ERISA Preemption:
Making Strategic Arguments for and Against Preemption in an Era of Inconsistent and Evolving Legal Standards

Presented by:

Shari Gerson
GrayRobinson, P.A.

Joelle Sharman
Lewis Brisbois Bisgaard & Smith LLP

Michael A. Coval
Miller & Martin
This Presentation Will Cover:

• Getting cases into federal court

• Conflict versus complete preemption

• Theories being advanced to avoid ERISA preemption

• Non-ERISA theories

• Analyzing the pros and cons of removal—even for cases where complete preemption is obvious
Advantages to Preemption

• litigation in a federal district court (rather than a state court)

• remedies limited to those specifically provided under ERISA

• a review of benefits determinations under ERISA’s deferential standard for most plan administrator determinations
PREEMPTION PRIMER

• ERISA’s preemption clause preempts all state laws that relate to an employee benefit plan.

• ERISA contains an exception to this preemption rule, referred to as the “savings clause,” that allows state laws to regulate the business of insurance.

• Finally, ERISA (through the “deemer clause”) prevents states from characterizing a self-insured plan as the business of insurance.
Complete Preemption under ERISA

ERISA §502(a)(1)(B) provides: “[a] civil action may be brought by a participant or beneficiary to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B).

ERISA’s civil enforcement provisions authorize plan participants or beneficiaries to file civil actions to recover benefits, enforce rights conferred by an ERISA plan, remedy breaches of fiduciary duty, clarify rights to benefits, and enjoin violations of ERISA.
Conflict preemption

• Unless a state law directly conflicts with an ERISA provision or purpose, the state law will not be preempted and may be enforced.

• Section 514 provides that state laws that “relate to” ERISA plans are preempted.

• “Insurance Savings Clause” requires insured ERISA plans to:
  • cover state mandated benefits; and
  • to varying degrees, adapt their plan administration to state regulation of insurance practices.
Rush Prudential HMO v. Moran

- Complete v. Conflict preemption analysis
- State law required HMOs to submit coverage denials to independent review and to be bound by the reviewer’s decision.
- The HMO did not comply with this provision. The HMO member paid for a denied treatment herself and filed an action under ERISA for reimbursement.
- The HMO argued that the state law was conflict-preempted because it interfered with the administration of the plan.
- The plaintiff/HMO member asserted that the Insurance Savings clause saved the law from preemption.
Rush v. Moran cont’d

• The Court held that the state statute was saved from preemption
  • terms of the statute were incorporated in the coverage policy issued by the HMO
  • HMO policy was a plan document that specified the plan’s covered benefits and administration
• The Court ruled that the plan member’s cause of action was for the wrongful denial of plan benefits pursuant to ERISA Section 502(a)(1)(B).
• Court emphasized that Section 502 completely preempts the remedies available
Preemption as Basis for Removal

• Conflict preemption is an affirmative defense that preempts state laws that “relate to” an ERISA plan, but does not serve as a basis for removal.

• Complete preemption, in contrast, “convert[s] an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.”

• That is, under the complete preemption doctrine, any “cause[] of action within the scope of the civil enforcement provisions of § 502(a) [is] removable to federal court.”

• So, only claims that are completely preempted by ERISA can be removed to federal court. A federal court judge cannot rule on conflict (defensive) preemption unless jurisdiction is conferred on some other ground.
Federal Court Removal

In addition to ERISA, check for other federal court jurisdiction in case complete preemption under ERISA is questionable

- Diversity (probably most common)
- ADA or other employment discrimination statutes (even if inapplicable to case and cannot be maintained, gets the case into federal court)
- Co-Defendants with independent grounds
Four types of provider claims

• (1) ERISA § 502(a)(1)(B) claims brought by the provider as an assignee of a participant or beneficiary
• (2) state law claims brought by providers in their individual capacity
• (3) state law claims brought pursuant to a service contract under which the provider agrees to provide services to the plan’s participants for agreed-upon fees (“Provider Agreement Claims”)
• (4) hybrid claims where the complaint alleges a violation of ERISA and a violation of a duty independent of ERISA.
Determining Complete Preemption


