

**ERISA PREEMPTION IN PROVIDER REIMBURSEMENT LITIGATION:  
RECENT CASES & CURRENT TRENDS**

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When healthcare providers bring state law reimbursement claims against healthcare payors, the parties are often forced to address the issue of Employee Retirement Income Security Act (ERISA) preemption. One of the most significant questions that arises in the early stages of reimbursement litigation is whether a provider's claims fall within ERISA's civil enforcement mechanism and can therefore be removed to federal court. Payors often argue that reimbursement claims are removable under ERISA because they challenge the denial of health plan benefits. In response, providers frequently maintain that their claims are not encompassed by ERISA because they are based on an independent provider contract or an independent duty arising under state law. Over the years, ERISA jurisprudence has slowly evolved to address these unique disputes. However, recent opinions issued by various district courts across the country illustrate that the scope of ERISA preemption in the context of reimbursement litigation is still in a state of flux. This briefing will identify some of those opinions and highlight the trends and inconsistencies in this complex area of the law.

## I. BACKGROUND

ERISA was designed to protect the interests of participants in employee benefit plans by establishing an exclusive set of standards to govern their administration.<sup>1</sup> As a result, ERISA contains infamously broad preemption provisions, which ensure that employee benefit plan regulation is “exclusively a federal concern.”<sup>2</sup>

It is important to recognize that there are two distinct types of ERISA preemption. The first stems from the statute’s preemption clause, which provides that ERISA “shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . .”<sup>3</sup> The comprehensive civil enforcement system imbedded in § 1132(a) of the statute provides a separate path to preemption.<sup>4</sup> This section authorizes a plan participant or beneficiary to bring suit to recover plan benefits they have been denied, enforce their rights under the plan, or clarify any rights to future benefits under the plan.<sup>5</sup> In *Pilot Life Ins. Co. v. Dedeaux*,<sup>6</sup> the Supreme Court outlined the basic principles of § 1132(a) preemption, holding that § 1132(a) must be “the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits . . . .”<sup>7</sup> As a result, the Court held that ERISA preempts any state law cause of action that would expand upon the remedies available under § 1132(a).<sup>8</sup>

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<sup>1</sup> See 29 U.S.C. §§ 1001 *et seq.*

<sup>2</sup> *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

<sup>3</sup> ERISA § 514(a), as set forth in 29 U.S.C. § 1144(a); see *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) (noting that the § 1144(a) preemption clause, while broad, is not boundlessly expansive).

<sup>4</sup> ERISA § 502(a), as set forth in 29 U.S.C. § 1132(a).

<sup>5</sup> 29 U.S.C. § 1132(a)(1)(B).

<sup>6</sup> 481 U.S. 41 (1987).

<sup>7</sup> *Id.* at 52.

<sup>8</sup> *Id.* at 54-56; see also *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 143-45 (1990).

In addition, the Supreme Court has concluded that § 1132(a) has “such extraordinary pre-emptive power that it converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.”<sup>9</sup> That is, claims that trigger § 1132(a) preemption, unlike claims that solely implicate the § 1144(a) preemption clause, are removable to federal court.<sup>10</sup> Although there is some variation between the Circuit Courts of Appeal, § 1132(a) preemption is widely referred to as “complete” preemption, and § 1144(a) preemption is labeled “conflict” preemption.<sup>11</sup> Due to the jurisdictional consequences of complete preemption, and the abundance of recent cases analyzing its applicability to provider reimbursement disputes, this briefing will be primarily focused on whether, and in what circumstances, state law reimbursement claims are preempted by § 1132(a).<sup>12</sup>

In June of 2004, in *Aetna Health Inc. v. Davila*,<sup>13</sup> the Supreme Court issued its most recent interpretation of the scope of § 1132(a) preemption. *Davila* involved consolidated cases in which two individuals, Juan Davila and Ruby Calad, brought state law claims against their respective health maintenance organizations (HMOs) for allegedly failing to exercise ordinary care while making coverage decisions.<sup>14</sup> Davila’s claim centered on his HMO’s refusal to pay for the pain reliever prescribed by his physician.<sup>15</sup> Calad’s claim challenged his HMO’s refusal to authorize an extended

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<sup>9</sup> *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004).

<sup>10</sup> *Id.*

<sup>11</sup> *See id.*; *but see* *Kidneigh v. UNUM Life Ins. Co.*, 345 F.3d 1182, 1190 (10th Cir. 2003) (referring to § 1144(a) preemption as “direct” preemption and § 1132(a) preemption as “conflict” preemption.)

<sup>12</sup> For an interesting discussion of the scope of § 1144(a) in the context of provider reimbursement claims, *see* *Temple Univ. Children’s Med. Ctr. v. Group Health, Inc.*, 413 F.Supp.2d 530 (E.D. Pa. 2006).

<sup>13</sup> *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004).

<sup>14</sup> *Id.* at 204.

<sup>15</sup> *Id.* at 205.

hospital stay notwithstanding her physician's recommendation to the contrary.<sup>16</sup> The Supreme Court held that both claims fell within § 1132(a) because both claims were, at bottom, attempts to recover benefits denied under the terms of each ERISA plan.<sup>17</sup> Thus, the Supreme Court held that their state law claims were preempted by ERISA.<sup>18</sup> In doing so, the Supreme Court reinforced the broad scope of complete preemption, emphasizing that,

Any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.<sup>19</sup>

However, when the Supreme Court restated the test for complete preemption, it included an important caveat:

[I]f an individual, at some point in time, could have brought his claim under ERISA [§1132(a)(1)(B)], *and where there is no other independent legal duty that is implicated by a defendant's actions*, then the individual's cause of action is completely pre-empted by ERISA [§1132(a)(1)(B)].<sup>20</sup>

Following the Supreme Court's decision in *Davila*, there has been a substantial amount of litigation over what, exactly, constitutes an "independent legal duty" for the purposes of the complete preemption analysis. The Supreme Court's caveat is particularly influential in provider reimbursement litigation, which can implicate dozens of arguably "independent" duties, depending on the relationship between the provider and payor at issue.

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<sup>16</sup> *Id.*

<sup>17</sup> *Id.* at 212.

<sup>18</sup> *Id.* at 209.

<sup>19</sup> *Id.*

<sup>20</sup> *Id.* at 210 (emphasis added).

## II. PREEMPTION & REIMBURSEMENT DISPUTES

In assessing whether a provider's reimbursement claims fall within the scope of § 1132(a), one of the primary questions a court must answer is whether the provider is seeking compensation pursuant to an assignment of their patient's ERISA plan benefits. In those instances, courts generally hold that the provider "stands in the shoes" of their patient and is limited to the claims that could have been brought by the patient.<sup>21</sup> Thus, wrongful denial of benefit claims, whether brought by the ERISA plan beneficiary or by a provider as an assignee of ERISA plan benefits, are subject to complete preemption.

