781 F.3d 182
United States Court of Appeals,
Fifth Circuit.

NORTH CYPRESS MEDICAL CENTER OPERATING COMPANY, LIMITED; North Cypress Medical Center Operating Company GP, L.L.C., Plaintiffs–Appellants Cross–Appellees
v.
CIGNA HEALTHCARE; Connecticut General Life Insurance Company; Cigna Healthcare of Texas, Incorporated, Defendants–Appellees Cross–Appellants.

No. 12–20695. | March 10, 2015.

Opinion

PATRICK E. HIGGINBOTHAM, Circuit Judge:

This is a dispute over an insurer's obligation to pay a hospital for medical services provided to insured patients. Under the insurance plans, patients are to pay for part of their hospital bills and the insurance company covers the rest. The parties dispute whether the hospital may discount patients' portion of the bills without affecting the patients' coverage under their insurance plans.

I.

Houston medical provider North Cypress Medical Center Operating Co., Ltd. and North Cypress Medical Center Operating Co. GP, LLC (collectively, "North Cypress" or "the hospital") sued Cigna Healthcare, Connecticut General Life Insurance Company, and Cigna Healthcare of Texas, Inc. (collectively, "Cigna") for breach of healthcare plans administered or insured by Cigna. North Cypress principally argues that Cigna failed to comply with plan terms and underpaid for covered services. Cigna counter-claimed, arguing that it paid more than was owed; that North Cypress as an out-of-network provider did not charge the patients for coinsurance, but billed Cigna as if it had. The district court dismissed or granted summary judgment on all claims.

A. Cigna's plans

The more than 8,000 insurance plans governing the claims in this case sort into classes along several different lines. Most are funded by employers, with Cigna acting only as an administrator—"Administrative Services Only" or "ASO" plans.[1] Some are funded by Cigna itself—"fully insured" plans. Some limit out-of-network benefits to a set percentage of a charge based on Medicare pricing—"MRC2" plans—while other plans limit reimbursement to a percentage of rates charged by other providers in the geographic area—"MRC1" plans. Patients generally assigned their rights under their insurance plans to North Cypress, though Cigna disputes the existence and adequacy of many assignments.

In general, across the different plans members can seek care from an in-network or out-of-network provider. In-network providers contracted with Cigna to provide services at agreed prices. Out-of-network providers did not. Members are responsible for certain deductibles, copayments, or coinsurance amounts, which are larger if the provider is not in the network.

Cigna maintains that these cost-sharing mechanisms ensure that in-network providers are less costly to patients than out-of-network providers. For example, in some of the plans at issue, once the member satisfies the deductible, the member's coinsurance level at in-network providers is 80%; the plan paying 80% and the member 20%. With an out-of-network provider, the member faces both a higher deductible and a greater coinsurance burden; the plan paying 60% and the member 40% of remaining costs.

Cigna argues that these cost-sharing mechanisms are essential to lower medical and health insurance costs; that incentivizing members to choose in-network providers—who charge both the members and the plans less—reduces overall plan costs, an incentive lost when an out-of-network provider does not require patients to pay all of the coinsurance or other obligations contemplated by the plans.

Relatedly, some or all of the plans at issue[2] contain the following or similar provisions:

> • "[P]ayment for the following is specifically excluded from this plan: ... charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan."[3]
>
> • "[Y]ou and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance."
>
> • "Coinsurance means the percentage of charges

> for Covered Expenses that an insured person is required to pay under the plan."
>
> • "The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance."

B. North Cypress and its billing practices

North Cypress opened its Houston hospital in 2007, boasting a "5 Star Atmosphere" and "all private patient suites with upscale room accommodations, including wood floors and trim[and] flat screen televisions."[4] North Cypress and Cigna unsuccessfully negotiated for an in-network contract prior to the opening. North Cypress then opened as an out-of-network provider after notifying Cigna it was implementing a "prompt pay discount" program through which some patients, for whom North Cypress was out-of-network, would get a discount on their coinsurance obligation if they paid upfront or within a short period of time.[5] North Cypress argues that its discount approach made good business sense because collecting on patient medical bills is expensive and often unrewarding.

North Cypress calculates the total cost of care for a patient based on its main fee schedule—called the "Chargemaster"—which contains prices usually four to six times Medicare rates.[6] Without the prompt pay discount, a patient might be expected to pay 40% of this total Chargemaster cost as her out-of-network coinsurance responsibility, while Cigna would cover the other 60%. If the total Chargemaster cost of care was $10,000, for example, the patient would be expected to cover $4,000. Cigna does not contend that it was ever charged more than its 60% share (here, $6,000) of the Chargemaster rates—the dispute solely concerns the fact that the *patients'* $4,000 portion of the bill was reduced in various ways.

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

If the patient paid the discounted coinsurance amount on time, North Cypress did not bill or attempt to collect any additional amount from the patient.[7] North Cypress would thus collect a substantially reduced amount from the patient in exchange for prompt payment. Importantly, if Cigna refused to pay its full 60% of the Chargemaster rate, North Cypress did not attempt to collect that amount from the patient.

