

**IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION**

BIO-MEDICAL APPLICATIONS OF
MISSOURI, INC., et al.,
Plaintiffs,

v.

PRIME HEALTHCARE WELFARE
BENEFITS PLAN, et al.,
Defendants.

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Case No. 22-0302-CV-W-FJG

ORDER

Before the Court is Plaintiffs' Executive Summary (Doc. No. 75), Defendants' response (Doc. No. 83), Plaintiffs' reply (Doc. No. 84), and Plaintiffs' Supplement and Update to Executive Summary (Doc. No. 88). The Court considers all, below.

I. Background

Plaintiffs Bio-Medical Applications of Missouri, Inc., Bio-Medical Applications of New Jersey, Inc., Fresenius Medical Care Montclair, LLC, Fresenius Medical Care Belleville, LLC, NNA-Saint Barnabas, LLC, and NNA of Harrison, LLC (collectively "FMCNA" or "Plaintiffs") are operators of dialysis clinics. Defendants are Prime Healthcare Welfare Benefits Plan (the "Plan") (an employer-sponsored health benefit plan covered by the Employee Retirement Income Security Act ("ERISA")) and Prime Healthcare Services, Inc. ("Prime") and Prime Healthcare Foundation, Inc. ("PHF") (collectively, "Defendants"), which are alleged to be the Plan's sponsors and administrators. Plaintiffs assert that Defendants violated ERISA and the Medicare Secondary Payer Act ("MSP Act") because Defendants did not cover chronic dialysis treatment after providing 39 covered dialysis treatments to eight patients identified in the Complaint. Plaintiffs assert

that the Plan attempted to limit their patients to “acute dialysis” treatment (for which the Plan provides a lifetime limit of 39 visits). Plaintiffs assert that the Medicare payment rates are much lower than most commercial insurance rates, and thus the Plaintiffs have been paid much less than what they would have been paid had Defendants continued to pay for dialysis treatments beyond the 39 treatments they covered here.

The Complaint contains four separate counts: (1) Claim for Unpaid Benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B); (2) Declaratory Relief Pursuant to the Declaratory Judgment Act, 28 U.S.C. § 2201, *et seq.* (seeking a declaration that under the MSP Act, the Plan had and has a responsibility to pay Plaintiffs for all chronic dialysis treatments as primary payer); (3) Violation of the MSP Act, 42 U.S.C. § 1395y(b)(3)(A); and (4) Claim for Attorneys’ Fees under ERISA § 502(g), 29 U.S.C. § 1132(g).

The Court previously granted Plaintiffs’ motion for summary judgment on the ERISA claims in Counts I and IV, and directed further briefing on the amounts of damages and attorneys’ fees, as well as the scope of declaratory relief available to Plaintiffs. The Court further found in favor of Plaintiffs on the MSP Act claims in Counts II and III, and directed further briefing on MSP Act damages and declaratory relief. This Order serves to finalize the Court’s awards on damages and declaratory relief.

II. Analysis

In Plaintiffs’ executive summary (Doc. No. 75), they detail their entitlement to damages, declaratory relief, attorneys’ fees and costs, and pre- and post-judgment interest. Plaintiffs note that they do not object to the dismissal of their claims against Prime Healthcare Foundation, Inc., and the Court will therefore dismiss those claims. See Doc. No. 75. From the remaining defendants, Plaintiffs seek the following categories of damages, fees, and relief:

