no less." *Quality Infusion Care, Inc. v. Health Care Serv. Corp.*, 628 F.3d 725, 729 (5th Cir. 2010) (quoting *FDIC v. McFarland*, 243 F.3d 876, 887 n.42 (5th Cir. 2001)). As we have previously explained, "claimants seeking benefits from an ERISA plan" are required to "exhaust available administrative remedies under the plan" before proceeding to court. *Bourgeois v. Pension Plan for Emps. of Santa Fe Int'l Corps.*, 215 F.3d 475, 479 (5th Cir. 2000). Taking Quality Infusion Care and Bourgeois together, in order to claim ERISA benefits as assignees, the Physician Groups must exhaust

under the member remedies unless an exception to the exhaustion requirement applies.

ERISA exhaustion is a court-imposed requirement intended to "minimiz[e] the number of frivolous ERISA suits, promot[e] the consistent treatment of benefit claims, provid[e] a nonadversarial dispute resolution process, and decreas[e] the time and cost of claims settlement[,] . . . [as well as] provide a clear record of administrative action if litigation should ensue, and to assure that judicial review is made under the arbitrary and capricious standard, not de novo." *Hall v. Nat'l Gypsum Co.*, 105 F.3d 225, 231 (5th Cir. 1997). However, "a court should not relinquish its jurisdiction because of a failure to exhaust administrative remedies when there was a valid reason for such failure[,]" including the futility or inadequacy of administrative remedies. *Bourgeouis*, 215 F.3d at 481-82 (first citing *Hall*, 105 F.3d at 232; then citing *Zipes v. Trans World Airlines, Inc.*, 455 U.S. 385, 393 (1982) (holding that a failure to exhaust EEOC administrative procedures is not a jurisdictional bar to a federal lawsuit); and then citing *Carl Colteryahn Dairy, Inc. v. W. Pa. Teamsters & Emps. Pension Fund*, 847 F.2d 113, 121 (3d Cir. 1988) (allowing claim under Multiemployer Pension Plan Amendments Act to proceed based on "equitable principles," despite a lack of prior arbitration)).

The Physician Groups raise multiple equitable bases for exemption from ERISA's exhaustion requirements. First, the record reflects multiple attempts by the

Physician Groups to request from BCBSTX "[a] description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review." The Physician Groups were entitled to that information as part of the provider appeals process under ERISA regulations, 29 C.F.R. § 2560.503-1(j),[7] but contend they never received this information in response to their appeals. The Physician Groups also allege that BCBSTX sometimes suggested that the appeals be sent to the out-of-state Blue Plans, but that when the Physician Groups sent their appeals out of state, they were referred back to BCBSTX.

The repeated testimony of the Blue Plans' Rule 30(b)(6) witness corroborates that appealing to BCBSTX was the pathway available to the Physician Groups as providers:

> Q: … Sticking with the same example of Texas being the host plan, you have [a Blue Plan] member living and working in Texas, receiving healthcare in Texas, where

[7] When a plan "fail[s] . . . [to] follow claims procedures consistent with the requirements" under § 2560.503-1, the "claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies" under ERISA's civil-litigation provision. 29 C.F.R. § 2560.503-1(l)(1). Thus, even if we did not hold that the Physician Groups were exempted from the exhaustion requirement, ERISA regulations would provide a separate basis for finding that the Groups had exhausted their appeals.

> does that Texas provider submit an appeal … if they want to challenge the payment they received?
>
> A: They would send that to Texas.
>
> Q: And … is that a requirement, that they send it to Texas?
>
> A: Yes.
>
> Q: Where is that requirement derived?
>
> A: As part of the licensure agreement that the plans hold with the Blue Cross Blue Shield Association, they're required to educate all providers within their defined service area, and part of that education says to [the providers,] you're required to communicate … only with your host plan.

At bottom, the Physician Groups argue that they made all possible efforts to obtain the underlying plans and understand alternative appeals processes, while still following the publicly available appeals process, but were not given copies of the plan. We have previously held that a claimant's efforts, or lack thereof, to obtain the plan can be a key fact in finding whether the claimant has cleared the hurdle of ERISA exhaustion. *See Meza v. Gen. Battery Corp.*, 908 F.2d 1262, 1278-79 (5th Cir. 1990). For example, we denied an exception to ERISA's exhaustion requirement where "there [was] no mention in the record that [the claimant] ever requested plan

information from Appellees." *Id.* at 1279. We added that our ruling was "not to say . . . that [the claimant] would have no judicial remedy if Appellees' failure to provide him with pension plan information prejudiced him," citing an out-of-circuit decision that held a "plan administrator's refusal to provide plan documents denied [the] claimant meaningful access to administrative remedies and excused claimant from [the] exhaustion requirement." *Id.* (citing *Curry v. Cont. Fabricators Inc. Profit Sharing Plan*, 891 F.2d 842, 846 (11th Cir. 1990), *abrogated in part on other grounds by, Murphy v. Reliance Standard Life Ins. Co.*, 247 F.3d 1313 (11th Cir. 2001)).

In *Bourgeois*, we again reasoned that an exception did not apply because the claimant "admit[ed] he had a copy of the [relevant] Pension Plan and had read it" and, citing *Meza*, the claimant had "a duty to seek the necessary information." 215 F.3d at 480 (citing *Meza*, 908 F.2d at 1279). And still, in *Bourgeois*, we "estop[ped] the defendants from asserting certain defenses" because "the company presented no evidence" that it provided the claimant with documents showing the proper avenues of exhaustion, and because the defendants "engaged [the claimant] in negotiations regarding his benefits without ever referring him to the proper channels[.]" *Id.* at 482. The Physician Groups have shown that they requested the underlying plans—as required under *Meza* and *Bourgeois*—and that BCBSTX and the Blue Plans did not "refer[] [them] to the proper channels" or direct them toward the actual appeals process. *Id.* The Blue Plans proffer a circular argument. They argue that the

Physician Groups should have used the member appeals process contained in the underlying plan, even though the Physician Groups did not have the underlying plan and requested a copy from the Blue Plans using the provider appeals process. But the Blue Plans failed to provide a copy of the underlying plan through the provider appeals process because the Physician Groups should have used the member appeals process contained in the underlying plan.

Without addressing this circular logic, the district court held that the Physician Groups "have not produced evidence that they've exhausted their administrative remedies," and that "filing appeals to the wrong body[] do[es] not satisfy the exhaustion requirement." *Angelina Emergency Med. Assocs. P.A.*, 2024 WL 102666, at *11. We will not credit the Blue Plans' flawed logic. At a minimum, there is a factual dispute as to whether the Physician Groups could have discovered the member appeals process without action by BCBSTX, and whether it would have been reasonable to require the Physician Groups to undertake that separate process when they were already being partially paid by BCBSTX.[8]

* * *

[8] The district court dismissed thirteen of the non-ERISA claims for failure to exhaust administrative remedies by the contractual language of these plans. This dismissal was improper for the same reasons discussed above—there are factual disputes as to whether the Physician Groups knew the contractual language of the plans, let alone the exhaustion procedures contained therein.

We AFFIRM summary judgment as to the claims with no written assignment in evidence and VACATE summary judgment as to the remaining claims. We REMAND the remaining claims to the district court for evidentiary determinations as to the validity of the underlying assignments and exceptions to exhaustion.

APPENDIX C

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

Civil Action No. 3:18-cv-0425-x

ANGELINA EMERGENCY MEDICINE ASSOCIATES P.A., et al.,

Plaintiffs,

v.

HEALTH CARE SERVICE CORPORATION, et al.,

Defendants,

MEMORANDUM OPINION AND ORDER
GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Mary Shelley's Frankenstein tells a story of Victor Frankenstein grieving his mother's death and discovering a way to create human life. As a result, he created a large, brooding, living, breathing, sentient, humanoid creature. But when Victor looked upon the creature's face, he did not see the beauty of life. He saw a monster. His monster. And his monster would later go on to wreak havoc, killing those whom Victor loved.

This case is the legal version of Frankenstein's Monster. In 2018—a year before the undersigned became a judge—49 physician associations brought an 11-count

complaint against Blue Cross Blue Shield, arguing it had underpaid 250,000 claims.[1] It has grown larger since, broadening this legal monster to over fifty physician associations suing around fifty defendants.[2] At the motion-to-dismiss stage, the Court lopped off Counts III–VII of the operative complaint.[3] The defendants now seek to wound Frankenstein's Monster by moving to dismiss the 182 bellwether claims[4] set for trial (Doc. 423) and strike certain expert testimony, (Docs. 417, 419). After reviewing the filings, and the law, the Court **GRANTS** the defendants' Motion for Partial Summary Judgment as to the bellwether claims and **FINDS AS MOOT** the motions to strike expert testimony.