C. Cigna's investigation and response

Cigna was concerned when it learned of North Cypress's prompt pay discount, believing the program would undermine plan incentives designed to encourage providers to join Cigna's network, and patients to seek care within that network. Despite Cigna's concerns, it initially paid North Cypress based on the Chargemaster rates as billed.[8] However, even as it was paying these charges, Cigna mobilized an "interdisciplinary team" to address North Cypress's billing practices and pressure North Cypress to come in-network.[9] The team came up with a multi-pronged approach, which contemplated making "[n]o payment or reduced payment" to North Cypress and convincing plan sponsors to switch to cheaper MRC2 reimbursement, among other measures.[10] Cigna's Special Investigations Unit ("SIU") also surveyed a few dozen members about their experience with North Cypress and eventually received 27 responses,[11] assertedly confirming its suspicion that North Cypress was engaging in "fee forgiving."[12]

In November 2008, Cigna informed North Cypress of SIU's investigation and adopted its "fee-forgiving protocol." Cigna began reimbursing North Cypress for medically necessary services at drastically reduced rates. The sharp reduction was based on two key claims: (1) Cigna claimed that patients were *not insured* for medical costs unless North Cypress billed them for the patient coinsurance responsibility contemplated by their plans; (2) Cigna posited that most North Cypress patients were billed only $100 or less.[13] To reiterate, Cigna's claim was that if North Cypress did not bill patients for their coinsurance responsibility, the patients' had *no insurance coverage* for their medical costs. Given its position that North Cypress billed each patient $100 or less—a miniscule proportion of the plans' anticipated patient coinsurance responsibility—Cigna asserted that patients

were only insured for a likewise miniscule proportion of their medical costs. Cigna justified its interpretation primarily based on language in at least some of the plans excluding from coverage "charges which you are not obligated to pay or for which you are not billed."

In practice, if a member's plan required Cigna to pay 60% of the cost of out-of-network care, and North Cypress reported a $10,000 total cost of care, Cigna would not pay $6,000. Instead, Cigna would assume the patient was billed $100; working backwards from that assumption, Cigna would calculate the "total cost of care" to be only $250. Accordingly, it would reimburse the hospital only $150—sixty percent of $250. Cigna told North Cypress it would calculate payments this way until clear evidence was presented that (1) the charges shown on the claim forms were actual charges for services rendered, and (2) the plan member had paid the applicable out-of-network coinsurance and deductible in accordance with the relevant plan.[14] North Cypress did not disclose the amount it billed any particular patient.[15] The hospital appealed some of Cigna's payment decisions, and argues that it would have been futile to appeal the rest.

Under the plans funded by Cigna rather than employers, it seems clear that Cigna directly benefited from its drastic reductions in reimbursement—Cigna kept the money. The parties dispute whether Cigna likewise stood to gain a portion of the "savings" when it reduced payments under the more numerous Administrative Services Only plans.

D. "Discount Agreements"

Cigna employed third-party re-pricing agents. The re-pricing agents, acting on behalf of Cigna, entered into agreements with medical providers including North Cypress to pay negotiated amounts for particular benefit claims. For example, a provider might accept a reduced reimbursement amount in exchange for quick payment from the insurance plan. All agreements stated that they were subject to the terms of the underlying plan covering the patient. North Cypress and Cigna entered into hundreds of these contracts with regard to specific claims. Cigna later refused to pay the negotiated amounts agreed to in the contracts because of the same concerns about "fee forgiving."

II. District Court Proceedings

North Cypress filed a First Amended Complaint asserting that Cigna failed to comply with group plan terms, breached fiduciary duties, failed to provide full and fair reviews of denied claims, violated claims procedures, and failed to provide requested information, all in violation of ERISA. The First Amended Complaint also asserted state-law breach of contract claims and violations of the Texas Insurance Code. The district court dismissed the Texas Insurance Code claims, concluding they were preempted by ERISA.[16] North Cypress then filed a Second Amended Complaint, adding claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"). The district court dismissed the RICO claims under Rule 12(b)(6).[17]

Cigna filed its answer and counterclaims, asserting state-law claims for fraud, negligent misrepresentation, and unjust enrichment. The district court dismissed these claims, concluding they were preempted by ERISA. Cigna filed an amended complaint asserting ERISA claims, and the parties filed cross-motions for summary judgment.

The district court dismissed North Cypress's ERISA claims for want of standing[18] and Cigna's ERISA claims as time barred.[19] Finally, the district court granted summary judgment against North Cypress's breach of contract claims, concluding there was no breach.[20]

North Cypress appeals and Cigna cross-appeals.

* * * * *

VII.

North Cypress argues that it properly pled claims under RICO. The district court held that North Cypress failed to state a plausible claim upon which relief could be granted under any RICO provision, and thus dismissed these claims under Rule 12(b)(6).[108]

Subsections 1962(a)-(d) of RICO essentially state that:

> (a) a person who has received income from a pattern of racketeering activity cannot invest that income in an enterprise;
>
> (b) a person cannot acquire or maintain an interest in an enterprise through a pattern of racketeering activity;
>
> (c) a person who is employed by or associated with an enterprise cannot conduct the affairs of the enterprise through a pattern of racketeering activity;

and
(d) a person cannot conspire to violate subsections (a), (b), or (c).[109]

Three elements are common to claims brought under any of these subsections: "(1) a person who engages in (2) a pattern of racketeering activity, (3) connected to the acquisition, establishment, conduct, or control of an enterprise."[110] The district court found that North Cypress presented sufficient facts to plead a pattern of racketeering activity,[111] but not the individual RICO subsections. We consider each subsection in turn.

