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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Physicians Surgery Center of Chandler, Plaintiff, v. Cigna Healthcare Incorporated, et al., Defendants.	No. CV-20-02007-PHX-MTL **ORDER**

Pending before the Court is the second motion to dismiss filed by Defendants Cigna Healthcare and associated parties (collectively, "Cigna"). Cigna moves to dismiss Plaintiff Physicians Surgery Center of Chandler's ("PSCC") first amended complaint. (Doc. 38.) For the following reasons, the Court grants the motion.

I. BACKGROUND

The Court previously set forth the factual background of this case in its previous Order. (Doc. 27.) In brief, PSCC provides medical care to patients with Cigna insurance plans, even though it is an out-of-network provider. (Doc. 28 ¶¶ 14, 26, 27.) In October 2018, PSCC received a letter from Cigna accusing PSCC of failing to bill its Cigna-insured patients their full out-of-network cost share, a practice known as "fee forgiveness." (*Id.* ¶¶ 40, 41.) PSCC contends it does not engage in fee forgiveness. (*Id.* ¶ 70.) Ever since Cigna determined that PSCC was engaging in this practice, Cigna has denied all claims submitted by PSCC based on its alleged fee forgiveness policy. (*Id.* ¶ 43, 47.) PSCC alleges that as of August 31, 2020, "Cigna has improperly withheld approximately $5.6 million dollars"

of payment due to PSCC to "create leverage against PSCC." (*Id.* ¶ 53.) PSCC filed a complaint in October 2020. (Doc. 1.)

On July 23, 2021, the Court entered an Order (Doc. 27) granting in part and denying in part as moot Cigna's first motion to dismiss PSCC's complaint. The Court also directed PSCC to file an amended complaint by August 20, 2021, and PSCC timely did so. (*Id.*, Doc. 28.) In its first amended complaint, PSCC asserts three derivate claims arising under ERISA brought on behalf of Cigna's members: failure to properly pay benefits (Count I); breach of fiduciary duties (Count II); and failure to provide full and fair review (Count III). (Doc. 28.) PSCC also asserts five direct claims in its own capacity: breach of contract (Count IV); breach of the duty of good faith and fair dealing (Count V); unjust enrichment (Count VI); violation of Arizona's Prompt Pay statute (Count VII); and consumer fraud (Count VIII). (*Id.*) Cigna moved to dismiss each of PSCC's claims for relief pursuant to Federal Rule of Civil Procedure 12(b)(6). (Doc. 38 at 1.)

II. LEGAL STANDARD

To survive a motion to dismiss, a complaint must contain "a short and plain statement of the claim showing that the pleader is entitled to relief" such that the defendant is given "fair notice of what the . . . claim is and the grounds upon which it rests." *Bell Atl. Corp. v. Twombly*, 550 U.S. 545, 555 (2007) (quoting Fed. R. Civ. P. 8(a)(2); *Conley v. Gibson*, 355 U.S. 41, 47 (1957)). A complaint does not suffice "if it tenders 'naked assertion[s]' devoid of 'further factual enhancement.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Twombly*, 550 U.S. at 556). Dismissal under Rule 12(b)(6) "can be based on the lack of a cognizable legal theory or the absence of sufficient facts alleged under a cognizable legal theory." *Balistreri v. Pacifica Police Dep't*, 901 F.2d 696, 699 (9th Cir. 1988). But the Court should not dismiss a complaint "unless it appears beyond doubt that the plaintiff can prove no set of facts in support of the claim that would entitle it to relief." *Williamson v. Gen. Dynamics Corp.*, 208 F.3d 1144, 1149 (9th Cir. 2000).

In deciding motions to dismiss, the court must accept material allegations in the complaint as true and construe them in the light most favorable to the plaintiff. *North Star*

Int'l v. Arizona Corp. Comm'n, 720 F.2d 578, 580 (9th Cir. 1983). "Indeed, factual challenges to a plaintiff's complaint have no bearing on the legal sufficiency of the allegations under Rule 12(b)(6)." *See Lee v. City of Los Angeles*, 250 F.3d 668, 688 (9th Cir. 2001). Additionally, review of a Rule 12(b)(6) motion is "limited to the content of the complaint." *North Star Int'l*, 720 F.2d at 581.

III. ANALYSIS

A. Derivative Claims

1. Plan Term

In its prior Order, the Court dismissed three of PSCC's ERISA claims: failure to properly pay benefits, breach of fiduciary duties, and failure to provide full and fair review. (Doc. 27 at 7–8.) The underpinning of that Order was PSCC's failure to plead any specific plan language. (*Id.* at 7.) Without that information, PSCC cannot state a claim for relief because "a plaintiff who brings a claim for benefits under ERISA must identify a specific plan term that confers the benefit in question." *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1155 (C.D. Cal. 2015) (citation and internal quotation marks omitted). PSCC conceded that it had not pleaded specific plan language. (Doc. 27 at 7.) Still, the Court allowed PSCC to amend its complaint to show efforts it had undertaken to obtain the plan language. (Doc. 27 at 17.)