---

[1] Doc. 1 (original complaint) ¶ 13. As the parties note, the operative complaint in this dispute is now the second amended complaint. *See* Doc. 423 at 1 n.1.

[2] Doc. 55 (second amended complaint).

[3] *Angelina Emergency Med. Assocs. PA v. Health Care Serv. Corp.*, 506 F. Supp. 3d 425, 428 (N.D. Tex. 2020) (Starr, J.) (granting in part the defendants' motion to dismiss).

[4] It is somewhat unclear to the Court the precise number of bellwether claims the defendants are seeking to dismiss. Throughout their motion, the defendants state that there are 158 bellwether claims at issue. See e.g., Doc. 424 at 1 n.2. But in the defendants' chart, defendants seek dismissal of 182 bellwether claims. See Doc. 435-2. Perhaps the reason for this discrepancy, 158 versus 182 bellwether claims, is because many parties have dropped out of this case while the Court was considering this motion, response, reply, and sur-reply. See Docs. 444, 451, 456. Nevertheless, the Court analyzed all 182 bellwether claims. To the extent this memorandum opinion and order resolves a bellwether claim on the merits featuring a dismissed party, that party should file a motion for reconsideration. That motion should briefly explain (1) where in the docket the party was dismissed, (2) identify the specific bellwether claim a dismissed party seeks for this court to reconsider, and (3) where, specifically, in this memorandum opinion the court examined the merits of that bellwether claim. Only one motion for reconsideration per side should be filed.

But the Court is well aware that the demise of the bellwethers doesn't mean the whole case is dead yet.[5]

I. Background

The defendants are members of the Blue Cross Blue Shield Association ("BCBSA"). BCBSA is comprised of thirty-three independent and locally operated Blue Cross Blue Shield Plans ("Blue Plans"). These thirty-three independent Blue Plans are each licensed to use BlueCross BlueShield Trademarks within their specific, designated service area. These service areas are geographically based, typically a state or a portion of a state. Generally speaking, the thirty-three independent Blue Plans are prohibited from contracting with providers outside of their geographically based service areas.

Sometimes members need—or rather, obtain—health care services outside of a Blue Plan's geographically limited service area. When this occurs, the health care provider who administered services to the member submits a claim to the local Blue Plan (the "Host Plan"). This out-of-network submission process to the local Host Plan is part of the BlueCard program.

The out-of-network submission process also includes a claim-shifting component. For example, when a health care provider submits a claim for non-

[5] *See* Jones, T., & Gilliam, T. (1975). *Monty Python and the Holy Grail*. Cinema 5 Distributing (relevant clip at https://www.youtube.com/watch?v=EfOW9QrLs0o).

contracted health care services for an out-of-state Blue Plan member to the Host Plan, the Host Plan reviews the claim and sends it to the member's Home Plan. In addition to sending the claim, the Host Plan sends the proposed amount for the member's outof-network health care services to the Home Plan. The Home Plan reviews the claim's information, processes the claim pursuant to the terms of the member's insurance policy, and calculates the amount the Home Plan must pay.

In 2018, approximately half-a-hundred physicians associations sued Blue Cross Blue Shield of Texas arguing that Blue Cross Blue Shield underpaid 250,000 medical claims. Nearly a year later, plaintiffs filed the operative complaint in this case, their second amended complaint, which now included around fifty defendants. In December 2020, the Court dismissed Counts III, IV, V, VI, and VII of plaintiff's complaint. After dismissal, only Counts II, III, VIII, and IX of plaintiffs' complaint remained.[6] In these counts, plaintiffs seek to recover benefits under individualized health benefit plans. For the sake of judicial economy, the parties agreed to deem a small subset of these claims, known as "bellwether claims," as a representative sample of all claims in this case.

The defendants now move for partial summary judgment on 182 "bellwether" claims. While each of these 182 bellwether claims contains particular, individualized,

[6] Claims VIII and IX of plaintiffs' complaint are claims for attorney's fees under ERISA and Texas law. These claims are derivative of plaintiffs remaining substantive claims. Doc. 136 at 53.

and unique facts concerning out-of-network health care services received by a patient, there are also a subset of general facts common among the 182 bellwether claims. The plaintiffs are "physician associations" comprised of various, unidentified members. Some members of these physician groups purportedly staff emergency rooms throughout Texas. When a patient arrives at one of these medical facilities possibly staffed by one member of the plaintiff physician associations, the patient fills out a series of forms provided by the medical facility. Relevant here, one of these forms is an "assignment of benefits" form or contains an assignment-of-benefits clause. As a preview of the upcoming resolution of this motion, these assignment-ofbenefits forms, which vary based on the specific bellwether claim at issue, are key in determining whether the plaintiffs have standing to sue the defendants in this case.

In any event, after signing all relevant intake forms, patients receive health care services by potentially one of the physician members in one of the plaintiffs' physician associations. That health care facility then submits a claim for reimbursement to BlueCross BlueShield Texas (the services are provided in Texas) which then transmits the claim information and allotted (pricing) amount to one of the defendants, who then administers the patients' health benefit plan. The claim is then sent back to BlueCross BlueShield Texas for processing. The price of the claim,

or alternatively, the pricing of the out-of-network health care services received is the substantive, merits issue in this motion.

II. Legal Standard

Summary judgment is appropriate only if, viewing the evidence in the light most favorable to the non-moving party, "the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law."[7] "A fact is material if it 'might affect the outcome of the suit'" and "[a] factual dispute is genuine 'if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.'"[8] Courts "resolve factual controversies in favor of the nonmoving party, but only where there is an actual controversy, that is, when both parties have submitted evidence of contradictory facts."[9]

III. Analysis

The defendants' omnibus partial motion for summary judgment as to the bellwether claims contains six arguments with an appendix spanning 701 exhibits and 32,758 pages. Here's the quick overview of those arguments.

---

[7] FED. R. CIV. P. 56(a).

[8] *Thomas v. Tregre*, 913 F.3d 458, 462 (5th Cir. 2019) (alteration in original) (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)).

[9] *Antoine v. First Student, Inc.*, 713 F.3d 824, 830 (5th Cir. 2013) (cleaned up).

First, the defendants argue that the plaintiffs lack standing because they lack valid and enforceable assignments.[10] Second, the defendants argue that the plaintiffs failed to exhaust their administrative remedies under the patients' health benefit plans before bringing suit in this Court.[11] Third, the defendants argue the plaintiffs' claims are now time-barred because they are untimely.[12] Fourth, the defendants argue that the plaintiffs' ERISA claims fail because the defendants are not ERISA fiduciaries.[13] Fifth, the defendants argue that they have properly paid the bellwether claims.[14] Sixth, the defendants argue that the plaintiffs sued the wrong party for a small subset of the bellwether claims (the non-ERISA claims).[15]

The defendants' first (subject-matter jurisdiction), second (exhaustion of administrative remedies), and third (time-barred) arguments are dispositive.

A. Subject-Matter Jurisdiction

The parties dispute whether this Court has subject-matter jurisdiction over the ERISA claims. First, the defendants note that the plaintiffs must possess "valid and enforceable" assignment of benefits for this Court to have subject-matter

---

[10] Doc. 424 at 21–31.

[11] *Id.* at 32–37.

[12] *Id.* at 51–55.

[13] *Id.* at 56–58.

[14] *Id.* at 37–51.

[15] *Id.* at 55–56.

jurisdiction over the plaintiffs' ERISA claims.[16] Second, the defendants argue that each of the plaintiffs lack "valid and enforceable" assignments in at least one of the following four ways: (1) some patients' health benefit plans contain valid and enforceable *anti*-assignment clauses;[17] some patients' health benefit plans do not contain valid assignments because either (2) some of the plaintiffs are not the named assignees in patients' health benefit plans[18] or (3) some patient health benefit plans contain only putative assignments;[19] and (4) some assignments are not accompanied by a written health benefit plan.[20]

In response, the plaintiffs contest each of these four categories.[21] First, the plaintiffs argue that the defendants have waived their ability to rely on the antiassignment clauses.[22] Second, the plaintiffs argue that those health benefit plans purportedly not naming the plaintiffs as intended assignees do in fact name the plaintiffs as intended assignees.[23] Third, the plaintiffs argue that those "putative"

---

[16] *Id.* at 21–24.

[17] *Id.* at 24–26.

[18] *Id.* at 27–30.

[19] *Id.* at 30–31.