A. 18 U.S.C. § 1962(a)

Subsection 1962(a) prohibits a person who has received income from a pattern of racketeering activity from investing that income in an enterprise.[112] To state a claim under § 1962(a), North Cypress had to plead: "(1) the existence of an enterprise, (2) the defendant's derivation of income from a pattern of racketeering activity, and (3) the use of any part of that income in acquiring an interest in or operating the enterprise."[113] Additionally, North Cypress had to show a nexus between the claimed violations and injury.[114] The injury "must flow from the use or investment of racketeering income."[115] "[A]lleging an injury solely from the predicate racketeering acts themselves is not sufficient because § 1962(a) does not prohibit those acts."[116]

The district court found two deficiencies in North Cypress's § 1962(a) pleading. First, North Cypress did not plead that Cigna used any part of its income to acquire an interest in or operate the alleged enterprise.[117] Second, North Cypress did not explain how the use or investment of racketeering income injured North Cypress.[118] North Cypress does not challenge these two specific determinations, offering only the conclusion that it sufficiently pled a § 1962(a) violation. This is not sufficient. The district court did not err in dismissing this claim.

B. 18 U.S.C. § 1962(b)

To state a claim under § 1962(b), North Cypress had to show that its injuries "were proximately caused by a RICO person gaining an interest in, or control of, the enterprise through a pattern of racketeering activity"—a nexus requirement.[119] The district court found that North Cypress did not successfully plead a nexus between its claimed injuries and Cigna's acquisition or maintenance of an interest in the enterprise.[120] On appeal, North Cypress insists in general terms that it successfully pled a § 1962(b) violation, but it does not explain how it showed such a nexus. The district court was correct in dismissing this claim.

C. 18 U.S.C. § 1962(c)

Subsection 1962(c) "prohibits any *person* employed by or associated with any *enterprise* from participating in or conducting the affairs of the enterprise through a pattern of racketeering activity."[121] To state a claim under § 1962(c), North Cypress had to demonstrate, among other things, "that the RICO person is distinct from the RICO enterprise."[122]

There are two Cigna enterprises involved in this case: Cigna Healthcare, Connecticut General Life Insurance Company ("CGLIC"), and Cigna Healthcare of Texas, Inc. ("CHT"). North Cypress asserts that CGLIC is the "person" under § 1961(c) because it is the parent or controlling company. And that CGLIC "has taken steps to cause [CHT] to be an 'enterprise' for illegal racketeering activities under the guise and direction of Cigna's alleged fee forgiving investigations."[123] But, as the district court correctly noted, simply alleging that the parent company is the RICO person and the subsidiary is the RICO enterprise cannot satisfy the distinctiveness requirement.[124] Because North Cypress did not sufficiently demonstrate that CGLIC and CHT were distinct, it did not state a plausible claim for relief. The district court was correct in dismissing this claim.

D. 18 U.S.C. § 1962(d)

Subsection 1962(d) prohibits a conspiracy to violate §§ 1962(a), (b), or (c).[125] To prevail on a RICO conspiracy claim, North Cypress had to demonstrate "(1) that two or more people agreed to commit a substantive RICO offense and (2) that [the defendants] knew of and agreed to the overall objective of the RICO offense."[126] Since North Cypress failed to properly plead a claim under §§ 1962(a), (b), or (c), it correspondingly failed to properly plead a claim under § 1962(d).[127] The district court correctly dismissed North Cypress's conspiracy claims. The district court was correct in its determination that North Cypress failed to plead a violation under any of the

RICO subsections, and we affirm.

* * * * *

We VACATE the district court's grants of summary judgment against North Cypress's ERISA claims and breach of contract claims,[155] and REMAND for further proceedings. We AFFIRM the remainder of the district court's judgment.

Footnotes

1 Although Cigna only administered many of the plans, we will sometimes speak in terms of what Cigna "owes" for simplicity.

2 There are thousands of plans involved in this case, but only a few appear in the record. Both parties make broad generalizations about plan language.

3 At least one of the plans, however, states that this exclusion does not apply if the "expenses are considered Medically Necessary."

4 As advertised on its website. *See* R. 9339.

5 While the parties appear to agree that emergency services and services under government-sponsored plans were not to be discounted under the "prompt pay" program, Cigna asserts that North Cypress discounted such services as well.

6 In the admitting process, patients acknowledge their ultimate responsibility for this total cost of care, even the portion covered by insurance.

7 The parties appear to dispute whether North Cypress would bill or attempt to collect the patients' full non-discounted portion of the bill (e.g. their full 40% of the total Chargemaster cost) if they *failed* to pay the discounted amount on time.

8 In other words, Cigna accepted the Chargemaster rate as the total cost of care (subject to the plan's Maximum Reimbursable Charge), and calculated its share of the cost based on that rate.