The complete preemption analysis differs substantially depending on the relationship between the provider and the payor involved in a given dispute. Courts often draw a broad distinction between "nonparticipating providers," providers that have not executed an independent contract with the payor they are bringing suit against, and "participating providers," those that have. Participating providers generally have a stronger argument that their claims are based on legal duties (contractual obligations) that are completely independent of their patient's ERISA plans. Nonparticipating providers, on the other hand, often have difficulty arguing that they are not bringing claims as assignees of ERISA plan benefits. For these reasons, many courts have treated the presence or absence of an independent provider contract as dispositive of the complete preemption issue.<sup>22</sup> However, as demonstrated below, some courts have recently held that reimbursement claims brought by a participating provider under an

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<sup>21</sup> See *infra* note 33 for a list of the Circuit Court opinions adopting the majority position that providers can obtain derivative standing to pursue remedies under ERISA by virtue of an assignment of ERISA plan benefits.

<sup>22</sup> See *infra* note 87.

independent contract can, in certain circumstances, fall within the scope of §1132(a). Conversely, some courts have held that state law claims asserted by a nonparticipating provider are not completely preempted, even though the provider held a valid assignment of ERISA plan benefits. The inconsistencies between these opinions are often striking.

Moreover, that simple dichotomy is not well suited to account for the complexities of provider reimbursement arrangements. Litigation stemming from preferred provider network discounts, for instance, raises additional questions about the scope of complete preemption. In such disputes, there is often no direct provider contract between the payor and the provider. Instead, the parties are linked by a Preferred Provider Organization (PPO), which contracts directly with the provider, securing discounts in exchange for promises of patient volume. The PPO then contracts with the payor, granting the payor access to the negotiated discounts. When provider reimbursement claims arise under these indirect contractual relationships, courts have had difficulty analyzing whether they fall within the scope of § 1132(a). However, over the past year, more and more courts have refused to exercise jurisdiction over such claims, holding that they are not completely preempted by ERISA.

In the following subsections, complete preemption is examined in the context of nonparticipating provider disputes, participating provider disputes, and PPO disputes. As these cases indicate, even though general principals of preemption have emerged in the context of provider reimbursement litigation, the courts still have not reached a consensus on a range of important issues.

## A. Nonparticipating Providers

When a nonparticipating provider brings suit against a payor, questions immediately arise about the provider's legal right to recovery against the payor. Because such providers cannot bring suit on an independent contract, they frequently bring suit as assignees of their patient's right to reimbursement from the payor. For a long time it was unclear whether provider reimbursement claims predicated on an assignment of ERISA plan benefits could fall within the scope of ERISA's civil enforcement mechanism. ERISA only permits plan participants, beneficiaries, and fiduciaries (in addition to the Secretary of Labor) to bring civil actions under § 1132(a).<sup>23</sup> Providers do not have independent standing to seek recovery through § 1132(a).<sup>24</sup> However, in *Misic v. Building Service Employees Health and Welfare Trust*, the Ninth Circuit directly addressed the issue and held that a provider pursuing reimbursement from a payor as an assignee of ERISA plan benefits has standing to access ERISA's civil enforcement mechanism.<sup>25</sup> The ERISA plan at issue in *Misic* provided that beneficiaries would be reimbursed for 80% of the amount billed for their dental care.<sup>26</sup> The plaintiff was a dentist who had been reimbursed at less than 80% of the amount billed and sought to recover the difference.<sup>27</sup> The plaintiff brought claims under both state law and ERISA.<sup>28</sup> The district court dismissed his state law claims as preempted, and dismissed his ERISA claim, concluding that ERISA prohibits the assignment of

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<sup>23</sup> 29 U.S.C. § 1132(a).

<sup>24</sup> *Id.*

<sup>25</sup> See *Misic v. Building Serv. Employees Health & Welfare Trust*, 789 F.2d 1374 (9th Cir.1986).

<sup>26</sup> *Id.* at 1375.

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

health benefits.<sup>29</sup> The district court reasoned that because § 1056(d) of ERISA prohibits the assignment of *pension* benefits, health and welfare benefits were governed by a similar restriction.<sup>30</sup> On appeal, the Ninth Circuit reversed, explaining that the anti-assignment provision established in § 1056(d) could not be imputed to health and welfare benefits:

Health and welfare benefit trust funds are designed to finance health care. Assignment of trust monies to health care providers results in precisely the benefit the trust is designed to provide and the statute is designed to protect. Such assignments also protect beneficiaries by making it unnecessary for health care providers to evaluate the solvency of patients before commencing medical treatment, and by eliminating the necessity for beneficiaries to pay potentially large medical bills and await compensation from the plan.<sup>31</sup>

As a result, the Ninth Circuit held that ERISA does not prohibit such assignments, and that the plaintiff, “as assignee of beneficiaries pursuant to assignments under ERISA, has standing to assert the claims of his assignors.”<sup>32</sup>

The Ninth Circuit’s decision in *Misic* has been followed by almost every Circuit Court of Appeal.<sup>33</sup> The widespread recognition that providers may recover benefits pursuant to an assignment has been a blessing and a curse for both payors and providers. *Misic* and its progeny have given providers an additional remedy through which they can seek reimbursement from payors. However, those remedies are

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<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> *Id.* at 1377.

<sup>32</sup> *Id.* at 1379.

<sup>33</sup> See *e.g.*, *Herman Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1290 (5th Cir. 1988); *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1277 (6th Cir. 1991); *Kennedy v. Connecticut Gen. Life Ins. Co.*, 924 F.2d 698, 700 (7th Cir. 1991); *City of Hope Nat’l Med. Ctr. v. Healthplus, Inc.*, 156 F.3d 223, 228-29 (1st Cir. 1998); *I.V. Servs. of Am. Inc. v. Trustees of the Am. Consulting Eng’rs Council Ins. Trust Fund*, 136 F.3d 114, 117 n. 2 (2d Cir. 1998); *Cagle v. Bruner*, 112 F.3d 1510, 1515 (11th Cir. 1997); *Yarde v. Pan Am. Life Ins. Co.*, 67 F.3d 298 (4th Cir. 1995); *Lutheran Med. Ctr. of Omaha NE v. Contractors, Laborers, Teamsters, and Eng’rs Health & Welfare Plan*, 25 F.3d 1616, 1619-20 (8th Cir. 1994).

typically not as expansive as the remedies provided under state law, and they are often subject to unfavorable standards of judicial review.<sup>34</sup> Most importantly, the availability of remedies under ERISA forecloses other potential sources of recovery. As noted above, “[a]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy” is completely preempted by ERISA.<sup>35</sup> Unfortunately, the courts have come to conflicting results when attempting to determine which state law claims merely “duplicate, supplement, or supplant the ERISA civil enforcement remedy” and which claims are based on duties that are “independent” of ERISA.