Two-part test

1. Whether the plaintiff *could have* brought its claims under §502(a)

2. Whether no other legal duty supports the plaintiff’s claim
Complete Preemption Test

Whether the plaintiff could have brought its claims under §502(a)

Two-step analysis
1. Do the claims fall within the scope of ERISA?
2. Does the plaintiff have standing?
Standing

• Three ways a medical provider can lack standing to bring an ERISA claim:
  • (1) Lacks standing under Article III of the Constitution.
  • (2) Lacks direct, statutory standing under § 502(a) of ERISA.
  • (3) Lacks standing to bring a claim as an assignee (“derivative standing”) if the assignment is not valid.
Article III Standing

• To have standing under Article III, a plaintiff must “adequately” establish:
  • (1) an injury in fact (i.e., a “concrete and particularized” invasion of a “legally protected interest”);
  • (2) causation (i.e., a “fairly . . . trace[able]” connection between the alleged injury in fact and the alleged conduct of the defendant); and
  • (3) redressability (i.e., it is “likely” and not “merely speculative” that the plaintiff’s injury will be remedied by the relief plaintiff seeks in bringing suit).

(Because a medical provider seeks to redress its own injury before the court, (s)he typically would have Article III standing to pursue even an assigned § 502(a)(1)(B) claim)
Statutory Standing

• Only a participant or beneficiary has standing to bring a claim for benefits under ERISA § 502(a)(1)(B).

• ERISA § 502(a)(3) by its terms only authorizes lawsuits by participants, beneficiaries, and fiduciaries.

• Rarely does a medical provider have statutory standing. BUT CF. OSF Healthcare System v. Marcone Appliance Parts Co. Employee Benefit Plan, No. 1:11-cv-01202-JBM-JAG, 2012 WL 264197 (C.D. Ill. Jan. 27, 2012) (medical provider could have standing as “appointed representative” of participant where plan used the term “claimant” but did not define it, and plan document provided that plan consider claim for benefits from “properly designated representative”).
Derivative Standing

• Providers mostly have to seek recourse as an assignee of a participant or beneficiary.
• Beneficiaries may assign their ERISA enforcement rights to providers that directly bill health plans.
• Assignee of an ERISA benefit claim “stands in the shoes of his assignor”
• Two issues:
  • (1) whether ERISA allows the assignment of health care benefits; and
  • (2) is the assignment valid?
    • Determined by federal law
    • check to see if the plan has unambiguous anti-assignment language
Standing

*Statutory* standing under ERISA 502(a) is generally limited to a participant, beneficiary or fiduciary

But a provider can obtain derivative standing under ERISA by obtaining a written assignment of benefits.

Beneficiaries may assign their ERISA enforcement rights to providers that directly bill health plans.
Independent Duty

A legal duty is not independent of ERISA if it derives entirely from the particular rights and obligations established by ERISA plan benefits

Independent Duty


- Defendant denied at least three of the disputed claims on the grounds that they were “duplicate charges.”
- Plaintiff sued for breach of contract
- Court held that although the plaintiff framed the breach of contract claim as a claim for a breach of an independent contract generated with defendant, the claim was dependent upon whether the charges were covered by the plan because in order to resolve the claim, the court needed to determine whether the specific services were covered as eligible expenses or not covered because the services exceeded the price of “reasonable and customary” services or were duplicative of other invoices already submitted and paid.
- Court reasoned that the dispute was not the applicable rate of payment but instead concerned coverage.
Historically, courts in determining whether provider claims were preempted by ERISA generally focused on: (1) whether the provider had standing to sue under ERISA § 502(a)(1), and (2) whether the claims focused on the amount paid for each claim (which is not preempted), or on a coverage determination (which is preempted).

Courts generally found that provider claims were completely preempted only if: (1) the claim was brought as an assignee of the beneficiary or participant; and (2) claims required a determination of coverage and eligibility under the Plan rather than on the application of discounted rates under the subscriber agreement.
Example of Past Davila Interpretations

• Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc., 187 F.3d 1045, 1051 (9th Cir. 1999).