9 R. 9006, 9021.

10 R. 9009.

11 The parties dispute whether the survey was random. The district court found that the results showed 12 members were billed nothing, 6 members were billed $102 or less, and 7 members were billed amounts of $320 or more. Two members could not remember what they were billed. No members were billed the amount contemplated by their insurance plans.
Cigna also points to other evidence, such as notices from North Cypress, phone calls with North Cypress employees, and a North Cypress flier.

12 Cigna refers to the practice of not charging members the full rate for their share of costs under the plan, while continuing to charge Cigna its share as "fee forgiving."

13 A position drawn largely from the results of its modest survey.

14 When reduced payments were appealed, Cigna would likewise explain that it would not increase payment unless it was given evidence that the patient was held financially responsible for her portion of the total charge reported by North Cypress.

15 Mem. and Order of August 10, 2012, 14.

16 Mem. and Order of March 2, 2011, 29–33.

17 Mem. and Order of November 3, 2011, 21.

18 Mem. and Order of June 25, 2012, 18–19.

19 Mem. and Order of July 25, 2012, 17.

20 Mem. and Order of August 10, 2012, 20.

21 *Rivera v. Wyeth–Ayerst Labs.,* 283 F.3d 315, 319 (5th Cir.2002).

22 *Id.*

23 *Ford Motor Co. v. Tex. Dep't of Transp.,* 264 F.3d 493, 498 (5th Cir.2001).

24 *Id.* (quoting Fed.R.Civ.P. 56(c)).

25 *R2 Invs. LDC v. Phillips,* 401 F.3d 638, 642 (5th Cir.2005).

26 *Cuvillier v. Taylor,* 503 F.3d 397, 401 (5th Cir.2007) (citing *Causey v. Sewell Cadillac–Chevrolet, Inc.,* 394 F.3d 285, 288 (5th Cir.2004)).

27 *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 555, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007).

28 *See Nat'l Fed'n of the Blind of Tex., Inc. v. Abbott,* 647 F.3d 202, 209 (5th Cir.2011).

29 *Cole v. General Motors Corp.,* 484 F.3d 717, 723 (5th Cir.2007) (quoting *Parker v. District of Columbia,* 478 F.3d 370, 377 (D.C.Cir.2007)).

30 *See* 29 U.S.C. § 1132(a)(1)(B).

31 *Harris Methodist Fort Worth v. Sales Support Servs.,* 426 F.3d 330, 333–34 (5th Cir.2005) (citing *Tango Transport v. Healthcare Fin. Servs. LLC,* 322 F.3d 888, 893 (5th Cir.2003)).

32 *Lujan v. Defenders of Wildlife,* 504 U.S. 555, 560, 112 S.Ct. 2130, 119 L.Ed.2d 351 (1992) (citations and internal quotation marks omitted).

33 To simplify, we speak at times of Cigna's obligations to insureds, but we recognize that Cigna only administers, and does not fund, many of the plans at issue. This distinction is not of consequence in our discussion of standing.

34 Cigna disputes the adequacy and existence of assignment for many claims. We leave it to the district court to resolve these fact-sensitive issues on remand.

35 *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.,* 770 F.3d 1282, 1288–91 (9th Cir.2014).

36 *Id.* at 1289.

37 *Id.* at 1291.

38 *Biomed Pharm., Inc. v. Oxford Health Plans (N.Y.), Inc.,* No. 10 CIV. 7427 JSR, 2011 WL 803097, at *4 (S.D.N.Y. Feb. 18, 2011).

39 *See Encompass Office Solutions, Inc. v. La. Health Serv. & Indem. Co.,* 2013 U.S. Dist. LEXIS 188315, at *26–27 (N.D.Tex. Sept. 17, 2013) ("Although it did not lead to a direct out-of-pocket damage to the patient, failure to pay as directed would nonetheless ... [injure] the patient in that [insurers] refused to honor the directions of the insured concerning services within the purview of the insurance contract."); *see also Katz v. Pershing, LLC,* 672 F.3d 64, 72 (1st Cir.2012) ("[W]e think the better view is that when a plaintiff generally alleges the existence of a contract, express or implied, and a concomitant breach of that contract, her pleading adequately shows an injury to her rights."); *DiCarlo v. St. Mary Hosp.,* 530 F.3d 255, 263 (3d Cir.2008) ("To have standing to assert a breach of contract claim, plaintiffs need not wait until lawsuits against them were filed or collection agents began harassing them.... The expense is incurred, whether paid or not, at the time the patient enters a hospital with the understanding that he or she is liable for all or part of the charges for the services to be rendered." (citation omitted and internal quotation marks omitted)).

The question of whether the money is in fact owed goes to the merits. Arguably, the money is owing as soon as the patient incurs covered charges, regardless of whether they are billed to her directly.

40 At least some of the contracts at issue state that benefits are payable to the patient, and will only be paid to a provider at Cigna's option. See, for example, page 53 of Exhibit 48 to Cigna's Motion for Summary Judgment.

41 *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 113–14, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989) (quoting *Massachusetts Mutual Life Ins. Co. v. Russell,* 473 U.S. 134, 148, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985)).

42 *Russell,* 473 U.S. at 148, 105 S.Ct. 3085.