(i) **Foregoing Claims as an Assignee**

The specter of ERISA preemption has had a substantial impact on the claims nonparticipating providers assert against payors. In an attempt to shelter their suits from preemption, such providers frequently disavow any potential claims they might have against the defendant as an assignee of ERISA plan benefits and bring claims under various state law theories, including unjust enrichment, constructive contract, promissory estoppel, negligent misrepresentation, and quantum meruit. Unfortunately, the federal courts are still reaching conflicting results when analyzing the viability of such claims in the context of complete preemption.

One of the most notable cases to address the issue was *In re Managed Care Litigation*,<sup>36</sup> the multi-district litigation in which providers and medical associations brought suit against managed care companies, alleging that they violated various state

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<sup>34</sup> See e.g., *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

<sup>35</sup> *Davila*, 542 U.S. at 209.

<sup>36</sup> 298 F.Supp.2d 1259 (S.D. Fla. 2003)

and federal laws by failing to process claims for reimbursement properly.<sup>37</sup> Because the suit involved both participating and nonparticipating providers, the court was forced to address the scope of ERISA preemption from a variety of different angles, including whether unjust enrichment/constructive contract claims brought by nonparticipating providers were preempted by § 1132(a).<sup>38</sup>

The managed care companies argued that any constructive contract claims brought by nonparticipating providers who held valid assignments of ERISA plan benefits were completely preempted by § 1132(a), as they were “in reality claims for ERISA plan benefits made by doctors rendered outside of a contractual relationship with the insurer.”<sup>39</sup> Ultimately, the court agreed, holding that,

Provider-Assignees possess derivative standing and thus all of their claims—including those for constructive contract—are recast under the doctrine of complete preemption as ERISA claims for benefits under Section [1132(a)]. Accordingly, this statute constitutes their exclusive avenue for enforcing claims for ERISA benefits. A caveat is in order, however. This finding is contingent upon production of valid subscriber assignments from the Provider-Assignee subclass. To the extent that Defendants are not able to produce proof of a valid assignment from patients, the derivative standing doctrine does not apply to those providers.<sup>40</sup>

Because the defendants could not establish that the constructive contract claims asserted by non-assignee, nonparticipating providers who were not assignees of ERISA plan benefits were preempted by § 1132(a), the defendants argued that such claims were subject to conflict preemption under §1144(a). That is, they argued that even though the providers could not pursue their claims through ERISA’s civil enforcement mechanism, such claims were preempted nonetheless because they “related to” ERISA

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<sup>37</sup> *Id.* at 1272.

<sup>38</sup> *Id.*

<sup>39</sup> *Id.* at 1291.

<sup>40</sup> *Id.* at 1292.

plans.<sup>41</sup> The court disagreed, holding that the connection between the constructive contract and unjust enrichment claims of the nonparticipating, non-assignee providers and the relevant ERISA plans was too tenuous to trigger preemption.<sup>42</sup> The court reasoned that such claims “are not based upon the ‘relationship between the insured and insurer’ but upon Defendants’ solicitation and knowing acceptance of the Providers’ services.”<sup>43</sup> The court explained:

While it is possible that some of the Non-Par Providers may obtain assignments, that fact alone does not force them to pursue the ERISA claims route instead of bringing claims against Defendants in their own independent right . . . Plaintiffs need not necessarily be channeled into the ERISA statutory scheme when simultaneously bringing direct claims in their own right.<sup>44</sup>

Even though this statement was issued solely in the context of the court’s *conflict* preemption analysis, it could, if taken out of context, obfuscate the court’s earlier conclusion that any claims brought by an assignee of plan benefits, including constructive contract claims, “are recast under the doctrine of complete preemption as ERISA claims for benefits . . . .”<sup>45</sup>

Since the court’s opinion was issued in December of 2003, many health plans and providers have wondered whether the court’s broad statement on conflict preemption would bleed into the complete preemption analysis. A recent case decided by the U.S. District Court for the Southern District of Florida demonstrates that it has.

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<sup>41</sup> *Id.* at 1292-93.

<sup>42</sup> *Id.* at 1293.

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

<sup>45</sup> *Id.* at 1292.

In *Riverside Medical Associates v. Humana, Inc.*,<sup>46</sup> it was unclear whether the provider at issue was a participating or nonparticipating provider.<sup>47</sup> The parties agreed that there was, at one point, a valid provider agreement between them.<sup>48</sup> The provider argued that Humana breached that agreement by failing to reimburse it at the negotiated rate.<sup>49</sup> Humana argued that the provider's contract expired and it was therefore only obligated to reimburse the provider at non-participating provider rates.<sup>50</sup> The provider filed suit in state court, alleging breach of contract, and Humana removed to the Southern District of Florida, arguing that the provider only had standing to seek reimbursement as an assignee of ERISA plan benefits.<sup>51</sup> The court ultimately remanded on the basis that Humana failed to prove the existence of a valid assignment.<sup>52</sup> However, the court implied that remand would be appropriate even if the plaintiff was a nonparticipating provider with a valid assignment by quoting *In re Managed Care Litigation* for the proposition that "Plaintiffs need not necessarily be channeled into the ERISA statutory scheme when simultaneously bringing direct claims in their own right . . . ."<sup>53</sup> The court emphasized that "whether or not Plaintiff was a participating provider, the claims in this case do not fall under ERISA preemption."<sup>54</sup>

Thus, the *Riverside* opinion only added more uncertainty to the question of whether nonparticipating providers are precluded from bringing reimbursement claims outside of ERISA when they hold a valid assignment of ERISA plan benefits. For

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<sup>46</sup> No. 06-61490-CIV-COHN, 2006 WL 3827541 (S.D. Fla. Dec. 28, 2006).

<sup>47</sup> *Id.* at \*1.

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> *Id.* at 2.