- Count I – Monetary Award for Unpaid Benefits Under ERISA: payment in the amount of \$5,482,588.39, exclusive of any interest (Doc. No. 88, p. 2);
- Count I – Declaratory Relief Under ERISA: declarations that (1) it is impermissible to apply a 39-treatment cap to deny coverage or payment for chronic end stage renal disease (“ESRD”) dialysis treatments; and (2) Defendants must pay benefits under the Plan, at applicable in-network rates, for in-network chronic dialysis treatments provided to patients with ESRD without application of a 39-treatment cap;
- Count II – Doubling of Monetary Damages Under the MSP Act: payment in the amount of \$10,965,176.78¹ (Doc. No. 88, p. 2);
- Count III – Declaratory Relief Under the Declaratory Judgment Act: declarations that (1) it is a violation of the MSP Act for Defendants to apply a 39-treatment cap to deny coverage or payment for chronic ESRD dialysis treatments, and (2) Defendants must pay FMCNA, as primary to the Medicare program, for all chronic dialysis treatments provided during a patient’s 30-month coordination of benefits period; and
- Count IV – Attorneys’ Fees and Costs Under ERISA: fees and costs of \$563,620.45 for work performed through May 2026 (Doc. No. 88, p. 2); and
- Pre- and Post-Judgment Interest: calculated in accordance with the rate set in 28 U.S.C. § 1961.

The Court examines entitlement to these forms of relief, below.

A. Count I: ERISA

1. Monetary relief

As discussed in its order on the motions for summary judgment, the Court has granted FMCNA’s motion for summary judgment on its ERISA claim for benefits, reasoning that “[c]hronic dialysis for ESRD is not the same thing as ‘acute dialysis,’” and “a reasonable individual reviewing the Plan” would not conclude that chronic dialysis was not covered. Doc. No. 74 at 32. The Court found that “the reasonable interpretation of the

¹ This amount is the total amount of monetary damages requested by Plaintiffs; they clarify in their briefing that they do not request MSP Act double damages and an additional award of damages under ERISA – in other words, their total damages request is for \$10,965,176.78, not \$16,447,765.17.

language in the Plan indicates that coverage shall be provided for dialysis treatment for those with ESRD [end stage renal disease] throughout the coordination of benefits period with Medicare.” Id. at 33.

FMCNA asserts that it is entitled to unpaid benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). It asserts that without Defendants’ unreasonable application of the “acute dialysis” cap to deny benefits for chronic dialysis treatment, Defendants would have been contractually obligated to pay Blue Cross Blue Shield (“BCBS”) network rates for covered in-network services. The FMCNA clinics providing the care to the patients at issue in this case are in-network with BCBS, and so they are entitled to be paid at BCBS network rates for all services covered by the Plan. FMCNA asserts that the amount of health benefits due as of July 2026 is \$5,482,588.39, exclusive of any interest (Doc. No. 88, p. 2).

In response, Defendants argue that Plaintiffs overstate the amount due by \$266,496.36. Specifically, Defendants argue that Patient F first received service on May 4, 2018, and thirty-three months from her first date of service is February 4, 2021. Defendants argue that under the Court’s interpretation of the Plan, Medicare would have been primary coverage for Patient F’s dialysis treatments after February 4, 2021. Defendants assert that treatment after February 4, 2021, should not be included in the calculations. Treatment of Patient F after February 4, 2021, cost \$266,496.36. In their reply to this argument, however, Plaintiffs note that Plaintiff F received short-term, acute dialysis in May 2018, and payment for that treatment is not at issue in this case. See Declaration of Teresa Andrillon, Doc. No. 84, Ex. 1, ¶¶ 6-7. Additionally, Patient F’s ESRD Medical Evidence Report certified by the patient’s nephrologist, provides that the date regular chronic dialysis began was in September 2019, thus making the coordination of

benefits period begin on December 1, 2019. Id. at ¶¶ 9-10. Given that the need for acute dialysis does not result in an ESRD diagnosis or trigger Medicare eligibility, the treatment in May 2018 should not be considered in the damages calculation. The Court finds that Plaintiff's damages should not be reduced as requested by Defendants in relation to Patient F.

Defendants further request that Plaintiffs be ordered to return \$357,047.56 from Medicare for unpaid benefit claims; otherwise, Plaintiffs would receive double recovery. Plaintiffs, however, note that they are already obligated by law to return payments to the Medicare program when this Court's judgment is issued. See Executive Summary Doc. No. 75 at p. 6 n.2 and 42 U.S.C. § 1395y(b)(2)(B)(i). The Court will decline Defendants' invitation to order Plaintiffs to return money to Medicare for unpaid benefits. Therefore, for the foregoing reasons, Plaintiffs are awarded **\$5,482,588.39** (exclusive of interest) on Count I of the Complaint.