43 *United Steel, Paper & Forestry, Rubber, Mfg., Energy, Allied Indus. & Serv. Workers Int'l Union, AFL–CIO/CLC v. Cookson Am., Inc.,* 710 F.3d 470, 474–75 (2d Cir.2013).

44 *See Cleveland Elec. Illuminating Co. v. Util. Workers Union of Am.,* 440 F.3d 809, 815–16 (6th Cir.2006); *United Steelworkers of Am., AFL–CIO v. Canron, Inc.,* 580 F.2d 77, 80–81 (3d Cir.1978).

45 *Firestone Tire,* 489 U.S. at 113–14, 109 S.Ct. 948; *see also Russell,* 473 U.S. at 148, 105 S.Ct. 3085.

46 29 U.S.C. § 1133(2).

47 *See* 29 U.S.C. § 1104(a)(1)(B) & (D).

48 29 U.S.C. § 1132(a)(1)(B). ERISA further allows suit to "(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." *Id.* at § 1132(a)(3).

49 Cigna Initial Br. 35–36.

50 *See, e.g., Cedars–Sinai Med. Ctr. v. Massachusetts Mut. Life Ins. Co.,* 67 F.3d 305 (9th Cir.1995) (unpublished). This case was decided in part based on a determination that the insurer was not obligated to pay charges not billed to the patients-a question that goes to the merits rather than to standing here. *See also Am. Med. Ass'n v. United HealthCare Corp.,* No. 00 CIV. 2800(LMM), 2007 WL 1771498, at *19 (S.D.N.Y. June 18, 2007).

51 *See, e.g., Harris Methodist Fort Worth v. Sales Support Servs. Inc. Employee Health Care Plan,* 426 F.3d 330, 333–34 (5th Cir.2005) ("It is well established that a healthcare provider, though not a statutorily designated ERISA beneficiary, may obtain standing to sue derivatively to enforce an ERISA plan beneficiary's claim."); *id.* at 337 (noting the benefits of allowing assignment to health care providers, and stating that "[t]o deny standing to health care providers as assignees of beneficiaries of ERISA plans might undermine Congress' goal of enhancing employees' health and welfare benefit coverage" (quoting *Hermann Hosp. v. MEBA Med. & Benefits Plan,* 845 F.2d 1286, 1289 n. 12 (5th Cir.1988))); *Tango Transp. v. Healthcare Fin. Servs. LLC,* 322 F.3d 888, 892–93 (5th Cir.2003).

52 *See* supra note 51.

53 *See Lujan,* 504 U.S. at 560–61, 112 S.Ct. 2130.

54 *See* 29 U.S.C. §§ 1132(a)(1)(B) & (a)(3).

55 *Dallas Cnty. Hosp. Dist. v. Associates' Health & Welfare Plan,* 293 F.3d 282, 285 (5th Cir.2002) ("It is clear in this Circuit that a health care provider may possess standing under ERISA by virtue of a valid assignment."). As already noted, we leave it to the district court in the first instance to resolve Cigna's attacks on the existence and adequacy of some of the assignments at issue.

56 "We are not limited to the district court's reasons for its grant of summary judgment and may affirm ... on any grounds supported by the record." *Vuncannon v. United States,* 711 F.3d 536, 538 (5th Cir.2013) (quoting *Aryain v. Wal–Mart Stores Tex. LP,* 534 F.3d 473, 478 (5th Cir.2008) and *Palmer ex rel. Palmer v. Waxahachie Indep. Sch. Dist.,* 579 F.3d 502, 506 (5th Cir.2009)) (footnotes omitted).

57 *See Anderson v. Cytec Indus., Inc.,* 619 F.3d 505, 512 (5th Cir.2010); *Holland v. Int'l. Paper Co. Ret. Plan,* 576 F.3d 240, 246 n. 2 (5th Cir.2009); *Aboul–Fetouh v. Employee Benefits Committee,* 245 F.3d 465, 472 (5th Cir.2001). The parties appear to agree that the plans give Cigna discretion to construe plan terms.

58 *Stone v. UNOCAL Termination Allowance Plan,* 570 F.3d 252, 257 (5th Cir.2009).

59 *Crowell v. Shell Oil Co.,* 541 F.3d 295, 313 (5th Cir.2008) (quoting *Gosselink v. AT & T, Inc.,* 272 F.3d 722, 727 (5th Cir.2001)).

60 29 U.S.C. § 1022(a).

61 *Stone,* 570 F.3d at 260 (internal quotation marks omitted) (quoting *Crowell,* 541 F.3d at 314).

62 Another factor to consider at the "legal correctness" stage is "whether the administrator has given the plan a uniform construction." The third is whether "unanticipated costs" result from the various plan interpretations. *Crowell,* 541 F.3d at 312.

63 *Stone,* 570 F.3d at 257.

64 *Id.*

65 *Threadgill v. Prudential Securities Group, Inc.,* 145 F.3d 286, 293 (5th Cir.1998).

66 *Anderson,* 619 F.3d at 512 ("In addition to not being arbitrary and capricious, the plan administrator's decision to deny benefits must be supported by substantial evidence.").