<sup>53</sup> *Id.* at 2-3

<sup>54</sup> *Id.* at 3.

instance, in August of 2006, the U.S. District Court for the Northern District of California came to the opposite conclusion and held that state law claims brought by a nonparticipating provider holding an assignment of benefits were completely preempted by ERISA. In *Catholic Healthcare West-Bay Area v. Seafarers Health & Benefits Plan*,<sup>55</sup> a nonparticipating provider brought suit against an ERISA plan after the plan only paid a portion of the provider's usual and customary charges.<sup>56</sup> The provider advanced state law claims for negligent misrepresentation (based on the plan's pre-certification of coverage), breach of implied contract, promissory estoppel, quantum meruit, and "indebitatus assumpsit (for work, labor, services and materials)."<sup>57</sup> The health plan removed to federal court, arguing that the provider's claims were completely preempted by ERISA.<sup>58</sup> The provider moved to remand the case, insisting that it was not bringing suit as an assignee of ERISA plan benefits and was merely asserting state law claims.<sup>59</sup> The district court, however, denied the provider's motion to remand.<sup>60</sup> The court concluded that, given the existence of a valid assignment, "St. Mary's could have brought suit under ERISA as [the patient's] assignee . . ." and that the pertinent question is "whether ERISA preempts plaintiff's solely state law claims."<sup>61</sup> Ultimately, the court concluded that, regardless of the manner in which the provider characterized its claims, they were preempted by ERISA because they necessarily required interpretation of the

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<sup>55</sup> No. 06-01741 (N.D Cal. Aug. 16, 2006).

<sup>56</sup> *Id.* at 2.

<sup>57</sup> *Id.* at 1.

<sup>58</sup> *Id.* at 3.

<sup>59</sup> *Id.*

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

patient's ERISA plan to determine whether the provider was entitled to the unpaid balance.<sup>62</sup>

The opinions in *Catholic Healthcare* and *Riverside* highlight some of the current ambiguities in the complete preemption analysis as applied to nonparticipating providers who hold valid assignments of ERISA plan benefits. At this point, it is not entirely clear whether such providers can completely forgo their claims as assignees and instead pursue other state law claims, such as unjust enrichment, constructive contract, promissory estoppel, or quantum meruit.

(ii) **Post-Service Settlement Agreements**

One further wrinkle in nonparticipating provider disputes involves whether ERISA preempts claims arising from *post-service* settlement contracts. In *Abilene Regional Medical Center v. United Industrial Workers Health and Benefits Plan*,<sup>63</sup> the Fifth Circuit examined whether a valid distinction could be drawn, for the purposes of ERISA preemption, between claims stemming from a pre-existing provider contract and claims stemming from a settlement agreement entered into after the benefits had already been provided. The provider in that case treated an ERISA plan beneficiary, accepted an assignment of the beneficiary's claim to benefits, and sent an invoice to the beneficiary's ERISA plan administrator.<sup>64</sup> The parties then negotiated a settlement agreement, wherein the provider agreed to accept a 15% reduction in its charges as payment in full for the services rendered.<sup>65</sup> However, after the settlement agreement

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<sup>62</sup> *Id.* at 4.

<sup>63</sup> No. 06-10151, 2007 WL 715247 (5th Cir. Mar. 6, 2007) (slip copy).

<sup>64</sup> *Id.* at 1.

<sup>65</sup> *Id.*

was executed, the ERISA plan administrator discovered that the beneficiary at issue was only eligible for a much smaller amount of benefits under the plan's lifetime benefits cap.<sup>66</sup> The plan administrator informed the provider that, notwithstanding the settlement agreement, it would only reimburse the provider the limited amount it was required to pay under the terms of the ERISA plan.<sup>67</sup> The provider brought suit against the plan for breach of contract and negligent misrepresentation.<sup>68</sup> The plan argued that the breach of contract claim was not independent of the patient's ERISA plan and was therefore preempted by ERISA.<sup>69</sup> The district court agreed, and dismissed the breach of contract claim as preempted.<sup>70</sup>

On appeal, the provider stressed that it was not suing as an assignee of ERISA plan benefits, and was instead suing under an independent provider contract.<sup>71</sup> The provider cited a substantial amount of authority to support its argument that ERISA does not preempt claims grounded in an independent provider contract.<sup>72</sup> However, the Fifth Circuit distinguished those cases:

[Plaintiff] has attempted to avoid ERISA preemption by suing on the basis of 'independent contracts' and not suing as an assignee, but it cannot escape the fact that those contracts arose from settlement negotiations about [the beneficiary's] claim for benefits. These contracts are not truly independent from [Plaintiff's] status as an assignee. The contracts have a significant 'nexus' with the ERISA plan and its benefit system. Given this 'nexus,' [Plaintiff] is properly characterized as an assignee asserting a derivative claim for benefits, and not as an independent third-party provider.<sup>73</sup>

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<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> *Id.* at 2.

<sup>71</sup> *Id.* at 3.

<sup>72</sup> *Id.*

<sup>73</sup> *Id.* (The court proceeded to analyze whether an anti-assignment provision in the ERISA plan precluded preemption. Ultimately, the court held that, pursuant to prior Fifth Circuit authority, the anti-assignment

Thus, the Fifth Circuit held that the provider's breach of contract claims were distinguishable from claims predicated on a pre-existing provider contract and were preempted by ERISA.<sup>74</sup> Interestingly, this case also highlights how the lines between conflict and complete preemption can become blurred. The Fifth Circuit technically analyzed these claims under the standard for conflict preemption, solely making reference to § 1144(a), because the U.S. District Court for the Northern District of Texas was able to sustain jurisdiction on the basis of diversity.<sup>75</sup> However, neither the Fifth Circuit nor the district court (which referenced standards applicable to both arms of preemption) made note of the distinction.<sup>76</sup> And, given the Fifth Circuit's statement that the provider "is properly characterized as an assignee asserting a derivative claim for benefits . . .," it is reasonable to assume that the court would have reached the same conclusion analyzing the claims under § 1132(a).<sup>77</sup> In either event, the court's opinion demonstrates that nonparticipating providers bringing claims under a post-service contract will have difficulty sheltering their claims from ERISA.

## **B. Participating Providers**

The scope of ERISA preemption, particularly complete preemption, narrows in reimbursement disputes involving participating providers. Many federal courts have recognized that where a provider's claim for reimbursement is based on contractual

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provision was unenforceable against healthcare providers because they were not specifically referenced in the anti-assignment clause).

<sup>74</sup> *Id.*

<sup>75</sup> See *Abilene Reg'l Med. Ctr.*, No. 04-232, Order Granting Defendant's Motion for Summary Judgment, fn. 6 (N.D. Tex. Dec. 23, 2005).

<sup>76</sup> *Id.*

<sup>77</sup> *Abilene Reg'l Med. Ctr.*, 2007 WL 715247, at 3.

rights and obligations that are completely independent of their patient's ERISA plan, the provider's claim does not fall within ERISA's civil enforcement mechanism and is not subject to complete preemption.