2. Declaratory relief

Plaintiffs further argue they are entitled to declaratory relief under ERISA § 502(a)(1)(B). They request an order prohibiting Defendants from applying a 39-treatment cap to chronic ESRD dialysis treatments. Specifically, they seek a declaratory judgment that: (1) it is impermissible to apply a 39-treatment cap to deny coverage or payment for chronic ESRD dialysis treatments; and (2) Defendants must pay benefits under the Plan, at applicable in-network rates, for in-network chronic dialysis treatments provided to patients with ESRD, without application of a 39-treatment cap.

In response, Defendants argue that any declaratory judgment under ERISA should only apply to the eight patients at issue in this case, Patients A-H, and not broadly to a class of plaintiffs. Defendants note that Plaintiffs did not seek such broad declaratory

relief in their complaint, and did not bring their claims under ERISA as a class action (further arguing that the Plaintiffs could not represent such a class as they are not Plan participants or beneficiaries). Given that this is not a class action, Defendants assert that any declaratory relief must be limited to Plaintiffs A-H. See Jewell v. U.S., 548 F.3d 1168, 1172 (8th Cir. 2008); Brady v. United of Omaha Life Ins. Co., 902 F.Supp.2d 1274, 1284 (N.D. Cal. 2012). In reply, Plaintiffs argue that in the absence of the declaratory relief they seek, Defendants may continue to violate ERISA and the MSP Act, both with respect to Patients A-H and with others.

Although the Court is sympathetic to Plaintiffs' concerns, the Court is also cognizant of the limits of its powers to decide cases and controversies between parties with Article III standing. The Court will grant Plaintiffs' request for declaratory relief, but only as to claims related to Patients A-H. The Court denies Plaintiffs' request, however, for broad declaratory relief under ERISA applicable to an unrepresented class of patients.

B. Count II: MSP Act Damages

Plaintiffs argue that they are entitled to double damages under the MSP Act, 42 U.S.C. § 1395y(b)(3)(A), which provides “a private cause of action for damages (which *shall be* in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with [the Act].” In its Order granting summary judgment the Court found that 39 treatments amounted to approximately three months for individuals with ESRD, such that under Defendants' interpretation of the Plan, Defendants only provided coverage until Medicare eligibility begins, ensuring “that the Plan never pays for a dialysis treatment for a Plan participant who potentially qualifies for Medicare, thus ensuring that it never pays primary to Medicare during the 30-month coordination of benefits period.” Order, Doc. No.

74 at p. 37. The Court further found that the Plan “violates the MSP Act by taking into account the patients’ ESRD-based Medicare eligibility in crafting their Plan in such a way that patients’ benefits could be cut off at the earliest possible moment,” and it “differentiates between those with ESRD and those without.” Doc. No. 74 at p. 35 n.15, p. 37. Given these violations of the MSP Act, Plaintiffs assert they are entitled to double damages, for a total damages award of \$10,965,176.78.

In response, Defendants argue that (1) Plaintiffs are not entitled to double damages under the MSP Act; (2) to the extent that Plaintiffs are entitled to double damages, those damages should be limited to amounts Medicare has paid; and (3) Plaintiffs have otherwise incorrectly calculated the amount of damages due under the MSP Act.

1. Entitlement to MSP Act double damages

Defendants raise two arguments that Plaintiffs are not entitled to double damages. First, Defendants argue that the Plan, as construed by the Court, does not violate the MSP Act, and therefore Defendants should not be punished for their actions. The Court concludes, however, that Defendants’ argument is inconsistent with the Court’s previous finding that Defendants’ actions violated the MSP Act. Accordingly, the Court finds that the MSP Act could support double damages.