• Healthcare-provider plaintiffs received assignments from plan participants (derivative standing under § 502(a)).

• Still, court held that the providers’ breach of contract claims were not completely preempted because dispute did not center on the right to payment (which typically turns on the ERISA benefit determination), but rather related only to the amount, or level, of payment (which depends on the terms of the provider agreements).
Tide begins turning in 2009

• Lone Star OB/GYN Assocs. v. Aetna Health, Inc., 579 F.3d 525 (5th Cir. 2009)

• Connecticut State Dental Assn. v. Anthem Health Plans, Inc., 591 F.3d 1337 (11th Cir. 2009)

• Defendants built strong records of assignment and showed that the providers’ claims depended, at least in part, on a benefit (coverage) determination.
First case: Lone Star OB/GYN Assocs. v. Aetna Health

- Health care provider sued Aetna under the Texas Prompt Pay Act arguing that Aetna had not paid Lone Star at rates set out in the Provider Agreement within the time period required by the Act.
- Aetna showed that Lone Star’s patients had assigned their rights to Lone Star, and that Lone Star had derivative standing.
- Aetna also showed some of the claims on which Lone Star sought recovery were claims that had been denied, reflecting a benefit determination governed under ERISA.
First case: Lone Star OB/GYN Assocs. v. Aetna Health (Cont’d)

• To avoid preemption, Lone Star amended its complaint to remove the claims that had been denied. Lone Star then argued that because it had received a partial payment from Aetna on each of its remaining claims, the dispute did not concern a benefit determination, but only the appropriate payment for those benefits.

• Aetna argued that the partial payment was due to a partial denial of benefits based on a determination that a given service was not medically necessary.
First case: Lone Star OB/GYN Assocs. v. Aetna Health

• Court remanded due to poorly developed factual record, but importantly noted that if “any individual payment claim potentially encapsulates multiple procedures only some of which were covered, and partial payment thus resulted from a denial of benefits under the plan, the claim may be preempted.”
Second Case: *Connecticut State Dental Assn. v. Anthem*

- Dentists and state dental association brought a claim against Anthem to collect unpaid amounts that were owed under their provider agreements as a result of Anthem’s allegedly improper use of payment methods (such as downcoding and bundling) under the guise of utilization review.
- Anthem removed the claims to federal district court, and district court denied Plaintiffs’ motion to remand.
- On appeal, Plaintiffs made two arguments:
  - while dentists had received assignments from plan participants, those assignments included only the right to submit a claim to the plan as opposed to the right to bring a legal claim under ERISA.
  - Also argued that claim did not pertain to rights under the plan.
Second Case: *Connecticut State Dental Assn. v. Anthem* (Cont’d)

• The Eleventh Circuit found the assignment was sufficient to give plaintiffs a colorable claim for benefits.

• Also held that some of the allegations in plaintiffs’ complaint related to rights under the plan (“systematically denying and/or reducing Dentists’ reimbursements,” denying “medically necessary claims through the use of so-called ‘guidelines,’” and “failing to provide an adequate explanation for the denial of claims for reimbursement”).

• Although not all allegations fell outside scope of ERISA, because at least part of the claim related to ERISA violations, the court held that plaintiffs’ breach of contract claim implicated ERISA and was preempted.
Third Case in 2011 Follows Suit

- Montefiore Medical Center v. Teamsters Local 272, 642 F.3d 321 (2d Cir. 2011) – state law reimbursement claim
- provider called prior to rendering services to ensure patient was eligible and that the anticipated services were covered. The provider argued that these verbal communications gave rise to an independent legal duty between it and the insurer.
- Court held in-network provider’s state law based reimbursement claim was completely preempted by ERISA.
- rejected the provider’s argument that an otherwise valid assignment of benefits is a “nullity” whenever care is provided in-network.
- found that the provider’s claims could be classified as claims for benefits because they involved the “right to payment”
Montefiore-No Independent Duty

Second Circuit was not persuaded by the provider’s argument and held that the pre-approval phone call to verify coverage required an interpretation of the plan’s coverage and benefits and were not independent legal duties derived from an oral agreement.