[20] *Id.* at 26.

[21] Doc. 442 at 26–27.

[22] *Id.* at 34–38.

[23] *Id.* at 29–32.

assignments still confer standing.[24] Fourth, the plaintiffs argue that those assignments lacking a written record still confer standing.[25]

The Court agrees with the defendants.

1. Subject-Matter Jurisdiction of ERISA Claims Generally

As a general matter, "ERISA does not supply the provider with a basis for bringing its claim directly against the appellants; instead, the provider's standing to bring this lawsuit must be derived from the beneficiary and it is subject to any restrictions contained in the plan."[26] "An assignment is a manifestation to another person by the owner of a right indicating his intention to transfer, without further action or manifestation of intention, his right to such other person or third person."[27] "Once a valid assignment is made, 'the assignor's right to performance by the obligor is extinguished in whole or in part and the assignee acquires a right to such performance.'"[28] "To decide whether [a party] became an assignee" for purposes of ERISA, a court "examine[s] and consider[s] the entire writing and give[s] effect to all

---

[24] *Id.* at 32–34.

[25] *Id.* at 27–29.

[26] *Dialysis Newco, Inc. v. Cmty. Health Sys. Group Health Plan*, 938 F.3d 246, 250 (5th Cir. 2019).

[27] *Harris Methodist Fort Worth v. Sales Support Servs. Inc. Emp. Health Care Plan*, 426 F.3d 330, 334 (5th Cir. 2005) (cleaned up).

[28] *Id.* (quoting RESTATEMENT (SECOND) OF CONTRACTS § 317(1) (1981)).

provisions such that none are rendered meaningless."[29] Specifically, "[c]ontractual terms receive their ordinary and plain meaning unless the contract indicates the parties intended to give the terms a technical meaning."[30] Additionally, "[w]here a contract is written so that it can be given a definite or certain legal meaning, it is not ambiguous." [31] But "where a contract is subject to two or more reasonable interpretations, it is ambiguous and extrinsic evidence may be considered."[32]

"In addition, ERISA requires that the [summary plan description] be 'written in a manner calculated to be understood by the average plan participant, and . . . be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.'"[33] Indeed, "the very purpose of having a summary plan description of the policy is to enable the average participant in the plan to understand readily the general features of the policy, precisely so that the average participant need not become expert in each and every one of the requirements, provisos, conditions, and qualifications of the policy and its legal terminology."[34]

---

[29] *Id.*

[30] *Id.*

[31] *Id.* (cleaned up).

[32] *Id.*

[33] *Id.* (quoting 29 U.S.C. § 1022)).

[34] *Hansen v. Cont'l Ins. Co.*, 940 F.2d 971, 981 (5th Cir. 1991) (emphasis in original), *abrogated on other grounds by Perez v. Bruister*, 823 F.3d 250 (5th Cir. 2016).

So if any of the plaintiffs' 182 purported assignments fail for any of the defendants' argued reasons, this Court lacks jurisdiction to hear that bellwether claim. Also, the plaintiffs assert jurisdiction in this Court and thus have "the burden of proving it exists"—despite the fact that they are not the movants.[35] This means that the Court will dismiss any bellwether claims where the plaintiffs have not carried their initial burden in proving subject-matter jurisdiction exists.

2. Are Plaintiffs Named Assignees?

The defendants' assert that many of the assignments purporting to confer subject-matter jurisdiction fail because certain patients' health benefit plans do not name the plaintiffs as assignees.[36] More specifically, the defendants argue that certain health benefit plans assign the patient's benefits to a different entity such as a "health care facility" and not to the plaintiffs who are physician associations.[37] In response, the plaintiffs argue that their physician associations fall within one of the various catch-all provisions such as "health care providers."[38] The Court agrees with the defendants.

---

[35] *Peoples Nat'l Bank v. Off. of Comptroller of Currency of U.S.*, 362 F.3d 333, 336 (5th Cir. 2004).

[36] Doc. 424 at 27–30.

[37] *Id.* at 27–30.

[38] Doc. 442 at 30–32.

For this Court to have subject-matter jurisdiction over the ERISA claims, the plaintiffs must be the named assignees of a patient's health benefit plan.[39] Take, for example, an analogous case from this Court: *Innova Hospital San Antonio LP* and *Victory Medical Center Houston, L.P., v. Health Care Services Corp*. In *Innova*, two hospitals in Texas sued forty out-of-state insurance conglomerates seeking reimbursement for products and services offered by Blue Cross Blue Shield.[40] There, the co-plaintiff Victory Medical Center claimed to be the named assignee based on the health plan assigning the patient's benefits to an incredibly similar name—"Victory Parent Company LLC d/b/a 'Victory Medical Center.'" [41] This Court disagreed.[42] Instead, this Court held that the health plan assigning the plaintiff's rights to "Victory Parent Company LLC d/b/a 'Victory Medical Center'" assigned rights only to the expressly listed parent company and not the "separate legal entit[y]" of that company's DBA name because a DBA name "has no legal existence."[43]

---

[39] *See Harris Methodist*, 426 F.3d at 334 (defining an assignment as "a manifestation to another person" (emphasis added)); *see also Innova Hosp. San Antonio LP v. Health Care Serv. Corp.*, No. 3:12-CV-01607, 2019 WL 13177034, at *4 (N.D. Tex. Oct. 2, 2019) (O'Connor, J.) (holding that plaintiff lacked derivative standing under ERISA because "the assignment of benefits unambiguously assign[ed] the patient's rights to" a different company).

[40] *Innova*, 2019 WL 13177034, at *1.

[41] *Id.* at *3 (quoting the plaintiff's health plan).

[42] *Id.* at *4.

[43] *Id.*

In short, an assignment naming one entity cannot confer jurisdiction onto a "separate legal entit[y]."[44]

Here, while the text of each of the 182 bellwether claims varies, most—if not all—of the catch-all provisions used in the patients' health benefit plans assign the right to pursue legal relief to an entity different than the plaintiffs. For example, bellwether claim DW4 assigns its rights to the "Facility[] and Facility-based physicians."[45] The plaintiffs, who are physician associations, are neither the operating "facility" nor a "facility-based physician." In this context, the "facility" is the hospital or other place where DW4 received health care services. And the "facility-based physician" would be the physician working at the place where DW4received health care services.

The plaintiffs argue that they fall under a catch-all provision such as a "facility-based physician" because one member in its association may have been a "facility-based physician" at the time one of the 182 patients received medical care. The plaintiffs' argument fails for two reasons.

First, as an evidentiary matter, the plaintiffs have not proffered any evidence that a member of their association was a "facility-based physician" at the time a patient received their health care services. Sure, the plaintiffs generally state in their

---

[44] *Id.*

[45] Doc. 424-1 at 22.

responsive brief that "[w]hen patients assign their benefits to physicians who provide them care *and those physicians are part of a physician group,* ***as Plaintiffs are***, the physician group falls within the scope of that assignment."[46] But the plaintiffs have not provided evidence as to *who* those physicians might be. And "at the summary judgment stage, [the party invoking federal-court jurisdiction] must set forth by affidavit or other evidence specific facts to survive a motion for summary judgment."[47] The plaintiffs have not provided the evidence of which of its members in one of its associations qualifies as a "facility-based physician." And this Court will not assume it has subject-matter jurisdiction at the summary-judgment stage.

But even if the plaintiffs had provided even a shred of evidence showing that one of its members was a physician for one of the bellwether patients to fall under the catch-all language, they still wouldn't belong in a federal court. Again, the plaintiffs are physician associations whose individual members may have provided health care services in various emergency rooms in Texas. But in Texas, an association and its members are distinct legal entities. By statute, "a professional association has the same powers, privileges, duties, restrictions, and liabilities as a for-profit corporation."[48]

---

[46] Doc. 442 at 32 (emphasis added).

[47] *Legacy Cmty. Health Services, Inc. v. Smith*, 881 F.3d 358, 366 (5th Cir. 2018), as revised (Feb. 1, 2018).

[48] TEX. BUS. ORGS. CODE § 2.108.

Speaking of corporations, "[u]nder Texas law, a corporation is an entity separate from its shareholders."[49] To highlight the point that an association is not its individual members, it's "[a] bedrock principle of corporate law . . . that an individual can incorporate a business and thereby normally shield himself from personal liability for the corporation's contractual obligations."[50] True, while this Court is not opining on the underlying liability between one of the physician associations and one of its members, the point stands that Texas law considers an association and its members distinct legal entities. As a result, even assuming one of the association's members was a "facility-based physician" at the time DW4 received care, the facility-based physician himself would have standing to sue, not the "separate legal entity" that is his association. To hold otherwise, that one member-physician establishes standing for his entire association, would effectively blend an injury to a member and its "separate legal entity."

