Recent Federal Lawsuit Case Summaries

In Case Studies # 1

North Cypress Med Ctr v. CIGNA – Fifth Circuit case - No negative appellate or subsequent history; no significant cases.

North Cypress Med Ctr v. CIGNA – So Dist Texas case – No negative appellate or subsequent history.

COMMENT – Parenthetical describes this case as "appealing part of [Fifth Circuit case above]. This district court case obviously is not an "appeal" from a higher court; it is here on remand. Suggest parenthetical be dropped.

Also, this is a decision on procedural motion to strike certain exhibits relevant to a pending summary judgment and is entirely procedural in nature, adding nothing to the substantive issue of fee forgiveness. Suggest you consider dropping it from the case studies.

North Cypress Med Ctr v. CIGNA – Fifth Circuit – IMPORTANT – Holdings called into question by subsequent reversal in part and vacatur in part in the Fifth Circuit's review of *Humble*. Query whether you wish to retain this series of *North Cypress* cases in your presentation given that development??

If you keep them in then I would add something to this case study. In reporting on the holding I suggest you discuss the important issue of a proper and valid assignment of benefits. This issue is unaffected by the *Humble* reversal and has important practical application for your audience. Something like this:

> An important issue discussed by the Court is the necessity of a properly drafted and properly signed assignment of benefits. North Cypress was unable to produce written assignments of benefits for some of its claims, alleging that they were misplaced or lost. Instead it tried to prove they were given by submitting affidavits from its business office personnel, alleging that each person who receives care must execute one, as indicate don each UB-04. North Cypress also argue that Cigna waived this issue because Cigna initially failed to deny claims on this ground. But North Cypress cited no controlling law on this point and the Court found none, hence it found that Cigna did not waive the issue of lack of proper assignment and it could be considered here.
>
> Because a health care provider's ERISA standing is based on the assignment of benefits, it was crucial that North Cypress prove assignment for each claim. However, Cigna could not point to any Fifth Circuit law holding that *individual written assignments* are the only acceptable proof, and courts in other circuits found affidavits or other evidence besides written assignment forms sufficient to prove assignment in certain circumstances. The Court also rejected Cigna's claim

that North Cypress provided no evidence with regard to assignment. So it held that there was a genuine dispute as to whether the patients in the claims at issue actually assigned their benefits to North Cypress. It denied Cigna's motion to dismiss the defense and allowed the issue to go to trial.

Also, I suggest adding in a case about anti-assignment clauses:

Zapiach v. Empire BlueCross BlueShield, 2018 U.S. Dist. LEXIS 64887, DC NJ April 17, 2018

The plaintiff, a healthcare provider in New Jersey, sued Empire alleging its failure to comply with emergency service cost sharing in violation of state law; and its failure to make all payments pursuant to a member's plan and breach of fiduciary duty in violation of ERISA.

The court found that the action was untimely for failure to exhaust administrative remedies. Even if administrative remedies had been pursued, however, the court found that the plaintiff did not have standing to sue because it did not secure a valid assignment of benefits. Healthcare providers that are neither participants nor beneficiaries in their own right may obtain derivative standing by assignment from a plan participant or beneficiary. A healthcare may bring a cause of action by acquiring derivative standing through an assignment of rights from the plan participant or beneficiary to the healthcare provider. In this case, the plaintiff does not allege that he is a participant or a beneficiary of an ERISA plan. Rather, he asserts he has derivative standing by virtue of an assignment of benefits he received from his patient. However, the health plan administered by Empire expressly contains an anti-assignment provision stating that "coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan."

Though the Third Circuit has not specifically spoken on the enforceability of anti-assignment clauses in ERISA-governed plans, the court found that the weight of legal authority appears to uphold the validity and enforceability of anti-assignment provisions in the plans as a majority of circuits, and district courts in the Third Circuit, have given effect to anti-assignment provisions and denied standing. Since the plain language of the anti-assignment provision is unambiguous, and because the plaintiff did not allege that the plan authorized an assignment of the member-patient's benefits, the court held that the assignment was invalid and the plaintiff lacked derivative standing to assert his claims.