Second, Defendants argue that Plaintiffs are not entitled to double damages because Defendants’ responsibility to pay has not yet been “demonstrated” under the MSP Act. See 42 U.S.C. § 1395y(2)(B)(ii). Defendants argue that responsibility can be demonstrated by a “judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary

plan's insured, or by other means.” Id. Defendants argue that in this instance, Defendants’ obligation to pay had not been demonstrated at the time Plaintiffs filed their lawsuit, which is a condition precedent to Defendants’ obligation to reimburse Medicare under Section 1395y(b)(2)(B)(ii). See Glover v. Liggett Group, Inc., 459 F.3d 1304, 1309 (11th Cir. 2006). Defendants argue that until their responsibility to pay for a Medicare beneficiary’s claims has been demonstrated by a judgment, Defendants’ obligation to reimburse Medicare does not exist under the statute.

In reply, however, Plaintiffs note that Glover (a case where plaintiffs asserted that a cigarette manufacturer should be held liable under the MSP Act as a tortfeasor) is distinguishable from the case at hand, involving insurance plan coverage. Notably, the Eleventh Circuit has already distinguished Glover from cases involving insurance contracts, finding that the phrase “by other means” contained within Section 1395y(b)(2)(B)(ii) includes contractual obligations. See MSP Recovery, LLC v. Allstate Ins. Co., 835 F.3d 1351, 1360 (11th Cir. 2016) (noting that contracts impose enforceable rights and obligations, whereas tortfeasors have no obligations until they are adjudged liable). See also MSP Recovery Claims, Series LLC v. Metro. Gen. Ins. Co., 40 F.4th 1295, 1303 (11th Cir. 2022); DaVita Inc. v. Virginia Mason Mem’l Hosp., 981 F.3d 679, 684 (9th Cir. 2020); MAO-MSO Recovery II, LLC v. Mercury Gen., No. CV1702525ABAJWX, 2018 WL 3357493, at *10 (C.D. Cal. May 23, 2018). Similarly, the Court here finds that Plaintiffs have demonstrated entitlement to MSP Act damages through Defendants’ contractual obligations. Defendants’ point is therefore denied.

2. Limiting damages to those paid by Medicare

Defendants further argue that since the purpose of the MSP Act is to ensure that Medicare is able to recoup any conditional payments it made in treatment, the amount of

double damages should be limited to the amount of money Medicare paid for the unpaid claims at issue in this case. Defendants assert that Medicare has paid \$357,047.56, so double that amount would be \$714,095.12. Defendants assert that limiting the amount of double damages in this way would prevent the damages from being excessive and punitive.

The Court can find no legal support for Defendants' suggestion that damages be calculated at double what Medicare paid. Instead, as discussed by Plaintiffs, the MSP Act provides that damages shall be double the amount otherwise provided. 42 U.S.C. § 1395y(b)(3)(A). Plaintiffs note that, but for Defendants' violations of the MSP Act, Defendants would have paid for the patients' ESRD dialysis treatment at the amounts calculated in Count I, and so the MSP Act damages calculation should result in the amounts in Count I being doubled. For the reasons stated by Plaintiffs, Defendants' point is denied.

3. Plaintiffs' alleged errors in calculating double damages

Finally, Defendants argue that Plaintiffs' calculation of double damages is flawed. First, Defendants assert that Plaintiffs improperly include \$266,496.36 for Patient F. However, in Section II.A.1., above, the Court has already found that reimbursement of \$266,496.36 for Patient F is proper. This point is denied, and the Court will include this amount in its final calculation.