In short, because an association and its members are distinct legal entities under Texas law, the Court does not have subject-matter jurisdiction here unless the health benefit plan expressly assigns the right to legal relief to one of the plaintiff associations.

---

[49] *Grain Dealers Mut. Ins. Co. v. McKee*, 943 S.W.2d 455, 458 (Tex. 1997).

[50] *Willis v. Donnelly*, 199 S.W.3d 262, 271 (Tex. 2006).

The Court has reviewed each of the 182 bellwether claims and dismisses those claims where one of the plaintiffs is not expressly named in the assignment: DBW1, DBW3, DBW4, DBW5, DBW6, DBW8, DBW9, DBW10, DBW11, DBW13, DBW14,DBW15, DBW16, DBW17, DBW18, DBW19, DBW20, DBW22, DBW23, DBW24, DBW25, DBW28, DBW31, DBW32, DBW34, DBW35, DBW36, DBW37, DBW38, DBW39, DBW40, DBW41, DBW43, DBW44, DBW45, DBW46, DBW47, DBW48, DBW49, DBW50, DBW51/PBW55, DBW52, DBW53, DBW55, DBW56, DBW57, DBW58, DBW65, DBW66, DBW70, DBW73, DBW74, DBW75, DBW78, DBW79, DBW80, DBW82, DBW83, DBW85, DBW86, DBW87, DBW88, DBW89, DBW91, DBW92, DBW93, DBW94, DBW95, DBW96, DBW97, DBW98, DBW99, DBW100, PBW2, PBW3, PBW4, PBW5, PBW6, PBW7, PBW8, PBW9, PBW10, PBW11, PBW13, PBW14, PBW15, PBW16, PBW17, PBW18, PBW19, PBW20, PBW21, PBW22, PBW24, PBW25, PBW26, PBWW30, PBW31, PBW32, PBW33, PBW34, PBW35, PBW37, PBW41, PBW43, PBW44, PBW46, PBW47, PBW48, PBW49, PBW50, PBW52, PBW53, PBW55/DBW51, PBW56, PBW57, PBW65, PBW70, PBW71, PBW72, PBW73, PBW74, PBW75, PBW76, PBW80, PBW81, PBW82, PBW83, PBW84, PBW85, PBW86, PBW88, PBW89, PBW90, PBW91, PBW92, PBW93, PBW94, PBW95, PBW96, and PBW99.[51]

[51] As mentioned earlier, the plaintiffs have submitted no evidence that a member of one of its associations worked at any of the health care facilities at the time a bellwether patient received care. Therefore, the Court cannot hold that the plaintiffs fall under any of the health benefit plans'

3. Putative Assignments

The defendants argue that many of the purported assignments fail because those health benefit plans designate to another entity the right to seek further administrative relief under the plan as an "authorized representative" instead of assigning away the right to seek legal relief,[52] which, again, is required for subject-matter jurisdiction. In response, the plaintiffs concede that, while some patient health benefit plans assign merely the right to pursue administrative relief as an "authorized representative" of the patient,[53] many of the patient health benefit plans also include additional language expressly assigning away the right to pursue judicial relief.[54] The Court agrees with the plaintiffs to an extent.

Health benefit plans can designate away rights to a third party distinct from an assignment to pursue legal relief.[55] For example, the Fifth Circuit has highlighted the distinction between a health plan designating away a "direct-payment

---

catch-all provisions because the Court is lacking documentary evidence that a member of one of the plaintiff associations worked at a health care facility at the relevant time. And because the plaintiffs have the burden to prove they belong in this Court, the Court cannot merely assume that one member of the plaintiffs' association provided health care services at the relevant facility at the relative time.

[52] Doc. 424 at 30–31.

[53] Doc. 442 at 33 ("Even if the Court were to accept the assignee-authorized representative distinction here, *it would only apply to* [*a*] *small subset of the Bellwether Claims*." (emphasis added)).

[54] *Id.* at 32–34.

[55] *See Dialysis Newco, Inc.*, 938 F.3d at 254.

authorization," which does not confer jurisdiction, and a full "assignment."[56] In the Fifth Circuit's words:

> A direct-payment authorization means only that the beneficiary tells the administrator to forward the checks owed to him or her on to the provider instead. An assignment of benefits is more than that. An assignment means that the provider has stepped into the metaphorical shoes of the beneficiary and is capable of exercising all the legal rights enjoyed by the beneficiary under the plan, to include suing the plan and/or its administrator over disputes that might arise in the plan's interpretation.[57]

Here, the defendants argue that many of these purported assignments fall short of assigning away the right to pursue legal relief.[58] Of these contested health benefit plans, the plaintiffs contest only bellwether PBW94 in their brief. While the defendants are correct that PBW94's health benefit plan contains authorized-representative language, such as PBW94 agreeing to "appoint ETMC, and any agent acting on its behalf, as [PBW94's] authorized representative to pursue any claims,

---

[56] *See id.*

[57] *Id.*

[58] *See* Doc. 435-4 (chart outlining invalid assignments).

penalties, and administrative . . . remedies," PBW94's health benefit plan also expressly states that its authorized representative also has the power "to pursue any . . . legal remedies on [PB94's] behalf."[59] The language in PBW94's health benefit plan expressly confers the assignment of rights and not merely the right for an entity to be an "authorized representative."

But the question remains as to *whom* that assignment has been made. PBW94 assigns the right to legal relief to "ETMC." the plaintiffs have proffered no evidence as to ETMC's connection with this case. ETMC does not appear to be a party in this case. For this reason, while PBW94 does assign away the right to pursue legal remedies to ETMC, there is no evidence connecting ETMC to this case. So the Court would lack subject-matter jurisdiction over PBW94.

The Court has reviewed the 182 bellwether claims and dismisses the claims that solely delegate away rights other than the right to pursue legal relief, such as the right to be an "authorized representative" on behalf of the patient: DBW3, DBW4, DBW8, DBW9, DBW10, DBW13, DBW16, DBW17, DBW18, DBW38, DBW40, DBW53, DBW55, DBW57, DBW58, DBW79, DBW99, PBW2, PBW5, PBW6, PBW8,

[59] *See* Doc. 434-16 at 284; Defs.' App. at 30,689.

PBW11, PBW18, PBW34, PBW43, PBW44, PBW52, PBW53, PBW56, PBW57, PBW72, PBW73, and PBW78.[60]

4. Existence of Assignments

The defendants argue that the Court lacks jurisdiction to hear disputes involving 29 bellwether claims that lack a physical, written health plan.[61] In response, the plaintiffs argue that a physical, written health plan is not required to establish jurisdiction because the plaintiffs can prove assignment through testimonial evidence.[62] The Court agrees with neither party.

As to the existence of valid assignments for purported assignments lacking a written health benefit plan, the Court finds the opinion in *Encompass Office Solutions, Inc. v. Connecticut General Life Insurance Co.* persuasive.[63] In *Encompass*, the Court confronted an identical issue—the assignment of patients' health benefit plans at the summary-judgment stage of litigation.[64] Notably, Encompass held that "an assignment of a claim for benefits need not be in writing to be effective unless

[60] In this and the subsequent lists of claims the Court is dismissing, the Court made the list exhaustive rather than just the claims that remained live until this section so the Fifth Circuit knows the Court's alternate and independent grounds for dismissal of a claim that is subject to dismissal on more than one basis.

[61] Doc. 424 at 26.

[62] Doc. 442 at 27–29.

[63] No. 3:11-CV-02487, 2017 WL 3268034, at *10 (N.D. Tex. July 31, 2017) (Lindsay, J.) (holding that the plaintiffs raised a fact dispute as to assignment of health plans).

[64] *Id.* at *6–10.

required by contract or statute."[65] Because of this, Encompass held that the following witness deposition testimony was, as an evidentiary matter, enough to survive an opposing motion for summary judgment as to whether there was a valid assignment:

> We standardly have an assignment of benefits signed by every patient. Everyone has signed one. It is nice to have the assignment of benefits signed. So they understand unequivocally that there is a third party involved in this called Encompass Office Solutions. It is always possible that those assignments could have ended up, A, in the doctor's file, B, in anesthesia's paperwork because we were doing all of their paperwork, or C, could have ended up with the pre-op and postoperative notes that are in our filing system. But we are confident that they signed them. Now, can I find them all? Obviously not, but they were all signed one way or another.[66]

---

[65] *Id.* at *10. It does not appear that the Fifth Circuit has held that a plaintiff can prove the existence of a valid ERISA assignment by oral evidence alone, nor does it appear that the Fifth Circuit has examined the issue directly. At best, in passing, the Fifth Circuit has stated "oral assurances have low probative value in ERISA cases." *Mello v. Sara Lee Corp.*, 431 F.3d 440, 447 n.6 (5th Cir. 2005). Nevertheless, without much more guidance from the Fifth Circuit, the Court will follow what was previously held in this Court—that is, that it is possible that a plaintiff can prove the existence of a valid ERISA assignment by oral evidence alone.