The Ninth Circuit's decision in *Blue Cross of California v. Anesthesia Care Associates Medical Group*<sup>78</sup> is frequently cited by participating providers for this principle. The providers in that case executed provider agreements with Blue Cross that contained fee schedules governing reimbursement under the contract.<sup>79</sup> The providers brought suit in state court against Blue Cross for breach of contract, alleging that Blue Cross improperly amended the fee schedules.<sup>80</sup> Blue Cross removed, arguing that, to the extent the providers were seeking payment for services rendered to ERISA plan beneficiaries, their right to reimbursement stemmed from an assignment of ERISA plan benefits.<sup>81</sup> The district court concluded that the claims did not fall within § 1132(a), and the Ninth Circuit affirmed on appeal.<sup>82</sup> The Ninth Circuit explained that its opinion in *Misic*<sup>83</sup> was inapplicable to reimbursement disputes arising out of independent provider agreements:

In *Misic*, the provider had no contractual agreement with his patient's health benefit plan, such as a provider agreement, specifying his fee entitlements. It is clear in *Misic* that the provider sought, as an assignee, to recover reimbursement due to his assignors under the terms of the benefit plan; indeed the terms of the benefit plan were the provider's only basis for his reimbursement claim. Here, in contrast, the Providers and Blue Cross have executed provider agreements, and

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<sup>78</sup> 187 F.3d 1045 (9th Cir. 1999).

<sup>79</sup> *Id.* at 1048.

<sup>80</sup> *Id.*

<sup>81</sup> *Id.* at 1050.

<sup>82</sup> *Id.*

<sup>83</sup> 789 F.2d 1374 (9th Cir.1986).

it is the terms of the provider agreements that Providers contend Blue Cross has breached.<sup>84</sup>

The court then summarized its conclusion with the following distinction:

The dispute here is not over the *right* to payment, which might be said to depend on the patients' assignments to the Providers, but the *amount*, or level, of payment, which depends on the terms of the providers' agreements.<sup>85</sup>

Thus, the Ninth Circuit held that the providers' claims were independent of ERISA and were not completely preempted by § 1132(a).<sup>86</sup>

After *Anesthesia Care* was decided, many courts cited it in support of drawing a straightforward distinction, for the purposes of the preemption analysis, between reimbursement disputes that involve independent provider contracts and reimbursement disputes that do not.<sup>87</sup> Given the exception to complete preemption announced in *Davila* for claims arising under an "independent legal duty," some courts held that *Davila* merely reinforces the distinction drawn in *Anesthesia Care*.<sup>88</sup> However, some courts have reassessed the viability of that distinction post-*Davila*. For instance, in *Radiology Associates of San Antonio v. Aetna Health, Inc.*,<sup>89</sup> the U.S. District Court for the Western District of Texas addressed whether a provider's claim against a payor could be completely preempted even if based on an independent provider contract. The provider in that case, Radiology Associate of San Antonio (RASA), entered into a

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<sup>84</sup> *Id.* at 1051.

<sup>85</sup> *Id.* (emphasis in original).

<sup>86</sup> *Id.*

<sup>87</sup> See e.g., *Orthopedic Surgery Assocs. of San Antonio, P.A. v. Prudential Health Care Plan, Inc.*, 147 F.Supp.2d 595 (W.D. Tex. 2001); *South Tex. Spinal Clinic, P.A. v. Aetna Healthcare, Inc.*, No. Civ. A.SA-03-CA0089FB, 2004 WL 1118712 (W.D. Tex. Mar. 22, 2004) (unreported); *Ashton Med. Assocs., Inc. v. Aetna Health Management, Inc.*, 395 F.Supp.2d 415 (S.D. W. Va. 2005); *Hill Physicians Med. Group, Inc. v. Pacificare of Cal.*, No. C 01-0318 SI, 2001 WL 492481 (N.D. Cal. Apr. 24, 2001) (unreported).

<sup>88</sup> See e.g., *Pascack Valley v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393 (3d Cir. 2004).

<sup>89</sup> No. 03-1152 (W.D. Tex.).

Physician Group Agreement with Aetna.<sup>90</sup> Aetna, in turn, entered into a contract with MedSolutions of Texas, Inc. to manage radiology patient referrals to RASA.<sup>91</sup>

RASA brought suit against Aetna and MedSolutions in state court, alleging fraud, negligent misrepresentation, quantum meruit, breach of contract, and multiple causes of action under the Texas Insurance Code.<sup>92</sup> RASA alleged, *inter alia*, that Aetna “repeatedly underpaid, delayed, or improperly denied payment” on a host of different claims for reimbursement.<sup>93</sup> RASA attached a spreadsheet to its complaint identifying the various claims that Aetna allegedly failed to pay in whole or part.<sup>94</sup> While some claims were denied on the grounds of medical necessity, presumably under the terms of an ERISA plan, some of the identified claims were merely “paid incorrectly.”<sup>95</sup>

The defendants removed the lawsuit to the Western District of Texas, arguing that RASA’s claims fell within the scope of § 1132(a) and were therefore completely preempted.<sup>96</sup> Issuing its opinion just months before *Davila* was decided, the court granted the motion, in part, but remanded RASA’s breach of contract claim, reasoning that, pursuant to *Anesthesia Care*, the claim “does not center on the *right* to payment, which might be said to depend on the patients’ assignments to the Providers, but instead focuses on the *amount* of payment, which depends on the terms of the provider

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<sup>90</sup> See *Radiology Assocs. of San Antonio v. Aetna Health, Inc.*, No. 03-1152, Order Granting In Part and Denying In Part Motion to Remand (W.D. Tex. Mar. 5, 2004).

<sup>91</sup> *Id.* at 1.

<sup>92</sup> *Id.* at 1-2.

<sup>93</sup> *Radiology Assocs.*, No. 03-1152, Notice for Removal by Aetna Health, at 10 (W.D. Tex. Nov. 20, 2003) (attaching a copy of Plaintiff’s Petition).

<sup>94</sup> *Id.* at 22-24 (spreadsheet attached to Plaintiff’s Petition).