Conn General v. Humble Surgical – So Dist Texas case - IMPORTANT – as discussed above, REVERSED IN PART AND VACATED IN PART by *Conn. Gen. Life Ins. Co. v. Humble Surgical Hosp*., L.L.C., 878 F.3d 478; United States Court of Appeals for the Fifth Circuit; December 19, 2017; *cert denied, Humble Surgical Hosp. v. Conn.*, 2018 U.S. LEXIS 3013 (U.S., May 14, 2018). To date there has been no subsequent reported District Court activity.

Since it is not contained in these materials (I think you said that it is in another presentation?) you may want to mention the subsequent activity here. Perhaps something like this.

Upon appeal to the Fifth Circuit the holding in *Humble* was reversed in part, vacated in part and remanded to the District Court. *Conn. Gen. Life Ins. Co. v. Humble Surgical Hosp., L.L.C.*, 878 F.3d

478; United States Court of Appeals for the Fifth Circuit; December 19, 2017; *cert denied, Humble Surgical Hosp. v. Conn*., 2018 U.S. LEXIS 3013 (U.S., May 14, 2018). To date there has been no subsequent reported District Court activity. The appellate court held that [1] Cigna did not abuse its discretion in interpreting plan language to mean that its obligation to reimburse a plan member was limited to the expenses actually incurred by the member; [2]-Even if this interpretation was legally incorrect, it was not an abuse of discretion; [3]-Because the insurer was not the designated or named plan administrator, the plan sponsor, or the employer, it was not liable for the ERISA financial penalties imposed in the lower court's decision, and [4] Cigna was not the *de facto* plan administrator by way of its conduct.

On the important issue of fee forgiveness the appellate court concluded that since Cigna had the discretion to interpret its own plan language to prohibit fee-forgiving, the issue became whether there was substantial evidence that Humble actually engaged in fee-forgiving, something the district court did not address. The court found that substantial evidence in the surveys Cigna sent to members who had received medical treatment at Humble, requesting "additional information." The surveys asked what the member had been told regarding "responsibility for any non-paid costs, i.e., deductible, coinsurance." Cigna received 154 responses, many indicating that Humble had informed them that they would not be charged their full member cost-share. The court held that this evidence was sufficient to support Cigna's belief that Humble was fee-forgiving and support a reversal of the lower court on this issue.

Arapahoe Surgery v Cigna, Dist Colorado No negative appellate or subsequent history.

Conn. Life v. Advanced Surgery Bethesda, Dist Maryland No negative appellate or subsequent history

(Suggest you refer the reader to *Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr*., 703 Fed. Appx. 126

United States Court of Appeals for the Third Circuit; March 16, 2017, July 19, 2017, which follows the *Aetna V. Huntingdon Valley* case study in Section 2.)

Cigna v. Health Diagnostic Laboratory (October 2014)

This is not a case decision; it is a report on the filing of a lawsuit. I suggest you move it to the end of Section 1, with an appropriate notation. Also, you may wish to add this follow up:

> On May 7, 2015, HDL filed a counterclaim, alleging that Cigna owed it some $65 million for blood-testing services. HDL defended its tests as diagnostically efficacious and necessary. HDL also alleged that Cigna refused to accept HDL and other small laboratories as in-network providers and it HDL less than the amount due under proper billings. HDL seeks dismissal of Cigna's suit.

In the case summaries I suggest you delete the editorial note at the end of the report on this case.

Advanced Ambulatory Surgical v. Cigna ND Illinois 2014 - No subsequent negative appellate history

Mt View Surgical Center v. Cigna C.D. Cal 2013 - No subsequent negative appellate history

Mt View Surgical Center v. Cigna C.D. Cal 2015 - No subsequent negative appellate history

Conn General v. True View Surgery Center – Dist CT 2015 No subsequent negative appellate history

In Case Studies # 2

HCA Health Services v. Aetna ED VA 1994 No subsequent negative appellate history

Aetna v. Bay Area Surgical CA Super Ct 2012 No subsequent negative appellate history

Follow up here that you may want to add

> On April 13, 2016, after a month-long trial against ten defendants, BASM and its three co-founders, a civil jury awarded Aetna a $37 million judgment against BASM. The jury found for Aetna on six claims alleging fraud, intentional interference with contractual relations and unjust enrichment; and that the defendants paid physician-investors excessive amounts in exchange for investing in surgical facilities, submitted false claims and failed to disclose the waiver of co-pays, and unlawfully directed patients to out-of-network surgical facilities in return for cash payments. BASM intended to appeal; no further information is publicly available at this time.