[66] *Id.* at 9 (cleaned up).

Here the plaintiffs lack written assignments for 29 of their 182 bellwether claims. And in an attempt to avoid summary judgment on the bellwether claims in which there is no written assignment, the plaintiffs have provided the declaration of Paul Jordan, the Director of Revenue Assurance with SCP Health.[67] Relevant here, Jordan states that it is "standard practice" at the hospitals where one of the plaintiffs' member physicians works to "routinely receive[] executed assignments of benefits from patients."[68] In following Encompass, Jordan's declaration stating that hospitals routinely administer health benefit forms to patients creates a fact dispute as to the existence of assignments where he works, SCP Health. But Jordan's declaration does not create a fact dispute as to the existence of assignments at other hospitals. The plaintiffs comprise nearly half-a-hundred physicians associations. Jordan lacks personal knowledge as to the routines at other medical facilities besides his own. And under the Federal Rules of Civil Procedure, the Court cannot consider portions of a "declaration used to support or oppose a motion" for summary judgment unless it is "made on personal knowledge."[69]

The next question for the Court is to ask if the plaintiffs have carried their burden in identifying which of these 29 bellwether claims lacking a written health

---

[67] *See* Doc. 443-3 at 2–15; Plaintiffs' App. at 27–40.

[68] Doc. 443-3 at 3 ¶ 8; App. at 28 at ¶ 8.

[69] FED. R. CIV. P. 56(c)(4).

benefit plan involve health care services performed at SCP Health. They haven't. Again, the plaintiffs assert jurisdiction in this Court, and they have "the burden of proving it exists."[70] Yet the plaintiffs have not directed the Court as to which of the 29 bellwether claims at issue were performed at SCP Health. Not a single one.[71] As the Fifth Circuit instructs, a "perfunctory and conclusional assertation that a particular affidavit creates" a fact dispute "normally will not suffice" because "Judges are not pigs, hunting for truffles buried in briefs" or worse—a 182-claim, 725-exhibit, 34,708-page record.[72] In short, the plaintiffs have not carried their burden in proving that Jordan's declaration creates a fact dispute concerning the assignment of 29 bellwether claims lacking a written assignment for health services performed at either SCP Health or elsewhere.

5. Waiver of Anti-Assignment Clauses

The defendants argue that this Court lacks subject-matter jurisdiction over a significant majority of the bellwether claims in this case because the patients' health benefit plans contain anti-assignment clauses.[73] In response, the plaintiffs argue that

---

[70] *Peoples Nat'l Bank*, 362 F.3d at 336.

[71] Doc. 442 at 27–29 (Plaintiffs' Response) (arguing that oral assignments can confer standing to the plaintiffs); Doc. 449-1 (Plaintiffs' Sur-Reply) (containing no argument as to oral assignments and standing).

[72] *See de la O v. Housing Auth. of City of El Paso, Tex.*, 417 F.3d 495, 501 (5th Cir. 2005) (emphasis added) (noting that a "perfunctory and conclusional assertion that a particular affidavit creates" a fact issue "normally will not suffice")

[73] Doc. 424 at 24–26.

the defendants have waived their ability to assert these anti-assignment clauses.[74] The Court agrees with the defendants.

As it pertains to those health benefit plans containing anti-assignment clauses, "[i]f the provider lacks standing to bring the lawsuit due to a valid and enforceable anti-assignment clause, then federal courts lack jurisdiction to hear the case."[75] Although a health benefit plan can include a jurisdiction-stripping, anti-assignment clause, a party can be judicially estopped from asserting an anti-assignment clause in the ERISA context.[76] In the Fifth Circuit, "[t]o establish an ERISA-estoppel claim, the plaintiff must establish: (1) a material misrepresentation; (2) reasonable and detrimental reliance upon the representation; and (3) extraordinary circumstances."[77]

In determining the ERISA-estoppel issue at the summary-judgment stage, many district courts have held that ERISA waiver constitutes a fact dispute resolvable only after trial; this is because district courts have held there are genuine issues of material fact related to the "reasonable" reliance prong.[78]

---

[74] Doc. 442 at 34–38.

[75] *Dialysis Newco, Inc.*, 938 F.3d at 250.

[76] *Mello*, 431 F.3d at 444 ; *see also Grand Parkway Surgery Ctr., LLC v. Health Care Serv. Corp.*, No. 4:15-CV-0297, 2015 WL 3756492, at *2 (S.D. Tex. June 16, 2015) ("In certain circumstances, however, the defendant may have waived or be estopped to assert the anti-assignment provision.").

[77] *Mello*, 431 F.3d at 444–45.

[78] *Jones v. Int'l Bus. Machs. Corp.*, No. 1:19-CV-0251, 2020 WL 6729088, at *6 (W.D. Tex. Nov. 15, 2020) (recommending that the court cannot determine ERISA estoppel at the summary-judgment stage), *report and recommendation adopted*, No. 1:19-CV-0251, 2020 WL 8361930 (W.D.

But this Court takes direction from the Fifth Circuit. And the Fifth Circuit has held that, as a matter of law, a party asserting an ERISA-estoppel claim cannot "reasonably rel[y]"[79] when the reliance runs contrary to the plain meaning of the anti-assignment clause.[80]

To this end, the Fifth Circuit's *Mello v. Sara Lee Corp.* decision warrants additional discussion. The plaintiffs cite *Hermann Hospital v. MEBA Medical and Benefits Plan* for the origin of the ERISA-estoppel theory.[81] Indeed, at base, *Hermann* held that a party can be estopped from relying on an anti-assignment clause.[82] But the Fifth Circuit did not expressly adopt the ERISA-estoppel theory until 20 years after *Hermann* in *Mello*.[83] In expressly adopting the ERISA-estoppel theory, the Mello court held, on appeal at the summary-judgment stage, that the plaintiff could not succeed in proving ERISA-estoppel theory because the plaintiff could not satisfy the

---

Tex. Dec. 29, 2020); *Malbrough v. Kanawha Ins. Co.*, 943 F. Supp. 2d 684, 696 (W.D. La. 2013) (holding that the court cannot determine ERISA estoppel at the summary-judgment stage); *Bunner v. Dearborn Nat'l Life Ins. Co.*, No. 4:18-CV-1820, 2021 WL 2119488 (S.D. Tex. May 25, 2021), *aff'd*, 37 F.4th 267 (5th Cir. 2022) (determining ERISA-estoppel theory after trial).

[79] *Mello*, 431 F.3d at 445.

[80] *Id.* at 447 (citing *Sprague v. GMC*, 133 F.3d 388, 404 (6th Cir. 1998)); *see also High v. E-Sys. Inc.*, 459 F.3d 573, 580 (5th Cir. 2006); *Cell Sci. Sys. Corp. v. La. Health Serv.*, 804 F. App'x 260, 266 (5th Cir. 2020) (per curiam).

[81] *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 959 F.2d 569, 574 (5th Cir. 1992), *overruled by Access Mediquip, L.L.C. v. UnitedHealthcare Ins. Co.*, 698 F.3d 229 (5th Cir. 2012).

[82] *Id.*

[83] *Mello*, 431 F.3d at 444 ("This circuit has yet to explicitly adopt ERISA-estoppel as a cognizable legal theory. . . . We now join other circuits in explicitly adopting ERISA-estoppel as a cognizable theory.").

ERISA-estoppel's "reasonable reliance" prong when the reliance runs counter to the anti-assignment clause's plain language.[84] And, to this point, the Fifth Circuit has cited Mello's holding favorably as recently as three years ago.[85]

Here, although every health benefit plan may differ in its language, many of the anti-assignment clauses are unambiguous. For instance, DBW99's health benefit plan plainly states that the plan's benefits "cannot be transferred":

> Benefits for covered services under this group health plan are for your personal benefit and *cannot be transferred or assigned* to anyone else without our consent. *You are prohibited from* assigning any claim or cause of action arising out of or relating to this group health plan.[86]

The plaintiffs cannot reasonably rely in in defiance of this unambiguous language.[87]

Accordingly, the Court dismisses the following bellwether claims because they contain a valid anti-assignment clause: DBW1, DBW2, DBW3, DBW4, DBW5, DBW6,

---

[84] *Id.* at 447 ("Mello's claim cannot surmount the clear and consistent case law forbidding recognizing reasonable reliance on informal documents in the face of unambiguous Plan terms.").