67 The district court recognized that any conflict of interest would have to be considered in evaluating Cigna's plan interpretation if that interpretation was not found to be "legally correct." We note that we also consider conflicts of interest as part of the "substantial evidence" inquiry. *See Holland,* 576 F.3d at 247–51 (considering conflict of interest as part of assessment of evidentiary basis for denial of benefits).

68 In some filings, the parties seem to agree that North Cypress did not apply its discount program to MRC1 plan emergency room services, but that Cigna *did* apply its fee-forgiving protocol to such claims. In others Cigna argues that it had substantial evidence on which to reduce payment to emergency room claims.

69 Mem. and Order of August 10, 2012, 12–14, 20. Because we vacate the grant of summary judgment against the contract claims in order to allow the district court to address the question of ERISA preemption in the first instance, we need not review, and express no opinion on, the district court's decision on the merits.

70 29 U.S.C. § 1144(a).

71 *Aetna Health Inc. v. Davila,* 542 U.S. 200, 208, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004) (quoting *Alessi v. Raybestos–Manhattan, Inc.,* 451 U.S. 504, 523, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981)).

72 *FMC Corp. v. Holliday,* 498 U.S. 52, 58, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990).

73 *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 46, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987).

74 Mem. and Order of August 10, 2012, 4–5.

75 The district court earlier held that the contract claims were not preempted even if there *was* ERISA standing, but this 2011 decision is based on a finding that one would not need to interpret the ERISA plans in order to resolve the contract dispute. Because this later proved to be untrue, we do not find the court's earlier decision persuasive. *See* Mem. and Order of March 2, 2011.

76 With certain exceptions, section 843.338 sets a 45–day deadline for nonelectronic claims and a 30–day deadline for electronic claims. Section 843.351 clarifies that the prompt payment provisions apply to out-of-network providers.

77 *Dedeaux,* 481 U.S. at 46, 107 S.Ct. 1549.

78 29 U.S.C. § 1144(b)(2)(A).

79 538 U.S. 329, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003).

80 *Ellis v. Liberty Life Assur. Co. of Bos.,* 394 F.3d 262, 276 (5th Cir.2004) (citing *Miller,* 538 U.S. at 341–42, 123 S.Ct. 1471).

81 *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 365, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002) (quoting *Metro. Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 740, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985)).

82 *Miller,* 538 U.S. at 342, 123 S.Ct. 1471.

83 *Id.*

84 *Id.* at 338, 123 S.Ct. 1471; *see also id.* ("A state law requiring all insurance companies to pay their janitors twice the minimum wage would not 'regulate insurance,' even though it would be a prerequisite to engaging in the business of insurance, because it does not substantially affect the risk pooling arrangements undertaken by insurer and insured.").

85 *Id.* at 338–39, 123 S.Ct. 1471.

86 *Id.* at 338, 123 S.Ct. 1471.

87 *Id.* at 339 n. 3, 123 S.Ct. 1471.

88 *Id.* at 339, 123 S.Ct. 1471.

89 394 F.3d 262 (5th Cir.2004).

90 *Id.* at 277 (internal quotation marks omitted) (quoting *Barber v. Unum Life Ins. Co. of Am.,* 383 F.3d 134, 143 (3d Cir.2004)).

91 *Id.* (internal quotation marks omitted) (quoting *Barber,* 383 F.3d at 143).

92 *See* Tex. Ins.Code. §§ 843.338, 843.351.

93 *Ellis,* 394 F.3d at 277 (quoting *Miller,* 538 U.S. at 338–39, 123 S.Ct. 1471).

94 *See Miller,* 538 U.S. at 337, 339, 341, 123 S.Ct. 1471.

95 *Metro. Life Ins. Co.,* 471 U.S. at 728, 105 S.Ct. 2380.

96 *UNUM Life Ins. Co. of Am. v. Ward,* 526 U.S. 358, 372, 119 S.Ct. 1380, 143 L.Ed.2d 462 (1999).

97 *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 359, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002).

98 *Miller,* 538 U.S. at 332, 123 S.Ct. 1471.

99 In *Miller,* the Court, describing the notice-prejudice rule at issue in *UNUM Life Insurance Company of America v. Ward,* 526 U.S. 358, 119 S.Ct. 1380, 143 L.Ed.2d 462, held that: "[t]he notice-prejudice rule governs whether or not an insurance company must cover claims submitted late, which dictates to the insurance company the conditions under which it must pay for the risk that it has assumed. This certainly qualifies as a substantial effect on the risk pooling arrangement between the insurer and insured." *Miller,* 538 U.S. at 339 n. 3, 123 S.Ct. 1471. Unlike in *Miller,* the laws at issue here do not govern whether or not an insurer must pay; rather they specify the *processes* by which payment must be made.

100 While the *Miller* Court held that, to be saved, "a state law must substantially affect the risk pooling arrangement between the insurer and insured," thus conflating to some extent the insurer/insured bargain and impact on the risk pool factor, these appear to be distinct concepts, at least within the insurance industry. *See* Beverly Cohen, *Saving the Savings Clause: Advocating a Broader Reading of the Miller Test to Enable States to Protect ERISA Health Plan Members by Regulating Insurance,* 18 Geo. Mason L.Rev. 125, 144 (2010). In light of this, several courts have concluded that the term "risk pooling" has a different meaning in the ERISA preemption context. *See, e.g., Standard Ins. Co. v. Morrison,* 537 F.Supp.2d 1142, 1151 (D.Mont.2008) (rejecting the argument that "the Court intended lower courts to interpret 'risk pooling' as an insurance industry actuary would").