Bay Area Surgical v. Aetna ND Cal. 2016 No subsequent negative appellate history

Aetna v. Huntingdon Valley Surgical Center ED PA 2015 AFFIRMED IN PART and VACATED IN PART by

Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr., 703 Fed. Appx. 126 (3rd Cir. March 16, 2017)

I suggest that the notation be added to the *Huntington* case, and that the following be added after the *Aetna v. Found Surgery Affiliates* case:

Aetna sued the Surgery Center alleging, among other things, that committed or aided and abetted the commission of insurance fraud. The District Court granted summary judgment in favor of the Surgery Center, holding that its billing practices were not fraudulent since it accurately listed its total charges on its bills to Aetna.

The court framed the issue appeal as whether the bills to Aetna either misrepresented or concealed information where they list the total Chargemaster prices without disclosing the fact that the Surgery

Center routinely waived the patients' fees and so would not collect the listed Chargemaster prices. The court concluded that the answer depends on the Center's disclosure obligations in the first place, which arise from the language of the billing forms it submits to Aetna and any contracts clarifying the forms' terms. (The court noted that "health insurers may create contracts that relieve them of the duty to pay physicians and dentists who routinely waive co-pays" and that whether "routine and hidden waiver of co-pays . . . states a claim for fraud" depends on the existence of a contractual obligation proscribing that practice.)

The court found that the form the Center used to bill Aetna is ambiguous as to the Center's contractual disclosure obligations. The form asks the provider to list "total charges" and does not specify whether that term refers to the list prices or amount the provider actually expects to receive (before the insurer deducts its negotiated discount rate). If the list price is all that the form requires, then the Center had no obligation to disclose the fact that it routinely waives patient fees. If, on the other hand, the Center is required to disclose the amount it actually expects to be paid before Aetna deducted its discount rate, then it has a duty to subtract the amount of any routine waivers it provides to patients from the "total charges" on the bill. If this is the case then when the Center waived the patients' obligations for portions of the bills, it reduced the amount of money it is actually expected to receive for services provided, and so would need to deduct the waived obligations from its bill to honestly represent its expected payment.

Either interpretation of the billing form was plausible. On the other hand, the language of the form—requesting only the "total charges"—as well as the fact that the form specifies that routine waivers are not permitted for a specific government health benefit program but makes no mention of waivers for other types of claims, may indicate that the form does not require the disclosure of waivers of co-payments, co-insurance, and deductibles for private health insurance claims.

Moreover, the network contracts -unlike those with other plans and payors under contract with the Center - did not clarify what information a provider is required to disclose on the billing form and thus did not resolve the ambiguity. Since both the billing form and contracts were ambiguous as to the Center's disclosure obligations, the court found an issue of fact as to whether the Center submitted fraudulent bills when it listed its Chargemaster rates as its "total charges" without deducting the waived patient fees from that figure or informing Aetna that it routinely provided such waivers. Thus, the District Court erred in concluding that Center's billing practices were not fraudulent as a matter of law.