[85] *See Cell Sci. Sys. Corp.*, 804 F. App'x at 266.

[86] Doc. 443-9 at 616 (emphasis added); Defs.' App. at 26,110 (emphasis added).

[87] In addition, Plaintiffs' waiver argument fails because they have "presented no allegation, argument, or evidence demonstrating 'extraordinary circumstances'"—which is the fourth and final element of an ERISA-estoppel theory. *Cell Sci. Sys. Corp.*, 804 F. App'x at 266 (holding that plaintiff's ERISA-estoppel theory fails at the summary-judgment stage).

DBW11, DBW12, DBW14, DBW17, DBW18, DBW19, DBW20, DBW21, DBW24, DBW26, DBW27, DBW28, DBW29, DBW30, DBW31, DBW32, DBW3, DBW34, DBW35, DBW36, DBW37, DBW38, DBW39, DBW40, DBW41, DBW42, DBW43, DBW44, DBW45, DBW46, DBW47, DBW48, DBW49, DBW50, DBW52, DBW53, DBW54, DBW57, DBW58, DBW65, DBW72, DBW76, DBW77, DBW78, DBW79, DBW81, DBW82, DBW83, DBW84, DBW85, DBW86, DBW87, DBW88, DBW89, DBW90, DBW91, DBW92, DBW93, DBW94, DBW95, DBW96, DBW97, DBW98, DBW99, DBW100, PBW1, PBW2, PBW3, PBW4, PBW6, PBW12, PBW17, PBW18, PBW19, PBW20, PBW21, PBW22, PBW24, PBW25, PBW27, PBW28, PBW29, PBW30, PBW32, PBW33, PBW34, PBW37, PBW38, PBW39 PBW40, PBW41, PBW42, PBW43, PBW44, PBW45, PBW46, PBW47, PBW48, PBW49, PBW50, PBW65, PBW72, PBW76, PBW77, PBW78, PBW79, PBW81, PBW82, PBW83, PBW84, PBW86, PBW87, PBW88, PBW89, PBW90, PBW91, PBW92, PBW93, PBW94, PBW95, PBW96, PBW98, and PBW99.

B. Exhaustion of Administrative Remedies for the ERISA-Governed Plans

The defendant argues that all ERISA-governed plans should be dismissed for the plaintiffs' failure to exhaust administrative remedies under the health benefit plans before filing suit.[88] In response, the plaintiffs argue that they've satisfied the

[88] Doc. 424 at 33–36.

exhaustion requirement because they filed appeals for some bellwether claims to Blue Cross Blue Shield Texas.[89] In the alternative, the plaintiffs argue that they're excused from the exhaustion requirement because the futility exception applies.[90] In reply, the defendants argue that the plaintiffs have not exhausted their administrative remedies because the home plans (and not Blue Cross Blue Shield Texas) is the proper body to which the plaintiffs should have filed appeals.[91] The Court agrees with the defendants.

A claimant "denied benefits under an ERISA plan must exhaust all administrative remedies afforded by the plan before instituting litigation for recovery of benefits."[92] By contrast, "informal attempts to substitute for the formal claims procedure" do not satisfy the exhaustion requirement because it "would frustrate the primary purposes of the exhaustion requirement."[93] "Exceptions to the exhaustion requirement exist where the available administrative remedies either are unavailable or wholly inappropriate to the relief sought, or where the attempt to

---

[89] Doc. 442 at 41–43.

[90] *Id.* at 42–43.

[91] Doc. 448 at 21–22.

[92] *Lacy v. Fulbright & Jaworski, Ltd. Liab. P'ship Long Term Disability Plan*, 405 F.3d 254, 256 (5th Cir. 2005).

[93] *Bourgeois v. Pension Plan for Emps. of Santa Fe Int'l Corps.*, 215 F.3d 475, 480 n.14 (5th Cir. 2000).

exhaust such remedies would be a patently futile course of action."[94] For an exhaustion requirement to be futile, it "usually involv[es] a finding of bias or hostility on the part of the review board."[95]

Here, as an initial matter, the plaintiffs have not produced evidence that they've exhausted their administrative remedies before filing suit. The health benefit plans at issue required the plaintiffs to file appeals regarding Rule of Three determinations to the home plan.[96] As an evidentiary point, the defendants have put evidence into the record that either: (1) the plaintiffs admit that they did not file a formal appeal with the proper body, (2) the plaintiffs admit that they cannot confirm or deny whether they filed a formal appeal to the proper body, and/or (3) that the defendants have no internal record of a formal appeal to the proper body.[97]

The plaintiffs did not rebut the defendants' evidentiary point. Instead, the plaintiffs argue that the appeals process was unclear[98] or that appeals filed to the wrong body constitute exhaustion.[99] While these points may or may not be true, the Fifth Circuit requires the plaintiffs "to offer proof of its compliance with the

---

[94] *Gosselink v. Am. Tel. & Tel., Inc.*, No. 4:97-CV-3854, 1999 WL 33737443, at *2 (S.D. Tex. Aug. 9, 1999).

[95] *Gosselink*, 1999 WL 33737443, at *2 (collecting cases).

[96] *See generally* Doc. 443-15; *see also id.* at 12.

[97] *See* Doc. 435-5 (table summarizing exhaustion of remedies).

[98] Doc. 442 at 39.

[99] *Id.* at 40.

exhaustion requirement"[100] and "informal attempts to substitute for the formal claims procedure," such as filing appeals to the wrong body, do not satisfy the exhaustion requirement.[101]

Second, the plaintiffs' alternative argument that they need not satisfy the exhaustion requirement because an appeal would have been futile fares no better. To prove futility, the plaintiffs must show "hostility or bias on the part of the administrative review committee."[102] Similarly to the exhaustion requirement, the Fifth Circuit requires plaintiffs to offer evidence of hostility or bias. Specifically, this evidentiary showing of hostility or bias must be *more* than statements made by a high-ranking company official stating that an administrative committee would reject a hypothetical appeal.[103] And a showing of hostility must be *more* than claiming that an additional appeal to the same administrative body who rejected the first appeal triggers the futility exception to the exhaustion requirement.[104]

Here, the plaintiffs argue for the futility exception on pages 42 through 43 of their brief.[105] In this section, the plaintiffs offer no evidentiary support suggesting

---

[100] *Trinity Home Dialysis, Inc. v. WellMed Networks, Inc.*, No. 22-10414, 2023 WL 2573914, at *5 (5th Cir. Mar. 20, 2023) (per curiam).

[101] *Bourgeois*, 215 F.3d at 480 n.14.

[102] *McGowin v. ManPower Int'l, Inc.*, 363 F.3d 556, 559 (5th Cir. 2004).

[103] *See Bourgeois*, 215 F.3d at 480.

[104] *Denton v. First Nat'l Bank of Waco*, 765 F.2d 1295, 1300 (5th Cir. 1985).

[105] Doc. 442.

that such an appeal would have been denied on the account of a hostility or bias.[106] In other words, the plaintiffs have offered even less evidentiary support than the Fifth Circuit's *rejected* evidentiary showing of a statement from a high-ranking company employee.[107] At best, in attempting to show hostility, the plaintiffs merely repeat their earlier argument that the appeals process was unclear. The Fifth Circuit has rejected this argument repeatedly.[108] In rejecting this argument, the Fifth Circuit expressly stated that plaintiffs arguing for forgiveness of the exhaustion requirement "are bound by the plan's administrative procedures and must use them before filing suit even if they have no notice of what those procedures are."[109] Even further, the Fifth Circuit "imposes a duty [on the plaintiff] to seek the necessary information even if it has not been made available."[110] So the plaintiffs' argument that the appeals process was unclear falls flat in this Circuit.[111]

---

[106] *Id.* at 42–43.

[107] *Bourgeois*, 215 F.3d at 478, 480 (holding that "we cannot excuse" plaintiff's "failure to exhaust" under the futility exception because the informal "exchang[ing]" of "numerous letters" with the administrative body's chairman stating that plaintiff's claim "would receive no additional consideration" is not strong enough evidentiary support "that the actual Committee would not have considered his claim").