In its amended complaint, PSCC provided a number of details about how it has sought the plan documents and also attached emails between PSCC's counsel and Cigna's counsel. (Doc. 28 ¶¶ 89–114, Doc. 28-4 at 2–22.) PSCC asserts that Cigna did not provide the plan documents for all 238 patients, but instead only provided summary plan documents for five of the patients. (*Id.* ¶¶ 89, 100, 114.) Based on these emails, PSCC accuses Cigna of "actively impeding the orderly disposition of this action through patent obfuscation." (Doc. 41 at 7.) Regardless, PSCC provided a representative plan term from the summary plan documents that it alleges "is contained in each Plan for each Claiming Patient." (Doc. 28 ¶ 10.)

Generally, a complaint must allege facts to "raise a right to relief above the

speculative level." *Bell Atl. Corp.*, 550 U.S. at 555. To adequately state a claim under ERISA Section 502(a)(1)(B), "a plaintiff must allege facts that establish the existence of an ERISA plan as well as the provisions of the plan that entitle it to benefits." *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1155 (C.D. Cal. 2015) (citation and internal quotation marks omitted). "Accordingly, a plaintiff who brings a claim for benefits under ERISA must identify a specific plan term that confers the benefit in question." *Id.* The Court finds that PSCC has sufficiently identified a specific plan term, but it still fails to state a claim under which relief can be granted.

In the amended complaint, PSCC alleges: (1) it provided health care services to Cigna patients as an out-of-network provider (Doc. 28 ¶¶ 14, 15); (2) it timely submitted claims to Defendants for payment (*id.* ¶¶ 37, 38); (3) Cigna wrongfully asserts that PSCC engaged in fee forgiveness (*id.* ¶ 41); (4) Cigna told PSCC that it would deny all claims from PSCC until it provided proof of payments by patients to Cigna's satisfaction (*id.* ¶ 42); and (5) PSCC does not engage in fee forgiveness (*id.* ¶ 47).[1] PSCC also provides this representative plan language, which it claims is contained in each patients' plan:

> [I]f Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna.

(*Id.* ¶ 45.) Essentially, the fee-forgiveness term gives Cigna "sole discretion" to refuse to pay for services if Cigna determines a provider is engaging in fee forgiveness. (*Id.*) And, in exercising that discretion, Cigna has the right to require proof that the patient has paid his or her cost share. (*Id.*) PSCC also alleges that Cigna sent a letter on October 4, 2018

[1] Fee forgiveness is when a provider does not bill its patients for the full out-of-network cost that the patient owes under the plan.

alerting PSCC that it had determined PSCC was engaging in fee forgiveness, and it "will continue to deny claims until [PSCC] can establish proof of payments by patients to [Cigna's] satisfaction." (*Id.* ¶¶ 41, 42, Doc. 28-1 at 13–15.) But PSCC never alleges that it made any attempts of proof of payment. (*See* Doc. 28 ¶¶ 41, 42.)

Accepting all of PSCC's allegations as true, PSCC has failed to state a claim for relief based on the alleged plan term. *North Star Int'l*, 720 F.2d at 580. The fee forgiveness term allows Cigna to decide whether a provider is engaging in fee forgiveness and then require proof of payment by the patient. (*Id.* ¶ 45.) The Court must assume, as it alleges, that PSCC was not engaging in fee forgiveness. (*Id.* ¶ 70.) But even still, Cigna had full discretion under the parties' contract terms to seek proof-of-payment. (*Id.* ¶ 45.) PSCC's complaint is silent about its efforts to provide proof-of-payment. In its letter to PSCC, Cigna explained: "[b]ecause [PSCC] failed to provide the requested documentation supporting that you have collected the applicable cost share and balance amounts from the affected customers that satisfies the terms of the plan language, a refund is required." (Doc. 28-1 at 14.) Thus, regardless of whether or not PSCC was forgiving fees, the term dictates that PSCC provide proof-of-payment. Because it did not allege that it did so, the Court cannot determine that Cigna breached the agreement or failed to pay benefits.

Beyond this fee forgiveness term, PSCC asserts no other provision in the ERISA plans that entitle it to payment of benefits. *Almont Ambulatory Surgery Ctr., LLC*, 99 F. Supp. 3d at 1155; *see also Glendale Outpatient Surgery Ctr. v. United Healthcare Servs., Inc.*, 805 Fed. App'x 530, 531 (9th Cir. 2020) (determining that a plaintiff failed to state a claim for relief because it did not any ERISA "plan terms that specify benefits that the defendants were obligated to pay but failed to pay"). Because of this shortfall, PSCC has failed to state a plausible claim for relief on its Counts I, II, or III.

Despite this failure, PSCC has assured the Court that it can allege it submitted documented proof of payment for the medical procedures in the ERISA claims at issue, after it received Cigna's October 4, 2018 letter. (Doc. 51.) As such, the Court grants leave to amend as explained herein.

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