Suggest you consider adding:

Ass'n of N.J. Chiropracters (sic) v. Aetna, Inc., 2014 U.S. Dist. LEXIS 178585, Dist NJ December 31, 2014 | 60 Employee Benefits Cas. (BNA) 1423 | 2014 WL 7409919

This suit concerns the payment and reimbursement procedure employed between Aetna and healthcare providers. The vast majority of Aetna Insureds are administered as part of various private employee welfare benefit plans governed by ERISA. The lead plaintiff in this putative class action, Dr. Manz, entered into a Physician Group Agreement ("PGA") with Aetna, which obligated Dr. Manz to offer covered cervices to Aetna Insureds at agreed-upon discounted rates. When Dr. Manz performed covered cervices for Aetna insureds he obtained claim assignments, giving him the right to receive

payment from Aetna. Dr. Manz asserts that, despite an initial determination of coverage and payment, Aetna conducted post-payment audits and made retroactive benefit determinations, seeking repayment of reimbursements already made for services previously determined to be covered by Aetna plans. Dr. Manz claimed that these retroactive benefit denials violate the terms of ERISA. Specifically, Dr. Manz brought three counts under ERISA, all of which allege that Aetna violated its obligations under ERISA with respect to adverse benefit determinations, including disclosure obligations and failure to provide a full and fair review of benefit denials.

Other plaintiffs filed a separate action and Aetna sought dismissal or to compel arbitration under the terms of the several network provider agreements to which the plaintiffs were parties. The district court dismissed asserted RICO claims but declined to dismiss ERISA claims. However, the Court dismissed all of Drs. Manz' claims and compelled the arbitration of those claims.

Subsequently the parties stipulated to, and the Court ordered, a stay of the proceedings pending a decision before the Third Circuit in the related case of *Tri3 Enters. LLC v.* Aetna, Inc., 535 F. App'x 192, and when decided the parties requested that the stay be lifted.

On May 6, 2014, the Third Circuit decided *CardioNet, Inc. v. Cigna Health Corp*., 751 F.3d 165, which Dr. Manz contends results in a change in the law controlling the Court's previous decision compelling arbitration, and he moved for reconsideration.

The Court held that if *CardioNet* effected a change in the controlling law then reconsideration is appropriate. Dr. Manz argued that *CardioNet* stands for the proposition that "the right to litigate ERISA claims in federal court 'travel[s] with a claim.'" (Pls.' Moving Br. 8, ECF 160 (quoting CardioNet, 751 F.3d at 178).) In other words, he asserts that an assignee of an ERISA claim, e.g., a healthcare provider, may bring those claims in federal court, regardless of any agreement between the provider and the insurer to arbitrate claims between them, if the assignor of the claim, e.g., a participant in an ERISA plan, was not obligated to arbitrate those same claims. Dr. Manz contends that this holding is an intervening change in the law mandating reconsideration and vacatur of the Court's order compelling arbitration. The Court agrees.

The Third Circuit, in *CardioNet*, evaluated the arbitrability of certain ERISA claims brought by providers. Prior to the Third Circuit's decision, the district court in *CardioNet* held that the providers' derivative claims were subject to arbitration. The district court held that the derivative claims were subject to the Providers' agreement to arbitrate claims with Cigna. The district court held that "[p]laintiffs have a preexisting duty under their agreements with CIGNA to arbitrate disputes that are substantively identical to the claims they now seek to bring as assignees."

The Third Circuit, however, held that the providers' claims were not subject to arbitration. First, the court held that the specific nature of the derivative claims brought in that case, in the context of the specific language of the arbitration clause at issue, did not mandate arbitration. The providers' claims sought to obtain coverage for the providers' services under participants' benefit plans. The arbitration clause at issue required arbitration of "only those disputes 'regarding the performance or interpretation of the [provider agreement].'" The Third Circuit held that patients' assigned ERISA claims for denial of benefits were not related to the terms or potential breach of the providers' agreement with Cigna. As a result, the Providers' claims did not fall within the scope of the arbitration clause.

Second, regardless of the language of the arbitration clause in question, the providers' claims were not subject to arbitration because the Providers' patients, had they brought the claims themselves, were not bound by the arbitration clause, "at least where ... the [provider agreement] does not explicitly require the arbitration of assigned claims." More specifically, the court held that where an agreement between a provider and insurer does not explicitly require that patient-assigned claims be arbitrated, and the patient-assignor did not have an independent duty to arbitrate, a provider-assignee bringing patient-assigned claims cannot be compelled to arbitrate. This is an assignee of a contract occupies the same legal position under a contract as did the original contracting party. He or she can acquire through the assignment no more and no fewer rights that the assignor had, and cannot recover under the assignment any more than the assignor could recover. Since the claims were derivative and assigned to the providers and the patients were not under an independent duty to arbitrate, the providers were not compelled to arbitrate, as they had only agreed to arbitrate direct claims.