[108] *Meza v. Gen. Battery Corp.*, 908 F.2d 1262, 1279–80 (5th Cir. 1990); *see also Bourgeois*, 215 F.3d at 480; *Trinity Home Dialysis, Inc.*, 2023 WL 2573914, at *5; *Innova*, 2019 WL 13177034, at *5 (district court).

[109] *Bourgeois*, 215 F.3d at 480.

[110] *Id.* (rejecting the plaintiff's argument that his exhaustion should be excused due to incomplete plan information because Fifth Circuit case law "imposes a duty to seek necessary information even if it has not been made available").

[111] An oddity is that the plaintiffs themselves have produced evidence of the proper appeals process. *See generally* Doc. 443-15; *see also id.* at 12. So the Court doubts the plaintiffs' contention

In short, the Court dismisses nearly all bellwether claims because the plaintiffs have not met their initial evidentiary burden of providing "proof of [their] compliance with the exhaustion requirement."[112] And in arguing futility, the plaintiffs have not made any evidentiary showing of hostility or bias.[113]

---

that the appeals process was unclear to the plaintiffs—associations whose members are medical professionals—or that it was difficult to find.

[112] *Trinity Home Dialysis, Inc.*, 2023 WL 2573914, at *5; *Bourgeois*, 215 F.3d at 480; *Meza*, 908 F.2d at 1279 (rejecting the plaintiff's argument that exhaustion was not necessary because the defendants never provided him with a copy of the plan and instead holding that ERISA requires a plaintiff to use a plan's administrative procedures before filing suit even if the plaintiff does not know what those procedures are).

[113] One last point: Although the Fifth Circuit in *Bourgeois* held that the futility exception didn't apply, the Fifth Circuit ultimately excused the plaintiff's non-exhaustion using "equitable estoppel" principles. *Bourgeois*, 215 F.3d at 481; *see also Swanson v. Hearst Corp. Long Term Disability Plan*, 586 F.3d 1016, 1019 (5th Cir. 2009) (distinguishing *Bourgeois*); *Gonzalez v. Aztex Advantage*, 547 F. App'x 424, 428 (5th Cir. 2013) (same). But the Court need not consider equitable estoppel because the plaintiffs have waived it, or worse, expressly disavowed its application to this case. First, the plaintiffs waived *Bourgeois*'s "equitable estoppel" defense by failing to plead it or raise it in their summary judgment response. In the Fifth Circuit, "futility" and "equitable estoppel" are pled separately, and a failing to argue one results in waiver of the other. *See McGowin*, 363 F.3d at 559–60 (considering futility but not equitable estoppel). Here, most of the plaintiffs' briefing on exhaustion is devoted to an argument that the plaintiffs' submission to the wrong administrative body satisfies the exhaustion requirement. *See* Doc. 442 at 14–15. Moreover, the plaintiffs only argue futility (in the alternative) in their final exhaustion paragraph, and they fail to mention equitable estoppel or even cite to *Bourgeois*. *See id.* at 15.

But the plaintiffs go even farther than waiving equitable estoppel by affirmatively disavowing it in their sur-reply:

> [I]n connection with Plaintiffs' exhaustion of administrative remedies, *Plaintiffs do not need to establish ERISA estoppel* to demonstrate that Plaintiffs appealed the Bellwether claims. *See* Dkt. 448 at 11. Plaintiffs' arguments *do not depend on* whether Defendants made *material misrepresentations* to Plaintiffs (indeed, the Blue Card system *does not even allow Plaintiffs to communicate directly* with Defendants). Instead, the question for the Court is whether Plaintiffs have raised a genuine material fact the Plaintiffs exhausted their administrative remedies. The record evidence establishes that (1) Plaintiffs *appealed* the bellwether claims, (2) Plaintiffs were never provided with any meaningful reason for any of the underpayments for any of the Bellwether claims, (3) Plaintiffs were *never clearly and unambiguously instructed* where the appeals were supposed to be sent (but if anything they were told to submit to BCBSTX), and (4)

Accordingly, the Court dismisses the following ERISA bellwether claims for failure to exhaust administrative remedies: DBW1–21, DBW23–40, DBW42–44, DBW46–51, DBW53–58, DBW72–85, DBW87–91, DBW93–97, DBW99, PBW1–21, PBW23, PBW25, PBW27, PBW28, PBW30, PBW32–36, PBW39–53, PBW55–58, PBW65–66, PBW72–74, PBW76–84, PBW86, PBW88–90, PBW93–98, and PBW100.

C. Exhaustion of Administrative Remedies for Non-ERISA Claims

The parties next dispute whether a small subset of bellwether claims not governed by ERISA[114] should be dismissed for failure to exhaust.[115] The defendants

---

> appealing was *futile* because BCBSTX failed to respond to appeals and failed to provide plan documents. *See* Dkt. 442 at 30-35. *Plaintiffs are not required to establish ERISA estoppel to raise a genuine issue of material fact as to exhaustion*. And the fact of whether Plaintiffs have or have not established the elements of ERISA estoppel *is irrelevant*.

Doc. 449-1 at 7 (emphases added). Notably, material misrepresentations by a defendant is a key fact when determining whether *Bourgeois*'s "equitable estoppel" defense applies. *See Bourgeois*, 215 F.3d at 481–82 ("A promissory estoppel theory would recognize such a basis when, as in the current situation, *a claimant relies to his detriment on the words and actions of high-ranking company officers* who purport to negotiate benefit decisions without actual authority" (emphases added)).

[114] Those claims are: DBW22, DBW41, DBW45, DBW52, DBW65, DBW66, DBW71, DBW86, DBW92, DBW98, DBW100, PBW22, PBW24, PBW37, PBW38, PBW54, PBW75, PBW85, PBW87, PBW91, PBW92, and PBW99.

[115] The exhaustion analysis as to the bellwether claims not governed by ERISA is somewhat unnecessary. Many of these claims have been dismissed for lacking subject-matter jurisdiction. For example, one of the non-ERISA claims the defendants argue should be dismissed for failure to exhaust administrative remedies is PBW24. *See* Defs.' App. at 31,346; *id.* at 31,335. Regardless of the exhaustion analysis, PBW24 lacks subject-matter jurisdiction because the PBW24's health benefit plan assigns the right to pursue legal relief to "Christus Spohn Hospital—Kleberg Hospital." *Id.* at 252–53. Christus Hospital is not a plaintiff in this litigation. And even if PBW24's health benefit plan included catch-all language assigning the right to pursue legal relief to "Hospital physicians" (it doesn't), the plaintiffs' brief does not point this Court in the direction of where it can find evidence in the record of what members of the plaintiffs' associations worked in the hospital at the time one of the 182 patients received health care services. Nevertheless, despite PBW24's subject-matter deficiency, the Court includes the exhaustion analysis so the

argue that the non-ERISA bellwether claims include contractual provisions requiring exhaustion of administrative appeals before bringing a claim in court.[116] The plaintiffs' response is two-fold. First, the plaintiffs argue that exhaustion is first a factual question unresolvable at the summary-judgment stage.[117] Second, the plaintiffs state that the defendants have failed to identify any non-ERISA plans requiring exhaustion. The Court agrees with the defendants.[118]

The parties have identified only a single case discussing the exact topic of a non-ERISA-governed health benefit plan contractually requiring exhaustion before suit in a federal or state court.[119] Nevertheless, at base, this issue is one of contract interpretation, so the Court must apply traditional, cookie-cutter principles of contract interpretation.

Fifth Circuit has the benefit of knowing the Court's belief as to all legally fatal deficiencies in each claim.

[116] Doc. 424 at 36–37.

[117] Doc. 442 at 43.

[118] *Id.*

[119] *Nunn v. City of Vernon*, No. 07-02-0486-CV, 2003 WL 22240577, at *2 (Tex. App.—Amarillo Sept. 30, 2003, no pet.) (mem. op.) (enforcing health plan's contractual provision requiring administrative exhaustion before filing suit).

In Texas,[120] when interpreting a contract, "courts must determine the parties' intent as reflected in the terms of the policy itself."[121] To do this, courts "examine the entire agreement and seek to harmonize and give effect to all provisions so that none will be meaningless."[122] More specifically, "no one phrase, sentence, or section [of a contract] should be isolated from its setting and considered apart from the other provisions."[123] "Unless the [contract] dictates otherwise, [courts] give words and phrases their ordinary and generally accepted meaning, reading them in context and in light of the rules of grammar and common usage."[124]

Here, the language used in all but two of the non-ERISA governed plans requires exhaustion before bringing suit. For instance, DBW100 states that "You shall not start legal action against us until You have exhausted the appeal procedure described in this section."[125] And PBW38 mandates that "You have the right to bring suit . . . in state or federal court (as appropriate) only after You have exhausted the

---

[120] Neither side argue what state law applies for this issue. Both sides concede on the subsequent topic of limitations that Texas law applies. So the Court applies Texas law to this issue too. The Court is mindful of the fact that choice of law only becomes an issue when competing laws diverge, and the Court is unaware of any state law that encourages judges to rewrite contracts.