Defendants further argue that Patient B did not have Medicare coverage at all, and Patient E did not have Medicare coverage after January 1, 2023, and therefore the unpaid claims related to those patients are not covered by the MSP Act. Defendants assert that this amounts to \$280,891.00 for Patient B and \$219,661.00 for Patient E for billing as of April 2024. In reply, Plaintiffs assert that the Court has already found that Defendants

differentiated in benefits between those with ESRD and others pursuant to 42 U.S.C. § 1395y(b)(1)(C), and that the Ninth Circuit has previously found that under the differentiation provision, “plans may not treat persons with ESRD differently even if they are not enrolled in Medicare.” DaVita Inc. v. Virginia Mason Mem’l Hosp., 981 F.3d 679, 693 (9th Cir. 2020). While this may be the law in the Ninth Circuit, the Ninth Circuit acknowledged that certain sister circuits, including the Eighth Circuit, have taken a narrower view of the MSP Act. See Stalley v. Catholic Health Initiatives, 509 F.3d 517, 524 (8th Cir. 2007) (finding “the apparent purpose of the [private cause of action] is to help the government recover conditional payments from insurers or other primary payers.”). Given the narrower view of the MSP Act taken by the Eighth Circuit, the Court finds that Defendants’ position is well-taken, and the amounts of \$280,891.00 for Patient B and \$219,661.00 for Patient E must be excluded from the double damages calculation.

Similarly, Defendants argue that Plaintiffs have improperly included \$1,760,970.99 as of April 2024 for benefit claims that were not submitted to Medicare and were not paid or conditionally paid by Medicare. Plaintiffs acknowledge that there is a split in authority on whether such claims can be reimbursed through the double damages provisions of the MSP Act; however, as discussed above, the Court believes that the Eighth Circuit’s holding in Stalley would lead to the conclusion that such claims should not be included in calculation of double damages. See Stalley, 509 F.3d at 425. Accordingly, the Court will exclude \$1,760,970.99 from its calculation of double damages.

Finally, the Court will also exclude the amounts for Patient E not submitted to Medicare and not paid or conditionally paid by Medicare from April 2024 through August of 2026. These excluded amounts are \$617,991.30.

Therefore, the Court finds that the total amount of damages for the MSP Act claims, inclusive of the ERISA damages awarded in Count I (above) is **\$8,085,662.49** (the sum of \$5,482,588.39 in ERISA damages and \$2,603,074.10 in MSP Act double damages).

III. Count III: Declaratory Judgment

Plaintiffs seek a declaratory judgment that (1) it is a violation of the MSP Act for Defendants to apply a 39-treatment cap to deny coverage or payment for chronic ESRD dialysis treatments, and (2) Defendants must pay FMCNA, as primary to the Medicare program, for all chronic dialysis treatments provided during a patient's 30-month coordination of benefits period. Defendants filed no response to Plaintiffs' opening brief. Plaintiffs argue this is unsurprising, given that this claim is being pursued in Plaintiffs' own stead, rather than through an assignment from the Plan participants (as the other counts of the complaint are being pursued). For the reasons stated by Plaintiffs, the Court will **GRANT** their request for declaratory relief under the Declaratory Judgment Act, 28 U.S.C. § 2201(a), finding that (1) it is a violation of the MSP Act for Defendants to apply a 39-treatment cap to deny coverage or payment for chronic ESRD dialysis treatments, and (2) Defendants must pay FMCNA, as primary to the Medicare program, for all chronic dialysis treatments provided during a patient's 30-month coordination of benefits period.

IV. Attorneys' Fees and Costs

Plaintiffs argue that they are entitled to their attorneys' fees and costs as they prevailed on Count I of their Complaint. Notably, the Court has already held "Plaintiffs are entitled to an award of attorneys' fees." See Order, Doc. No. 74, p. 33. Plaintiffs request attorneys' fees and costs in the amount of \$563,620.45 for work performed through May 2026. Factors considered by courts in the Eighth Circuit to determine whether to award attorneys' fees and costs in ERISA cases include: "(1) the degree of

the opposing parties' culpability or bad faith; (2) the opposing parties' ability to satisfy an award; (3) deterrence of others in similar circumstances; (4) whether the requesting parties sought to benefit all participants and beneficiaries of an ERISA plan, or to resolve a significant legal ERISA question; and (5) the relative merits of the parties' positions." Johnson v. Charps Welding & Fabricating, Inc., 950 F.3d 510, 525 (8th Cir. 2020). Plaintiffs argue that all of these factors weigh in favor of an award of attorneys' fees, as (1) Defendants are highly culpable, (2) they have not shown an inability to satisfy an award, (3) they should be deterred from future similar conduct, (4) the case involved significant legal questions, and (5) Plaintiffs' legal positions have prevailed.