“[The] pre-approval process was expressly required by the terms of the Plan itself (court's emphasis) and is therefore inextricably intertwined with the interpretation of Plan coverage and benefits.”
Application Inconsistencies

Notwithstanding what was intended to refine the complete preemption analysis, Courts, even sister courts, have been ruling inconsistently on each *Davila* step
Both prongs analyzed

- Plaintiff sued Aetna in state court for breach of two written contracts and declaratory relief. Defendants removed the action to federal district court contending ERISA completely preempted plaintiff’s state law claims. Plaintiff moved to remand, arguing the claims were not completely preempted.
- The court determined plaintiff could *not* have brought its claim under ERISA because it arose from the two written contracts and the fact that plaintiff received assignments of benefits from its patients did not alone convert its claims into claims to recover benefits under ERISA.
Both prongs analyzed (con’t)

• The court found defendants’ alleged actions implicated an independent legal duty—i.e., under the two written contracts between the plan and the hospital.

• Finding neither Davila prong satisfied, the court held plaintiff’s state law causes of action were not completely preempted and granted the motion to remand.
Recent Southern District of Florida Cases

In 2013, the same plaintiff (a recovery company that is allegedly an assignee of the providers’ claims) brought three cases against Aetna and four against United.

All but one United case were removed to federal court based on complete preemption under ERISA.

The causes of action were identical in all the cases and none of the claims were paid. Although the underlying provider in the Aetna cases was a different provider than in the United cases, the denials were similar.
Recent Southern District of Florida Cases

Allegations included the following:

• that it rendered services “because the Defendant by agreement with the patient/insured, receives the benefit of a premium . . . for services rendered to the insured as a result of the insuring agreement. “

• that “the provision of these services satisfied Defendant’s obligations to the patient to provide and pay for medical services under Defendant’s agreement with the patient.”

• that “Defendant understood that the subject medical services were provided to the patient by the medical provider, in satisfaction of Defendant’s agreement with the patient.

• [provider] received the appropriate authorization from the Defendant

• Neither Plaintiff nor [provider] has received payment

• This action arises out of insurer’s breach of the applicable health insurance contract . . . as an intended third party beneficiary of the insurance contract between the insurer and the insured

• The health insurance contract obligates defendant to pay third party medical service providers

• Defendant has violated the pertinent subject contractual provisions

• Defendant . . . orally agreed that the patient was covered under the healthcare plan, authorized the medical provider to proceed with the delivery of the healthcare service to the insured and that it would timely pay the provider

• Defendant failed to pay . . . the amounts due under the oral agreement
Recent Southern District of Florida Cases

The six cases ended up in front of five different judges:

• King, Graham, Moore, Altonaga and Lenard

Despite filing Notices of Related Cases, none were transferred
Southern District of Florida

• Judge King was the first to rule

• Judge King’s order noted that the case was about claims that Defendant did not pay “but agreed to pay”

• Judge King decided that the nature of the claims was therefore about the “rate of payment” and not the “right to payment”

• Accordingly, Judge King remanded the case
Southern District of Florida

- Judge Graham ruled next

- Judge Graham found that plaintiff *could have* brought its claims under ERISA so prong one of *Davila* was met

- However, Graham relied upon the allegations that defendant orally agreed that the patient was covered and authorized the medical provider to proceed with the service. Graham viewed those allegations as sufficient to establish an independent legal duty

- Because prong two of *Davila* was not met, Judge Graham remanded the case
Southern District of Florida

• Next to rule was Judge Moore, who had two of the cases

• Judge Moore, like Judge King, decided that the cases were about the “rate” of payment

• Judge Moore’s Order of remand includes language that the allegations implicate separate legal duties and therefore involve the rate of payment

• The foregoing illustrates just how unsettled this area of the law continues to be
After the remand orders were entered, the plaintiff filed them as supplemental authority in the cases where the motions were still pending.