Although the court relied on well-accepted principles of assignment law in formulating its holding, it found that the Third Circuit had not previously held whether a patient-assigned ERISA claim is subject to arbitration pursuant to an agreement between a provider and insurance company. Consequently, for the first time in this circuit the appellate court in *CardioNet* answered an important threshold question of law, holding that "health care providers may obtain standing to sue by assignment from a plan participant."

Thus the court found that the intervening change in the Third Circuit's ERISA and arbitrability jurisprudence mandated reconsideration and required that the court vacate its prior order compelling arbitration.

In Case Studies # 3

Garcia v. HealthNet, NJ Superior Ct 2007. Appeal to:

Garcia V. HealthNet, NJ Superior Ct App Div 2009 No subsequent negative appellate history

Conn. General v. Roseland Ambulatory Care Dist NJ 2013 No subsequent negative appellate history

Oxford v. Josephson Sup Ct NY 2010 No subsequent negative appellate history

Josephson v. Oxford Sup Ct NY 2012 No subsequent negative appellate history

United Healthcare v. Sanctuary Surgical SD Fla 2014 No subsequent negative appellate history

Biomed Farms v. Oxford Second Circuit 2013 No subsequent negative appellate history

Add to citation "2013 U.S. App. LEXIS 12241

Horizon BlueCross BlueShield v. East Brunswick Surgery Center Dist NJ 2009

Add to citation "2009 US Dist LEXIS 34397" No subsequent negative appellate history

In Case Studies # 4

Aetna v. Humble Surgical Hospital, SD Tx 2012 Appeal to:

Aetna v. Humble Surgical Hospital, 5th Circuit 2013 No subsequent negative appellate history

Follow up:

Aetna Life Ins. Co. v. Humble Surgical Hosp., LLC, 2016 U.S. Dist. LEXIS 180545, Dist Tx 12/31/2016 – Humble pleadings stricken and judgments for Aetna

Appeal dismissed *Aetna Life Ins. Co. v. Humble Surgical Hosp., L.L.C.*, 2017 U.S. App. LEXIS 16969 5th Cir. 2017 No subsequent negative appellate history

Suggest you read the SD Tx case to see if you want to include it. Set out in full here; it's quite a read!

Opinion by: Lynn N. Hughes

Opinion on Debt and Truculence

I. Introduction.

A hospital waived patient fees and paid kickbacks to referring physicians. In three years it billed more than $86. 2 million to an insurer. Because the hospital's dishonest bills and illegal payments tricked the insurer into overpaying claims, the insurer can elect to take one of three remedies.

2. Background.

Humble Surgical Hospital, LLC, is a five-bed hospital in Humble, Texas. Since it opened in August 2010, it has collected over $41.4 million from Aetna Life Insurance Company for services to Aetna members.

A. Plans.

Aetna insures patients through an array of plans that vary broadly in cost and coverage. All of the plans have three things in common: (a) the insurer pays a portion of the patient's bill; (b) the insurer pays a smaller portion when the patient uses a hospital with which the insurer does not have a fee schedule; and (c) the insurer does not pay when a hospital waives the patient's share.

In-network healthcare providers contract with Aetna to serve patients at agreed prices; out-of-network providers do not. A patient who seeks care from an out-of-network hospital pays more out of his pocket than if he had used an in-network hospital. Aetna does not have a relationship with Humble; it is outside of Aetna's network of hospitals. Humble charges a lot more than a hospital in Aetna's network would.

B. Scheme.

Humble is a five-bed, out-of-network hospital that set its prices comparable to major Houston hospitals. In fact, it used Memorial Hermann in the Medical Center with 3,803 beds as its standard. Because no economically rational patient would choose it over an in-network provider, Humble paid referral fees to doctors, waived patient costs, and submitted inflated bills to Aetna.