101 While none of the four examples the Court gave in *Miller* directly discussed the pool size, the type of examples it gives in *Ward* and *Metro Life* do concern access to coverage. Moreover the plain meaning of "risk pool" necessarily entails a numerosity component.

102 *Miller,* 538 U.S. at 342, 123 S.Ct. 1471.

103 *Ellis,* 394 F.3d at 277 (internal quotation marks omitted).

104 *See id.* at 274–75 (recognizing that the statutes at issue "subjects insurance companies to civil liability" if they "breach the common law duty of good faith and fair dealing" or if they "unfairly and untimely process and treat a claim").

105 579 F.3d 525 (5th Cir.2009).

106 *Id.* at 530.

107 *Id.* at 530–31.

108 Mem. and Order of November 3, 2011, 6.

109 *Crowe v. Henry,* 43 F.3d 198, 203 (5th Cir.1995).

110 *Abraham v. Singh,* 480 F.3d 351, 355 (5th Cir.2007).

111 Mem. and Order of November 3, 2011, 7–10.

112 *Crowe,* 43 F.3d at 203.

113 *St. Paul Mercury Ins. Co. v. Williamson,* 224 F.3d 425, 441 (5th Cir.2000).

114 *Id.*

115 *Id.*

116 *Nolen v. Nucentrix Broadband Networks Inc.,* 293 F.3d 926, 929 (5th Cir.2002).

117 Mem. and Order of November 3, 2011, 11.

118 *Id.*

119 *Abraham,* 480 F.3d at 357 (internal quotation marks omitted); *see also Vanderbilt Mortg. & Fin., Inc. v. Flores,* 735 F.Supp.2d 679, 701 (S.D.Tex.2010); *Blanchard & Co., Inc. v. Contursi,* No. Civ. A. 99–1758, 2000 WL 574590, at *2 (E.D.La. May 11, 2000).

120 Mem. and Order of November 3, 2011, 12.

121 *Abraham,* 480 F.3d at 357 (internal quotation marks omitted) (emphasis original).

122 *Id.*

123 Second Amended Original Complaint, ¶ 88.

124 *See ISystems v. Spark Networks, Ltd.,* No. 10–10905, 2012 WL 3101672, at *4–5 (5th Cir. March 21, 2012); *Khurana v. Innovative Health Care Sys., Inc.,* 130 F.3d 143, 155 (5th Cir.1997), *vacated on other grounds by Teel v. Khurana,* 525 U.S. 979, 119 S.Ct. 442, 142 L.Ed.2d 397 (1998); *Office Outfitters, Inc. v. A.B. Dick Co., Inc.,* 83 F.Supp.2d 772, 779–80 (E.D.Tex.2000); *Compagnie De Reassurance D'Ile de France v. New England Reinsurance Corp.,* 57 F.3d 56, 91–92 (1st Cir.1995); *Lorenz v. CSX Corp.,* 1 F.3d 1406, 1411–12 (3d Cir.1993).

125 *Word of Faith World Outreach Ctr. Church, Inc. v. Sawyer,* 90 F.3d 118, 122 (5th Cir.1996).

126 *Chaney v. Dreyfus Service Corp.,* 595 F.3d 219, 239 (5th Cir.2010) (quoting *United States v. Sharpe,* 193 F.3d 852, 869 (5th Cir.1999)).

127 *See Nolen,* 293 F.3d at 930 ("The 'failure to plead the requisite elements of either a § 1962(a) or a § 1962(c) violation implicitly means that [the defendant] cannot plead a conspiracy to violate either section.' ") (quoting *Simon v. Value Behavioral Health, Inc.,* 208 F.3d 1073, 1084 (9th Cir.2000)); *see also Pan Am. Mar., Inc. v. Esco Marine, Inc.,* No. C.A. B–04–188, 2005 WL 1155149, at *8 (S.D.Tex. May 10, 2005).

128 Mem. and Order of September 27, 2012, 1.

129 *See S.E.C. v. Van Waeyenberghe,* 990 F.2d 845, 848 (5th Cir.1993); *Macias v. Aaron Rents, Inc.,* 288 Fed.Appx. 913, 915 (5th Cir.2008).

130 *Macias,* 288 Fed.Appx. at 915.

131 *See Nixon v. Warner Commun., Inc.,* 435 U.S. 589, 598, 98 S.Ct. 1306, 55 L.Ed.2d 570 (1978).

132 North Cypress Initial Br. 57.

133 *Id.* at 58.

134 *Hogan v. Kraft Foods,* 969 F.2d 142, 145 (5th Cir.1992) (citing *Kennedy v. Electricians Pension Plan, IBEW # 995,* 954 F.2d 1116 (5th Cir.1992)).

135 Mem. and Order of July 25, 2012, 8.

136 *Fortune Production Co. v. Conoco, Inc.,* 52 S.W.3d 671, 683 (Tex.2000).