Judge Altonaga ordered the defendant to file a memo explaining why she should not follow the rulings of the other judges and remand the case before her. Plaintiff filed a reply.
Southern District of Florida

• After fully briefed, Judge Altonaga found remand to be IMPROPER
  • Judge Altonaga found the claims fell within the scope of 502(a) of ERISA as they involve a right to payment
  • She also found that plaintiff had derivative standing so prong one was met
  • Lastly, Judge Altonaga found no independent legal duty
  • Montefiore Med. Ctr. V. Teamsters Local 272, 643 F.3d 321 (2d Cir. 2011) (finding no independent duty where provider called to verify coverage)
Litigation Trends

• challenges to state regulation of health plans and insurers

• challenges to state tort lawsuits for delay or denial of health care.
Litigation Trends

Allegations that provider called to verify eligibility, verify that the service to be rendered is covered under the plan and even that the plan agreed to pay

These allegations are becoming increasingly more common in an effort to avoid removal to federal court or if removed, as a basis to seek remand
Litigation Trends

In an effort to avoid removal, providers are alleging oral contracts—usually related to the call made to verify benefits.

Some providers even allege (untruthfully) that the payer agreed to pay them for their services.
Litigation Trends

• Providers suing in their individual capacity

“[A] healthcare provider’s claims of negligent misrepresentation and estoppel based on a plan’s oral misrepresentations are not ERISA claims because they do not arise from the plan or its terms.”

Conn. State Dental Assoc. v. Anthem Health Plans, Inc., 591 F.3d 1337, 1344 n. 7 (11th Cir. 2009).
Recent Ninth Circuit Case


Port Medical Wellness provided chiropractic care, medical services, physical therapy and acupuncture almost exclusively to participants in a self-funded union plan administered by CIGNA.

Port Medical Wellness had a participating practitioner agreement (PPA) with Chiropractic Health Plan of California (CHPC).
Port Medical Wellness (Cont’d)

• 2010 CIGNA audited billing practices of provider and kept claims in pending status; provider had to close 3 locations
• Union-affiliated entity also opened similar healthcare service locations nearby under a similar name to Port Medical Wellness
• Port Medical Wellness then sued CIGNA, the plan, and the union on a variety of state law grounds (breach of implied-in-fact contract, intentional misrepresentation, services rendered, violation of California business statutes, and intentional interference with prospective economic relations)
• Defendants removed the case under ERISA, and Port Medical Wellness moved for remand
Port Medical Wellness Remand

• District court remanded the case
  • Port Medical Wellness could not have brought its claim directly under ERISA Section 502(a)(1)(B).
  • Defendants did not prove that the plan patients validly assigned their benefits to Port Medical Wellness
  • While state law claims required some judicial interpretation of the plan terms, coverage and eligibility were not in dispute; provider was seeking compensation for covered services rendered per the terms of the PPA, not the plan.
Prompt Pay State Regulations

• Georgia’s prompt payment law required self-funded plans and TPAs to pay errorless digital claims within 15 business days and paper claims within 30 calendar days, with no extensions (the same schedules for traditional health plans), while the federal ERISA regulations allow 30 days for processing claims and a 15 day extension.

• On Sept. 14, 2012, AHIP moved to enjoin Commissioner Hudgens from enforcing the statute.
  • Federal district judge temporarily blocked law.
Prompt Pay Regulations (Cont’d)

Court rejected Commissioner’s three preemption arguments that:

• 1) AHIP lacked standing to file a claim (group had not suffered a cognizable injury; its claim was not ripe, and the court lacked subject matter jurisdiction);

• 2) Third-party administrators and not self-funded ERISA plans themselves were subject to the law and its penalties (because TPAs are not ERISA fiduciaries and, thus, Georgia may regulate their claims processing); and

• 3) the law governs only a ministerial function; that is, the required timing for paying or denying claims
Lessons from the AHIP case

- States trying to indirectly regulate self-funded benefit plans, through entities such as their TPAs and stop-loss insurers.

- Self-funded plans must have the ability to administer claims uniformly and in accordance with plan terms.