<sup>95</sup> *Id.*

<sup>96</sup> *Id.* at 2.

agreements.”<sup>97</sup> The court held that the remaining claims were completely preempted by ERISA.<sup>98</sup> The court explained:

On the breach of contract claim, where interpretation requires interpretation and enforcement of the Physician Group Agreement, then a contract separate from ERISA benefit plans exists and defeats complete preemption. On the other hand, as to Plaintiffs’ bad faith claims—unfair settlement, filing of false financial statements, and misrepresentation—Defendant has carried its burden to demonstrate that at least some of the services were provided under employee benefit plans. Plaintiff’s own characterization of the claim as an effort to recover benefits and its failure to allege or argue that it is not an assignee of the patients’ claims, indicates that the claims arising under the Texas Insurance Code are primarily claims for the recovery of benefits assigned to RASA by patients and claims processing disputes.<sup>99</sup>

Following the Supreme Court’s decision in *Davila*, Aetna requested that the court reconsider its order remanding RASA’s breach of contract claim.<sup>100</sup> Aetna argued that the test set forth in *Davila* made it clear that RASA’s breach of contract claim was completely preempted.<sup>101</sup> Aetna contended that the provider contract was “inextricably linked to the ERISA-regulated plan” because key provisions in the contract, such as the definition of “covered services,” could only be defined in the context of a given patient’s ERISA plan.<sup>102</sup> RASA argued, in turn, that its claim was predicated on precisely the type of “independent legal duty” described in *Davila*.<sup>103</sup> Further, RASA insisted that it was “not suing as an assignee, and there is no evidence in the record that [it] is an

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<sup>97</sup> *Id.* at 6 (*quoting* *Anesthesia Care*, 187 F.3d at 1047) (internal quotations omitted).

<sup>98</sup> *Id.* at 8.

<sup>99</sup> *Id.*

<sup>100</sup> See *Radiology Assocs.*, No. 03-1152, Defendant’s Motion for Reconsideration (W.D. Tex. June 28, 2004).

<sup>101</sup> See *Radiology Assocs.*, No. 03-1152, Report and Recommendation of Judge Nowak (W.D. Tex. March 2, 2005).

<sup>102</sup> *Id.* at 15.

<sup>103</sup> *Id.* at 10.

assignee of plan beneficiaries.”<sup>104</sup> On reconsideration, the court agreed with Aetna that even RASA’s breach of contract claim was preempted under *Davila*:

[T]he parties’ contract is not independent of the ERISA-regulated plan. Rather, the rights and obligations of the parties are defined by reference to the ERISA-regulated plan. Because the entire scope of the parties’ agreement is determined by the ERISA-regulated plan, the parties’ agreement is tethered to the ERISA-regulated plan. The contract, therefore, is not ‘independent’ and does not establish the kind of ‘independent legal duty’ contemplated by *Davila*.<sup>105</sup>

Needless to say, the opinion in *Radiology Associates* significantly blurs the scope of complete preemption. To the extent that other district courts choose to adopt the above reasoning, substantial questions will arise about how far the court’s “tethered-to” principle can be stretched. Moreover, and as demonstrated below, *Radiology Associates* has influenced the way some health plans are structuring their arguments in both participating provider and PPO disputes.

### **C. PPO Disputes**

The Western District of Texas’ opinion in *Radiology Associates* illustrates that even the relatively straightforward distinction between participating and nonparticipating providers is not always going to be dispositive of the complete preemption issue. PPO disputes further complicate the analysis. In many PPO arrangements, payors and providers do not contract directly with one another and are linked instead by their contracts with a common PPO. As a result, such providers do not fall neatly into the category of participating providers, because they have not executed a direct contract with the payor. Neither can they be categorized as nonparticipating providers, as they have an indirect contractual relationship with the payor. The analysis is even more

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<sup>104</sup> *Id.* at 15

<sup>105</sup> *Id.* at 16 (the Magistrate’s conclusions were adopted by District Judge Ferguson, Mar. 29, 2005).

complicated in “silent PPO” lawsuits, where the provider alleges that the PPO it contracted with inappropriately “leased” or “assigned” the negotiated discount to *another* PPO, the “silent” one, which contracted with insurers unbeknownst to the provider.<sup>106</sup>

Whether a PPO dispute involves two, three, or four different parties, payors have sought to channel PPO-related claims into ERISA’s civil enforcement mechanism, arguing that the providers, lacking a direct provider contract, only have standing to seek reimbursement from the payors as assignees of ERISA plan benefits. Providers typically argue in response that they are suing as third party beneficiaries of the contract between the payor and the PPO, by virtue of their own contract with the PPO. Given the complexity of these disputes, the courts have struggled in determining whether they are encompassed by ERISA’s civil enforcement mechanism. However, over the past year, many courts have begun to take a relatively consistent position on the applicability of complete preemption to such disputes. A series of opinions out of the District of New Jersey illustrate how the law in this area is beginning to crystallize, at least within the Third Circuit. To understand how the complete preemption analysis applicable to PPO disputes has developed over the past year, it is necessary to begin with the Third Circuit’s 2004 opinion in *Pascack Valley v. Local 464A UFCW Welfare Reimbursement Plan*.<sup>107</sup>

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<sup>106</sup> See *HCA Health Servs. of Georgia v. Employers Health Ins. Co.*, 240 F.3d 982 (11th Cir. 2001) (providing an in-depth discussion of “silent PPOs”); see also, *Liberty Mut. Ins. Co. v. Gunderson*, No. 04-2405, 2006 WL 367700 (W.D. La. Feb. 15, 2006) (discussing the scope of Louisiana’s “silent PPO” statute).

<sup>107</sup> 388 F.3d 393 (3d Cir. 2004).

*Pascack*

The dispute in *Pascack* centered on discounts taken pursuant to a PPO network established by MagNet, Inc.<sup>108</sup> Pascack Valley Hospital entered into a “Network Hospital Agreement” with MagNet, wherein it agreed to accept discounted rates from payors, like the Local 464A UFCW Welfare Reimbursement Plan (Plan), that entered into a “Subscriber Agreement” with MagNet.<sup>109</sup> After two beneficiaries of the Plan were treated at Pascack Valley Hospital, the Plan reimbursed the hospital at the discounted rate established by its Subscriber Agreement.<sup>110</sup> The hospital argued that the Plan had forfeited its right to access the subscriber discounts by failing to pay the claims within the time period established by the Subscriber Agreement.<sup>111</sup> The hospital filed suit against the Plan in the Superior Court of New Jersey, alleging that it was a third-party beneficiary of the Plan’s Subscriber Agreement, and that the Plan breached that Agreement by attempting to access discounts that were void under the terms of the contract.<sup>112</sup> The Plan removed the case to federal court on the basis that the hospital’s claims were completely preempted by ERISA.<sup>113</sup> The Plan argued that the hospital was suing as an assignee of ERISA plan benefits because it could not have brought suit on a direct provider contract.<sup>114</sup> The district court agreed, and denied the hospital’s motion to remand.<sup>115</sup>

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<sup>108</sup> *Id.* at 396.

<sup>109</sup> *Id.*

<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> *Id.* at 397.

