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9th Circ. Clarifies ERISA Preemption for Healthcare Industry

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On May 31, the U.S. Court of Appeals for the Ninth Circuit published an opinion in Bristol SL Holdings Inc. v. Cigna Health and Life Insurance Co., which has significant implications for the healthcare industry.

Most notably, this decision clarifies the broad scope of the Employee Retirement Income Security Act's preemption of state law causes of action arising from preservice coverage communications between medical providers and health plan administrators.

The opinion held that ERISA preempted an out-of-network provider's state law claims arising from verification of benefit and preauthorization communications with a health plan administrator under both the "reference to" and "connection with" prongs of ERISA preemption analysis.

The opinion also distinguished prior Ninth Circuit case law finding no preemption of state law claims on the ground the member was not covered by an ERISA plan at the time services were rendered.

This opinion stands to benefit payors and health plan administrators as it will limit the ability of health care providers to plead around ERISA preemption or expand the scope of ERISA benefits actions by asserting nonderivative state law claims.

Background

Health plan payors and ERISA benefits administrators in California have faced an increasing number of lawsuits brought by noncontracted healthcare service providers asserting state law claims for breach of implied contract and other quasi-contract or equitable claims based on preservice communications verifying benefits or preauthorizing treatment.

Some providers attempt to plead around ERISA and avoid federal jurisdiction by asserting only state law causes of action and disclaiming assignment of the benefits. Others, as in Bristol, assert the state law claims as an alternative to a claim for benefits under ERISA.

Bristol sued Cigna as successor-in-interest to Sure Haven Inc., a bankrupt for-profit substance abuse treatment

center that was out-of-network with Cigna, claiming Cigna failed to pay claims for 106 Sure Haven patients with health plans administered by Cigna.

Bristol alleged that prior to providing the services at issue, Sure Haven called Cigna to verify the members' benefits and obtain preauthorization for its intended services. At issue on appeal, was whether state law claims of promissory estoppel, breach of oral contract and breach of implied contract based on alleged agreements to pay usual and customary rates during those pre-service communications are preempted by ERISA.

Holding and Analysis of Bristol v. Cigna

The Ninth Circuit concluded[1] that ERISA preempts state law causes of action arising from verification of benefit and preauthorization calls under both the "reference to" and "connection with" prongs of ERISA preemption analysis.

The court found state law claims based on preservice communications had reference to ERISA plans, because the calls arose in the context of determining reimbursement under ERISA plans, damages would require inquiry into plan terms, and the provider simultaneously brought an ERISA benefits claim as an assignee.

The court also found ERISA preempted Bristol's state law causes of action for having an impermissible connection with ERISA plans. In this respect, the court noted that verification of benefit and preauthorization calls are central matters of plan administration, and allowing the state law claims would interfere with uniform plan administration by allowing ERISA benefits to be determined by innumerable phone calls leading to variable results.

Finally, the court distinguished The Meadows v. Employers Health Insurance, a Ninth Circuit case from 1995 finding no ERISA preemption of state law claims based on preservice verification of benefit because there, the patient was not covered by an ERISA plan at the time of service, so there were no ERISA benefits to apply.

Our Take

This decision is important because it resolves ambiguity caused by seemingly disparate holdings by district courts within the Ninth Circuit on the scope of ERISA preemption in this context.

Some courts had held state common law causes of action were laws of general applicability, applying equally to ERISA and non-ERISA plans, meaning the ERISA plan was not essential to the claims' survival, and thus not preempted. The Bristol opinion makes clear ERISA may preempt even generally applicable state common law causes of action where they are asserted merely as an alternative mechanism to obtain ERISA benefits.

Other lower court decisions held ERISA did not preempt state law claims because the medical providers were not ERISA-regulated entities. The Bristol opinion confirms the expansive scope of ERISA preemption, by holding state law claims arising from pre-service communications interfere with nationally uniform administration of benefits, which satisfies the connection-with test for ERISA preemption, notwithstanding the providers' status.

The decision also puts to rest the notion that alleged agreements made during verification of benefit and preauthorization calls give rise to an independent legal duty to pay benefits, when the plan terms provide

otherwise.

In doing so, the opinion distinguishes claims that are “independent of an ERISA plan” such as those in The Meadows, from claims that merely “aris[e] from an independent source of law” but still involve administration of ERISA benefits, such as those in Bristol.

The U.S. Court of Appeals for the Second Circuit also issued a summary order in Park Avenue Podiatric v. Cigna Health and Life Insurance Co. last year, similarly holding that ERISA preempted state law claims arising from preservice communications with out-of-network providers.

The impact of these recent decisions should be significant, given the growing trend of providers seeking to plead around ERISA by alleging state law causes of action either exclusively, or in the alternative to an ERISA benefits claim.

Restricting providers’ ability to bring state law claims is in keeping with the intent of ERISA to maintain a streamlined and uniform process for resolving benefits disputes, by limiting discovery to the administrative record and ensuring ERISA benefits are adjudicated in accordance with federal law.

Health plan payors and administrators should take note of these decisions and make use of them in litigation by noncontracted providers treating members with ERISA plans.

Additionally, the Ninth Circuit’s detailed discussion of the purpose of preservice verification of benefit and preauthorization communications may arguably be extended to support challenges to state law quasi-contract causes of action outside of the ERISA context.

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[1] In a separate unpublished memorandum disposition, the Ninth Circuit affirmed the district court’s grant of summary judgment to the plan administrator on plaintiff’s ERISA claim seeking recovery of benefits under 29 U.S.C. § 1132(a)(1)(B).
https://ecf.ca9.uscourts.gov/n/beam/servlet/TransportRoom?servlet=ShowDoc/009034386473.

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