137 *Foley v. Daniel,* 346 S.W.3d 687, 690 (Tex.App.2009).

138 *City of the Colony v. North Tex. Mun. Water Dist.,* 272 S.W.3d 699, 731 (Tex.App.2008).

139 *Sw. Elec. Power Co. v. Burlington N. R.R. Co.,* 966 S.W.2d 467, 469–70 (Tex.1998) (listing cases).

140 *Italian Cowboy Partners, Ltd. v. Prudential Ins. Co. of Am.,* 341 S.W.3d 323, 337 (Tex.2011) (quoting *Aquaplex, Inc. v. Rancho La Valencia, Inc.,* 297 S.W.3d 768, 774 (Tex.2009)).

141 *Id.* (quoting *Smith v. KNC Optical, Inc.,* 296 S.W.3d 807, 812 (Tex.App.2009)).

142 *See Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot and Wansbrough,* 354 F.3d 348, 360 (5th Cir.2003) (stating in a different context that funds paid out by a plan and retained in violation of plan terms constituted unjust enrichment of the holder), *abrogated on other grounds by ACS Recovery Services, Inc. v. Griffin,* 723 F.3d 518 (5th Cir.2013).

143 Mem. and Order of July 25, 2012, 8. As the district court explained, "recovery is not predicated upon intentional, false representations by [North Cypress]. Rather, the core of [Cigna's] claim is that [North Cypress] listed charges on claim forms without requiring patients to pay the full amount of those listed charges. In turn, the 'plans made overpayments to [North Cypress] in the amount of the difference between the benefits that the plans paid and the benefits to which the plan members were contractually entitled, based on the amounts that [North Cypress] actually required them to pay.' " *Id.* (citations omitted).

144 *Id.* at 15.

145 A logical relationship "exists when the claim and the counterclaim arise from the same 'aggregate of operative facts,' or 'the aggregate core of facts upon which the original claim rests activates additional rights, otherwise dormant, in the defendants.' " *Rossi v. Wohl,* 633 F.Supp.2d 270, 285 (N.D.Tex.2009) (quoting *Nayani v. Horseshoe Entm't,* No. 3:06–CV–01509–M, 2007 WL 1288047, at *2 (N.D.Tex. May 2, 2007)).

146 A counterclaim is compulsory when "(1) ... the issues of fact and law raised by the claim and counterclaim largely are the same; (2) ... *res judicata* would bar a subsequent suit on defendant's claim absent the compulsory counterclaim rule; (3) ... substantially the same evidence will support or refute plaintiff's claim as well as defendant's counterclaim; [or] (4) ... there

is [a] logical relationship between the claim and the counterclaim." *Park Club, Inc. v. Resolution Trust Corp.,* 967 F.2d 1053, 1058 (5th Cir.1992).

147 § 1419 Compulsory Counterclaims–Statute of Limitations, 6 Fed. Prac. & Proc. Civ. § 1419 (3d ed.) (footnote omitted).

148 *Distribution Servs., Ltd. v. Eddie Parker Interests, Inc.,* 897 F.2d 811, 812–13 (5th Cir.1990) ("The rationale is that because recoupment is in the nature of a defense, it is never barred by the statute of limitations so long as the plaintiff's main action itself is timely.").

149 *See, e.g., Pennsylvania R. Co. v. Miller,* 124 F.2d 160, 162 (5th Cir.1941) ("Recoupment goes to the foundation of the plaintiff's claim; it is available as a defense, although as an affirmative cause of action it may be barred by limitation."); *Matter of Gober,* 100 F.3d 1195, 1207–08 (5th Cir.1996) ("Defensive claims for recoupment are never subject to statutes of limitations as long as the plaintiff's action is timely. Counterclaims for setoff, however, are subject to the applicable statute of limitations just as if they were asserted as independent actions.") (internal citations omitted); *see also Kadonsky v. United States,* 216 F.3d 499, 507 n. 9 (5th Cir.2000) ("Counterclaims in the nature of recoupment filed after the statute of limitations has run are nonetheless timely if the suit prompting the counterclaim were timely.").

150 *Ruben A. v. El Paso Independent School District,* 414 Fed.Appx. 704, 707 (5th Cir.2011).

151 *Id.* (citing *Jonathan H. v. The Souderton Area Schl. Dist.,* 562 F.3d 527, 529 (3d Cir.2009)).

152 *Id.* (emphasis added).

153 *Id.* at 706–07.

154 Sound policy reasons support enforcing statutes of limitations. *See CTS Corp. v. Waldburger,* ––– U.S. ––––, 134 S.Ct. 2175, 2183, 189 L.Ed.2d 62, *reh'g denied,* ––– U.S. ––––, 135 S.Ct. 23, 189 L.Ed.2d 874 (2014) (noting that statutes of limitations "require plaintiffs to pursue diligent prosecution of known claims" and "promote justice by preventing surprises through [plaintiffs'] revival of claims that have been allowed to slumber") (internal quotation marks omitted); *Taylor v. Bunge Corp.,* 775 F.2d 617, 619 (5th Cir.1985) (emphasizing the "policy of finality underlying the statute of limitations").

155 This includes the claims for state law damages and attorney's fees. *See* Second Amended Complaint, Counts 6, 9–11.

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