<sup>113</sup> *Id.*

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

On appeal, Third Circuit began its analysis by quoting the Supreme Court's recent interpretation of the scope of complete preemption in *Davila*:

if an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA § 502(a)(1)(B).<sup>116</sup>

Relying on that principle, the Third Circuit noted that the hospital's claims were only removable if "(1) the Hospital could have brought its breach of contract claim under § 502(a), and (2) no other legal duty supports the Hospital's claim."<sup>117</sup> The court then rejected the Plan's contention that Pascack Valley Hospital was pursuing its claims as an assignee of ERISA plan benefits, emphasizing that "there is nothing in the record indicating that [the ERISA beneficiaries] did, in fact, assign any claims to the Hospital."<sup>118</sup> The court found the lack of such evidence dispositive of the preemption issue because "the Plan bore the burden of proving that the Hospital's claim is an ERISA claim."<sup>119</sup> As a result, the court reversed and remanded because the first prong of the test had clearly not been satisfied.<sup>120</sup>

Had the court stopped there, *Pascack* would have been an unremarkable case. However, the court proceeded to analyze, in *dicta*, whether the hospital's claims satisfied the second prong of the complete preemption analysis. Ultimately, the Third Circuit concluded that they would not:

[T]he Hospital's state law claims are predicated on a legal duty that is independent of ERISA . . . The crux of the parties' dispute is the meaning of . . .

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<sup>116</sup> *Id.*

<sup>117</sup> *Id.*

<sup>118</sup> *Id.* at 401.

<sup>119</sup> *Id.*

<sup>120</sup> *Id.*

the Subscriber Agreement . . . . Were coverage and eligibility disputed in this case, interpretation of the Plan might form an ‘essential part’ of the Hospital’s claims.<sup>121</sup>

The court relied heavily on the Ninth Circuit’s decision in *Anesthesia Care*, concluding that Pascack Valley Hospital’s claims were analogous to the claims advanced in *Anesthesia Care* in three critical ways:

(1) the Hospital’s claims . . . arise from the terms of a contract—the Subscriber Agreement—that is allegedly independent of the Plan; (2) the participants and beneficiaries of the Plan do not appear to be parties to the Subscriber Agreement; and (3) the dispute . . . is not over the *right* to payment, which might be said to depend on the patients’ assignments to the [Hospital], but the *amount*, or level, of payment, which depends on the terms of the [Subscriber Agreement].<sup>122</sup>

Thus, the Third Circuit’s *dicta* in *Pascack* set the stage for arguments over the scope of complete preemption where it can easily be proved that a provider, unlike Pascack Valley Hospital, actually possessed an assignment of ERISA plan benefits.

### *The Progeny of Pascack*

In the wake of *Pascack*, the applicability of complete preemption to PPO disputes has been heavily litigated. As in participating provider disputes, parties involved in PPO disputes vigorously disagree over whether the PPO contracts establish an “independent legal duty” under *Davila*. Although it has been difficult to determine what role the ERISA plans play in those disputes, over the past year, many courts have begun to treat PPO disputes in a relatively consistent fashion. A series of opinions issued by the U.S. District Court for the District of New Jersey highlights the current tendency to remand such claims when they are removed on complete preemption grounds.

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<sup>121</sup> *Id.* at 402 (internal citations omitted).

<sup>122</sup> *Id.* at 403-4 (emphasis in original) (internal citations omitted).

The issue arose in a spate of lawsuits brought against the Northern New Jersey Teamsters Benefit Plan (Plan).<sup>123</sup> The contractual arrangements at issue in those cases were very similar to the one analyzed in *Pascack*. In fact, they all involved the same PPO, MagNet, Inc.<sup>124</sup> Like Pascack Valley Hospital, the providers in those lawsuits contracted with MagNet and eventually fell into a dispute with a MagNet subscriber over access to the PPO discounts.<sup>125</sup> The providers alleged that the Plan failed to pay certain claims within the time period specified in the MagNet Subscriber Agreement and therefore could not access the negotiated discounts pursuant to the terms of that Agreement.<sup>126</sup> The Plan removed each case to federal court, arguing that the providers' claims were completely preempted by ERISA.<sup>127</sup> The providers moved to remand their respective cases based on the reasoning set forth in *Pascack*.<sup>128</sup> The providers contended that they had an independent right to recovery as third-party beneficiaries of the MagNet Subscriber Agreement.<sup>129</sup> In response, the Plan distinguished *Pascack* by emphasizing that the providers bringing suit against the Plan actually possessed valid assignments of ERISA plan benefits.<sup>130</sup> In addition, the Plan cited to *Radiology Associates* in support of its argument that the Subscriber Agreement

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<sup>123</sup> See *Newark Beth Israel v. Northern New Jersey Teamsters Benefit Plan*, No. 03-2922 (D.N.J.); *St. Barnabus Med. Center v. Teamsters Health and Benefit Fund*, No. 03-3187 (D.N.J.); *Cathedral Healthcare Sys.—St. Michael's Med. Ctr. v. Northern New Jersey Teamsters Benefit Plan*, No. 05-05305 (D.N.J.); *Saint Barnabus Med. Ctr. v. Teamsters Health and Benefit Fund*, No. 05-5309 (D.N.J.); *Bayonne Med. Ctr. v. Northern New Jersey Teamsters Benefit Plan*, No. 05-5737 (D.N.J.).

<sup>124</sup> See *Newark Beth Israel v. Northern New Jersey Teamsters Benefit Plan*, No. 03-2922, Defendant's Motion to Consolidate (D.N.J. Mar. 5, 2006) (explaining procedural history of the cases).

<sup>125</sup> *Id.* at 1-5

<sup>126</sup> *Id.*

<sup>127</sup> *Id.* at 5.

<sup>128</sup> See *Newark Beth Israel v. Northern New Jersey Teamsters Benefit Plan*, No. 03-2922, Opinion of Judge Lifland (D.N.J. Sept. 29, 2006).

<sup>129</sup> See *id.*

<sup>130</sup> *Id.*

was “tethered to” various ERISA plans.<sup>131</sup> The Plan emphasized that the Subscriber Agreement, like the provider agreement in *Radiology Associates*, only authorized payment for “covered services” furnished to “eligible persons,” and that those terms could not be defined without making reference to the underlying benefit plans.<sup>132</sup>

Four of the cases were consolidated for joint consideration of the providers’ motions to remand.<sup>133</sup> While the motions to remand on the consolidated cases were pending, the motion to remand in the fifth case, *St. Barnabas v. Northern New Jersey Teamsters Benefit Plan*,<sup>134</sup> was denied by the Magistrate Judge.<sup>135</sup> In a spare opinion, he concluded that the provider’s claim was completely preempted by ERISA.<sup>136</sup> About a month later, District Judge Lifland came to the opposite conclusion, and granted the providers’ Motions to Remand in the remaining four cases.<sup>137</sup> In his opinion, Judge Lifland explicitly rejected the Plan’s contention that *Pascack* was distinguishable because the providers in the cases at bar were assignees of ERISA plan benefits.<sup>138</sup> Adopting the reasoning in *Pascack*, the district court held that “another legal duty,

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<sup>131</sup> See *St. Barnabus Med. Ctr. v. Teamsters Health and Benefit Fund*, No. 03-3187, Defendant’s Memorandum of Law in Opposition to Plaintiff’s Motion to Remand (D.N.J. Apr. 12, 2006).