Plaintiffs utilize the lodestar method to calculate attorneys' fees, "multiplying the number of hours reasonably expended by the reasonable hourly rates." Johnson, 950 F.3d at 526. Plaintiffs further note their reasonable costs and expenses are recoverable See 29 U.S.C. § 1132(g); 28 U.S.C. § 1920; Johnson, 950 F.3d at 527-28. Plaintiffs have prepared declarations from their attorneys (Doc. Nos. 75 Exs. 2 and 3 and Doc. No. 88 Exs. 2 and 3) showing billing entries for litigation work related to the ERISA claims; Plaintiffs indicate that they have removed billing entries and expenses related to pre-litigation efforts to exhaust administrative appeals. Plaintiffs also assert that they have attempted to remove billing related solely to the MSP Act claims. In total, Plaintiffs seek \$563,620.45 for attorneys' fees and expenses through May 2026.

In response, Defendants first argue that the Court should reconsider whether attorneys' fees are appropriate in this case, given that they are discretionary, not mandatory, under 29 U.S.C. § 1132(g). See Lawrence v. Westerhaus, 749 F.2d 494, 496 (8th Cir. 1984). The Court, however, finds that an attorneys' fee award is appropriate in this case, for the reasons stated by Plaintiffs.

Defendants further argue that the amount of attorneys' fees is unreasonably high, and includes fees for time spent pre-litigation. First, Defendants argue that a number of Plaintiffs' counsel's time entries are vague and reflect block billing of time (giving as examples 2.9 hours billed on January 10, 2022 for "prepare litigation analysis," 8.6 hours on January 14, 2022 for "prepare litigation analysis memorandum, and 4.6 hours billed on March 11, 2022 for "revise litigation analysis"). Defendants argue the Court should reduce Plaintiffs' fees by \$60,554.60 for such vague billing. In reply, however, Plaintiffs' counsel has attached a declaration noting that the "litigation analysis memorandum" was a document prepared by counsel for the client, evaluating and outlining potential claims, defenses, and key documents, making recommendations to the client (who understood what it was being billed for, such that it did not require further discussion or elaboration on invoices). See Doc. No. 84, Ex. 2, ¶ 6. The Court finds that Plaintiffs' counsel's billing records are sufficiently detailed and will not deduct for allegedly vague billing.

Defendants also complain that Plaintiffs are seeking \$104,187.40 for 269 hours of time spent prior to the filing of this matter on May 6, 2022. Defendants assert that the Eighth Circuit has held that pre-litigation fees and costs are not recoverable under ERISA. Parke v. First Reliance Standard Life Ins. Co., 368 F.3d 999, 1011 (8th Cir. 2004) (finding that fees and costs related to pre-litigation administrative proceedings are not recoverable). In reply, however, Plaintiffs note that the case cited by Defendants relates to administrative proceedings, not work taken in support of the filing of a federal complaint. As noted by a federal district court in Iowa examining this same type of argument, the determining factor is whether the work was related to litigation as opposed to administrative proceedings:

Parke is not relevant to the instant analysis. The hours billed prior to the drafting of the Complaint are not related to the administrative proceedings. . . . Such fees billed in preparation for a judicial action—not during the pendency of administrative proceedings—are generally recoverable under § 1132(g)(1). Accordingly, the court finds that *Parke* does not bar Plaintiff from recovering fees billed prior to the drafting of the Complaint.

Vollenweider-Leos v. Hartford Life and Acc. Ins. Co., No. 07-CV-110-LRR, 2010 WL 457743, at *4 (N.D. Iowa Feb. 1, 2010) (internal citation omitted). The Court finds that Plaintiffs are entitled to the costs and fees related to litigation, including those related to attorney time expended in order to draft and file the complaint in this matter.