[121] *Nassar v. Liberty Mut. Fire Ins. Co.*, 508 S.W.3d 254, 257–58 (Tex. 2017) (cleaned up).

[122] *Gilbert Tex. Constr., L.P. v. Underwriters at Lloyd's London*, 327 S.W.3d 118, 126 (Tex. 2010).

[123] *Forbau v. Aetna Life Ins. Co.*, 876 S.W.2d 132, 134 (Tex. 1994) (alteration in original).

[124] *RSUI Indem. Co. v. The Lynd Co.*, 466 S.W.3d 113, 118 (Tex. 2015) (second alteration in original).

[125] Doc. 443-9 at 773; Defs.' App. at 26,227.

Appeal of an Adverse Decision."[126] DBW100's and PBW38's language expressly sets a condition precedent (exhaustion of remedies) before filing suit.

After reviewing the record, the Court dismisses the following non-ERISA bellwether claims for failure to exhaust administrative remedies: DBW22,[127] DBW41,[128] DBW65,[129] DBW92,[130] DBW98,[131] DBW100,[132] PBW24,[133] PBW38,[134]

[126] Doc. 427-2 at 60; Defs.' App. at 7,421.

[127] "You may not sue until you have completed the disputed claims process." Def.'s App. at 3,931.

[128] "The Member may not bring a lawsuit to recover Benefits under this Benefit Plan until the Member has exhausted the administrative process described in the section entitled Individual Benefit Determination and Appeal Procedure." *Id.* at 12,903.

[129] *Id.* at 29,112 ("This Procedure is the exclusive method of resolving any Dispute."); *id.* at 29,112–14 (describing review procedure).

[130] "No Court suit shall be brought to recover on this Policy before sixty (60) days after a claim has been submitted in accordance with the terms of this Policy." *Id.* at 21,246.

[131] "You should not start legal action against us until you have exhausted the appeal procedure described in this section." *Id.* at 25,994.

[132] "You should not start legal action against us until you have exhausted the appeal procedure described in this section." *Id.* at 26,227.

[133] "You may not take legal action against us to receive benefits earlier than 60 days after we receive the claim." *Id.* at 7,276.

[134] "You have the right to bring suit (including under ERISA Section 502(a) if applicable) in state or federal court (as appropriate) only after You have exhausted the Appeal of an Adverse Decision, whether or not You pursue External Review." *Id.* at 7,421.

PBW85,[135] PBW87,[136] PBW91,[137] PBW92,[138] and PBW99.[139] As explained below, two claims run through the gauntlet of the above arguments for summary judgment.

D. Timeliness

After reviewing the record, only two bellwether claims survive at this point: DBW71 and PBW54. As to DBW71, the defendants raise limitations and payment.[140] As to PBW54, the defendants raise exhaustion of administrative remedies,[141] limitations, and other contractual limitations. Because both claims are untimely, the Court only reaches the limitations arguments.

The defendants argue that, because Texas law imposes a four-year statute of limitations, any bellwether claim accrued on or before February 19, 2015, which is

---

[135] *See id.* at 16,183–86 (describing a "Level 5 Appeal" made to a "Federal District Court" as the last step to occur, which occurs only if you exhaust the previous stages).

[136] "No Court suit shall be brought to recover on this Policy before sixty (60) days after a claim has been submitted in accordance with the terms of this Policy." *Id.* at 18,960.

[137] "No Court suit shall be brought to recover on this Policy before sixty (60) days after a claim has been submitted in accordance with the terms of this Policy." *Id.* at 19,487.

[138] "No Court suit shall be brought to recover on this Policy before sixty (60) days after a claim has been submitted in accordance with the terms of this Policy." *Id.* at 19,606.

[139] "You shall not start legal action against us prior to the expiration of 60 days after receiving written notice of an adverse determination." *Id.* at 25,727.

[140] Doc. 435-2 at 6.

[141] Unlike the mandatory appeals requirements of the plans in the others claims in Section III.C, *supra*, that the Court held were mandatory, PBW54's text states that the appeals process "must be exhausted as required by ERISA." Defs.' App. at 29,707. PBW54 is a non-ERISA claim, so it is governed by contract. *Id.* at 31,347. ERISA doesn't require appeals of non-ERISA claims. So there is no contractual requirement to appeal PBW54 before filing suit.

four years before the date of the plaintiffs' amended complaint, is time-barred.[142] In response, while the plaintiffs agree that Texas law imposes a four-year statute of limitations, the plaintiffs argue that any bellwether claim accrued on or before February 19, 2014, which is four years before the date of the plaintiffs' original complaint, is time-barred.[143] Regardless of which complaint date applies, the statute of limitations ran on DBW71's and PBW54's claim before the plaintiffs filed their original complaint.

"ERISA does not provide a statute of limitations for suits to recover benefits."[144] Instead, "[t]he limitations period for analogous claims under state law may fill the gap."[145] "In Texas, the most analogous state statute of limitations is the four[-]year limitation governing suits on contracts."[146] "Alternatively, the parties may fill the gap by agreement."[147] And as for when the clock starts, "[u]nder ERISA, a cause of action accrues after a claim for benefits has been made and formally denied."[148]

---

[142] Doc. 424 at 51–54.

[143] Doc. 442 at 54–56.

[144] *Faciane v. Sun Life Assurance Co. of Canada*, 931 F.3d 412, 417 (5th Cir. 2019).

[145] *Id.*

[146] *Dye v. Assocs. First Cap. Corp. Long-Term Disability Plan 504*, 243 F. App'x 808, 809 (5th Cir. 2007) (citing TEX. CIV. PRAC. & REM. CODE § 16.004(a)).

[147] *Faciane*, 931 F.3d at 417.

[148] *Harris Methodist*, 426 F.3d at 337.

Here, DBW71[149] is a payment receipt relating to health care services performed at Houston Methodist Hospital.[150] The total for these services was $773.00, yet the receipt indicates $114.91 was charged.[151] In any event, receipt of this alleged underpayment occurred on August 22, 2013.[152] This is the accrual date of the claim, as there is no record of appeal.[153] This predates the date of the plaintiffs' original complaint: February 20, 2018.[154]

Likewise, PBW54[155] is a payment remittance for healthcare services dated January 31, 2014.[156] There is no record of appeal for this claim, so the Court takes this date as the accrual date. Applying Texas's four-year statute of limitations, DBW71's claim became time-barred on August 22, 2017. And PBW54's claim became time-barred on January 31, 2018. This also predates the date of the plaintiffs' original complaint: February 20, 2018.[157]

---

[149] *See* Doc. 431-7 at 42–45; Defs.' App. at 11,605–09.

[150] Doc. 431-7 at 43–46; Defs' App. at 11,606–69.

[151] *Id.* at 45, 11,608.

[152] *Id.* at 46, 11,609.

[153] Plaintiffs have not provided evidence as to a different accrual date—that is, Plaintiffs have not provided record of an appeal for these services. So the Court will use the date of the payment receipt as the accrual date.

[154] *See* Doc. 1.

[155] *See* Doc. 425-3 at 262–63; Defs.' App. at 536–37.

[156] Doc. 425-3 at 263; Defs.' App. at 537.

[157] *See* Doc. 1.

Therefore, the Court dismisses the two remaining claims, DBW71 and PBW54, as time barred.

IV. Conclusion

Accordingly, the Court **GRANTS** the defendants' Motion for Partial Summary Judgment as to the bellwether claims, (Doc. 423). The Court **DISMISSES WITHOUT PREJUDICE** all bellwether claims but DBW71 and PBW54. Those claims had issues such as exhaustion of administrative remedies and assignment problems that deprive the Court of jurisdiction, so the Court lacks power to reach the merits, and dismissal without prejudice is appropriate. The Court has jurisdiction over DBW71 and PBW54, but those claims are barred by limitations, which is a merits issue. As such, the Court **DISMISSES WITH PREJUDICE** DBW71 and PBW54. Additionally, the Court **FINDS AS MOOT** the Motions to Strike or Exclude Expert Testimony, (Docs. 417, 419).

IT IS SO ORDERED this 9 day of January, 2024.

/s/ Brantley Starr
BRANTLEY STARR
UNITED STATES DISTRICT JUDGE