Humble was joined by 103 doctors through a written proposal — printed in four colors — that offered them thirty percent of facility fees it collected from Aetna in exchange for referrals. Each doctor paid Humble only $3,500 in yearly "administrative and investment fees" — not a contribution of capital — to be entitled to the kickbacks.

To hide the referral-fee arrangement, the doctors created their own limited liability companies — shell entities. Humble agreed with the shells that they would pretend to assume Humble's billing responsibilities. Then they would do nothing, giving Humble and its affiliate, K&S Consulting, LLC, (a) control of billing and payments, and (b) five percent of the fees collected from Aetna. K&S Consulting would charge Aetna — identifying only Humble as the provider — and Aetna would pay the allowed amounts on each bill into Humble's bank account. Humble would kick back to the shells thirty percent of the facility fee paid by Aetna. In sum, Humble got seventy percent and the doctors got thirty percent.

Humble also promised patients (a) that their out-of-pocket expenses would be equal to or less than in-network, and (b) possibly a refund if their insurer paid in full. Without disclosing the illegal conditions under which it agreed to treat patients, Humble submitted claims. Aetna processed and paid them based on Humble's certification that each one was "true, accurate, and complete.

Aetna sues Humble for (a) money had and received, fraud, and negligent misrepresentation, and (b) relief under the Employee Retirement Income Security Act. The court now addresses the claim for money had and received.

3. Money Had and Received.

A case for money had and received looks solely to whether the defendant holds money that belongs to the plaintiff. Aetna must show that Humble has been paid money that — in equity — belongs to Aetna.

A. Assignments.

As an out-of-network provider, Humble is only entitled to a patient's benefits through an assignment. Despite having obtained assignments for its services only, Humble testified that the shells actually performed the services for which Aetna paid. No assignments exist from the patients to the shells, and Humble has no assignments from the shells to bill and collect for their services. The shells are not licensed; had they assigned any claims to Humble, the assignments would have been void for their multifaceted illegality.

Without an assignment, Humble has no right to be paid under Aetna's contracts with the patients. Aetna will recover $41,411,650.98 from Humble for overpayments from August 2010 through October 2013 — an amount that Humble concedes.

B. In-network.

Texas does not allow hospitals to bill patients one way and the plan another. Humble is an out-of-network hospital, but it did not oblige patients to pay out-of-network amounts. Instead, it told patients that its services' costs would be equal to or less than at an in-network facility.

From August 2, 2010, to May 11, 2012, Humble submitted $68,626,126.71 of out-of-network claims, and Aetna paid $27,813,059.61. If Humble had billed Aetna the same way it told the patients it would — at in-network rates — Aetna would have paid $7,564,799.96.

Aetna will take $20,248,259.65 — the difference between what it paid Humble as an out-of-network provider from August 2, 2010, to May 11, 2012, and what it would have paid Humble as an in-network provider.

C. Kickbacks.

Humble tries to characterize its agreements with the unlicensed shells as leases for use of its hospital. Unlicensed entities cannot lease hospitals. An entity that does nothing except cash checks does not need hospital space — it is a conduit. Humble's agreements with the shells are referral-fee arrangements, not leases.

Texas prohibits hospitals from paying doctors to refer patients.9Link to the text of the note Because Humble kicked back to the doctors thirty percent of its collections, Aetna is entitled to $12,423,495.29 — thirty percent of the $41,411,650.98 it paid Humble.

4. Preemption.

Aetna seeks to recoup money that it improperly paid because of Humble's fraud. Humble says that Aetna's claims attempt to enforce the plans with state law, improperly circumventing ERISA's enforcement provisions.

Claims that seek to enforce the plans — like a plaintiff suing an insurer for denial of benefits — are covered by the Act. Aetna's claims do not seek to enforce the plans. Aetna wants to recoup

the money Humble tricked it into paying for no benefit at all to the patients; the plans are merely the context of Humble's fraud.

The Act does not give comprehensive regulations and procedures for all eventualities that might be tangentially related to a benefit plan. It is silent about overpayment by an insurer to a provider. Recourse to the common-law right to recover an insurer's overpayments does not interfere with the national scheme. Aetna's claims are not preempted.