The Court finds that the fees requested by Plaintiffs are reasonable, and awards Plaintiffs attorneys' fees and costs in the amount of \$563,620.45.

V. Pre- and Post-Judgment Interest.

Finally, Plaintiffs seek pre- and post-judgment interest. The Court has discretion to award pre-judgment interest, but a court “abuses its discretion when denying a prevailing ERISA benefit claimant’s request for prejudgment interest, absent exceptional or unusual circumstances.” Tussey v. ABB Inc., No. 06-4305-CV-C-NKL, 2012 WL 2368471, at *4 (W.D. Mo. June 21, 2012). “The Eighth Circuit has held that in an ERISA case, a court must ‘calculate [] prejudgment interest using the rate established by [28 U.S.C.] § 1961.’” Tussey, 2012 WL 2368471, at *4 (citations omitted). Post-judgment interest awards “*shall* be allowed on any money judgment in a civil case recovered in a district court,” and shall be calculated as instructed by the statute. 28 U.S.C. § 1961(a) (emphasis added). The applicable interest rate is “equal to the weekly average 1-year constant maturity Treasury yield, as published by the Board of Governors of the Federal Reserve System, for the calendar week preceding the date of the judgment.” 28 U.S.C. § 1961(a). Post-judgment

interest “shall be computed daily” from the date of the entry of judgment “to the date of payment,” and “shall be compounded annually.” 28 U.S.C. § 1961(a)-(b).

Here, Plaintiffs seek an award of both pre- and post-judgment interest, calculated at the rate called for in 28 U.S.C. § 1961. Plaintiffs seek interest on the double damages amount, running from the date 60 days following the date services were rendered (to allow a reasonable time for claim processing had Defendants properly processed and paid each claim as required by ERISA and the MSP Act), until the date of payment, computed daily and compounded annually. See 28 U.S.C. § 1961. Plaintiffs offer to submit pre- and post-judgment interest calculations after the Court’s entry of judgment in this matter.

Defendants file no objections to Plaintiffs’ request for pre- and post-judgment interest. Therefore, the Court **GRANTS** Plaintiffs’ motion, and allow interest on double the damages amount for each service date, running from the date 60 days following the date of services until the date of payment, computed daily and compounded annually, at the rate in 28 U.S.C. § 1961. Plaintiffs shall submit their pre- and post-judgment interest calculations to the Court on or before **October 20, 2026**.

III. Conclusion

For the foregoing reasons, the Court dismisses all claims against Defendant Prime Healthcare Foundation, Inc., and enters judgement awarding the following damages and declaratory relief to Plaintiffs against Defendants Prime Healthcare Welfare Benefits Plan and Prime Healthcare Services, Inc.: (a) \$5,482,588.39 in ERISA benefits; (b) a doubling of a portion of those damages under the MSP Act for a total damages award in this case of \$8,085,662.49; (c) \$563,620.45 in attorneys’ fees and costs; (d) pre- and post-judgment interest in an amount to be calculated later; and (e) declaratory relief under

ERISA § 502(a)(1)(B) as to Patients A-H only, and declaratory relief under the MSP/Declaratory Judgement Act for Plaintiffs, entering a declaratory judgment that (1) it is a violation of the MSP Act for Defendants to apply a 39-treatment cap to deny coverage or payment for chronic ESRD dialysis treatments, and (2) Defendants must pay FMCNA, as primary to the Medicare program, for all chronic dialysis treatments provided during a patient's 30-month coordination of benefits period.

Plaintiffs shall submit their pre- and post-judgment interest calculations to the Court on or before **October 20, 2026**.

IT IS SO ORDERED.

Date: September 29, 2026
Kansas City, Missouri

/s/ FERNANDO J. GAITAN, JR.
Fernando J. Gaitan, Jr.
United States District Judge