5. Defenses.

Humble has no defense.

A. Voluntary Payment.

Humble says that Aetna cannot recover because it knowingly paid what Humble charged it when it could have contested those payments. Humble misunderstands Aetna's claim. Aetna does not claim merely that Humble overcharged. It says that Humble overcharged it and (a) did not charge patients as the plans required, (b) did not provide the services for which it was billing, (c) had no assignments from the shells, and (d) paid kickbacks to referring doctors.

Because Aetna had no knowledge of these facts and never led Humble to believe that its bills would not be challenged if they turned out to be false, the voluntary payment rule cannot apply.

B. Accord and Satisfaction.

Humble has not shown that Aetna disputed the bills, and intentionally agreed to relinquish any claims it might have had against Humble for its overcharges.

Aetna never released its right to seek a refund from Humble on any claim. In fact, Humble expressly agreed that all payments by Aetna are subject to the patients' policy and Aetna was not guaranteeing any payment.

C. Unclean Hands.

Aetna's hands are clean. Humble is filthy up to the elbows from lies and corrupt bargains.

D. Express Contract.

Humble says that because it is an assignee of the patients' benefit plans, Aetna's right to a refund is barred by the express contract rule. The plans do not cover overpayments to a provider much less claims tainted by illegal inducements that lured patients and doctors.

As explained, Humble has no assignments from patients. Even if it did, overpayments under a contract can be recovered under a theory of restitution or unjust enrichment. Aetna's claims are not eliminated.

6. Sanctions.

Assuming Aetna's motion for judgment was not meritorious, Humble's answer and counterclaims would be struck. From the beginning Humble has been recalcitrant and obstreperous. Through six sets of lawyers, countless orders, hearings, and conferences, Humble's behavior has ranged from openly defiant to evasive — always feigning compliance. The court has admonished Humble time and time again. These points are illustrative:

A. Humble refused to comply with the court's orders to produce. A year later, when threatened with contempt, Humble finally produced some of its records, despite claiming that it had complied all along.

B. In an effort to deliberately obstruct discovery, Humble removed from its papers "some of the references to use and co-management agreements in the summary as it would be prepared for Hughes.

C. Only after Aetna collaterally discovered in related litigation Humble's use agreements did Humble admit it had them.

D. Though it finally capitulated and produced what was ordered, Humble restricted access to its papers by using the court's order on confidentiality improperly — Humble designated all of its papers for attorneys only without determining whether the restriction was proper. It then blamed Aetna and sought sanctions against it for violating the confidentiality order.

E. Unhappy with the court's denying it relief, Humble surreptitiously sought to re-litigate the issue by suing in Connecticut and unjustifiably seeking to intervene in a proposed class action in New Jersey.

This case has had a tortured existence, and the bulk of the activity has been trying to force Humble to tell the truth. Humble has conducted guerrilla warfare against this court, Aetna, the patients, and common decency.

Humble has been repeatedly warned about its conduct. It has been given the opportunity to reform and has not done so. Its answer and counterclaims are struck as a consequence of its malfeasance.

7. Conclusion.

Hospitals that obtain patients through illegal remuneration to them or their doctors may not be paid under the plans. At its election, Aetna will take from Humble:

A. $41,411,650.98 — the amount Aetna paid Humble from August 2010 through October 2013;

B. $20,248,259.65 — the difference between what Aetna paid Humble as an out-of-network provider from August 2, 2010, to May II, 2012, and what it would have paid Humble as an in-network provider; or

C. $12,423,295.29 — the thirty percent kickbacks paid by Humble with Aetna's money.

Signed on December 31, 2016, at Houston, Texas.

/s/ Lynn N. Hughes

United States District Judge

United Healthcare v. Asprinio, Sup Ct NY 2015 2015 N.Y. Misc LEXIS 3165

No subsequent negative appellate history

United Healthcare v. Paracha, MD., Sup Ct NY Co., 2015 (Index No. 70033/2014)

No subsequent negative appellate history