<sup>132</sup> *Id.* at 27-28.

<sup>133</sup> See *Newark Beth Israel v. Northern New Jersey Teamsters Benefit Plan*, No. 03-2922, Order Consolidating Civil Action Nos. 03-2922, 03-3187, 05-5305, 05-5309, 05-5737 & 05-5742 under Civil Action No. 03-2922 (D.N.J. Mar. 29, 2006). It appears from the record that all five cases were originally consolidated, but the Magistrate in *St. Barnabas v. Northern New Jersey Teamsters Benefit Plan* (03-3187), who had denied *St. Barnabas*’ Motion to Remand prior to consolidation, revisited the issue on reconsideration *after* consolidation. It is unclear from the record why the Magistrate did not consolidate the Motion for Reconsideration with the Motions to Remand of the remaining cases. See *Newark Beth Israel v. Northern New Jersey Teamsters Benefit Plan*, No. 03-2922, Opinion of Judge Lifland (D.N.J. Sept. 29, 2006) (merely noting that “[i]t appears that Magistrate Judge Hedges has already ruled on the motion to remand in *St. Barnabas Medical Center v. Teamsters Health and Benefit Fund*, Civil Action No. 03-3187.”)

<sup>134</sup> No. 03-3187 (D.N.J.).

<sup>135</sup> *Saint Barnabas v. Northern New Jersey Teamsters Benefit Plan*, No. 03-3187, Opinion and Order Denying Plf’s Motion to Remand (D.N.J. Aug. 22, 2006).

<sup>136</sup> *Id.* at 3-4.

<sup>137</sup> See *Newark Beth Israel v. Northern New Jersey Teamsters Benefit Plan*, No. 03-2922, Opinion of Judge Lifland (D.N.J. Sept. 29, 2006).

<sup>138</sup> *Id.* at 13.

independent of ERISA . . . supports the Hospital’s claim.”<sup>139</sup> In doing so, the court refused to discard the Third Circuit’s additional analysis as “mere *dicta*,” noting:

Although it may have been technically unnecessary for the Third Circuit to address the second prong [of the complete preemption analysis], the fact remains that it did. The Court of Appeals went to great lengths to thoroughly analyze, and ultimately decide whether an independent legal duty existed. This being the case, the Third Circuit’s opinion is highly persuasive authority.<sup>140</sup>

As a result, the court remanded the providers’ claims to state court.<sup>141</sup> After Judge Lifland issued his opinion on the consolidated cases, Judge Martini reversed the Magistrate Judge’s order denying remand, reasoning that Judge Lifland’s opinion was “based on a correct interpretation of the relevant law . . . .”<sup>142</sup> Thereafter, the scope of complete preemption in the context of PPO disputes, at least as interpreted in the District of New Jersey, became a little more clear.<sup>143</sup>

Although the court did not directly address the Plan’s argument that, pursuant to *Radiology Associates*, the providers’ claims were “tethered to” various ERISA plans, the U.S. District Court for the Southern District of Texas issued a detailed opinion in June of 2006 attempting to harmonize *Pascack* and *Radiology Associates*. The dispute in *St. Luke’s Episcopal Hospital v. Acordia National et al.*,<sup>144</sup> also involved PPO discounts.<sup>145</sup> St. Luke’s had entered into a contract with a local PPO, akin to MagNet, wherein it

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<sup>139</sup> *Id.*

<sup>140</sup> *Id.* at 16.

<sup>141</sup> *Id.*

<sup>142</sup> Saint Barnabas v. Northern New Jersey Teamsters Benefit Plan, No. 03-3187, Order Vacating Magistrate Order (D.N.J. November 20, 2006).

<sup>143</sup> See also Englewood Hosp. and Med. Ctr. v. AFTRA Health Fund, No. 06-0637, 2006 WL 3675261 (D.N.J. Dec. 12, 2006) (where a PPO dispute resembling the dispute in *Pascack* was remanded from the District of New Jersey despite the existence of an assignment of ERISA plan benefits.)

<sup>144</sup> No. 05-1438, Memorandum and Opinion (S.D.Tex. June 8, 2006); see also Ambulatory Infusion Therapy Specialists v. Aetna Life Ins. Co., No. H-05-4389, 2006 WL 1663752 (S.D.Tex. June 13, 2006) (decided five days later by the same district judge and including similar preemption analysis).

<sup>145</sup> *Id.* at 1.

agreed to provide discounts to insurers and health plans that entered into subscriber agreements with the PPO.<sup>146</sup> The beneficiary of a payor that contracted with the PPO was treated at St. Luke's, and St. Luke's forwarded the bills to the beneficiary's third party administrator (TPA).<sup>147</sup> The TPA then forwarded the bills to the PPO for repricing pursuant to the negotiated discount.<sup>148</sup> After the third party administrator received the repriced bill, it refused to pay any of the billed amount on the basis that the beneficiary was ineligible for services under the terms of her plan.<sup>149</sup> St. Luke's brought suit against the plan and the third party administrator in state court, alleging multiple causes of action, including breach of the PPO contract, and negligent misrepresentation of the beneficiary's coverage during precertification.<sup>150</sup> The defendants removed, arguing that the claims were completely preempted by ERISA.<sup>151</sup>

The court began its analysis of the provider's Motion to Remand by addressing the first prong of the *Davila* test—whether the hospital could have brought its claim under § 1132(a). The court held that the first prong was satisfied because St. Luke's held a valid assignment of ERISA plan benefits.<sup>152</sup> In deciding whether St. Luke's breach of contract claim was predicated on an “independent duty,” the court reasoned that the claim was distinguishable from the claim asserted in *Pascack*:

In the present case, unlike *Pascack Valley Hospital* . . . the crux of the parties' dispute is over the right to payment, not over the level, rate, or amount of payment. Defendants did not pay St. Luke's any of the amounts billed for [the beneficiary's] care on the ground that she was not eligible for Plan benefits and

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<sup>146</sup> *Id.* at 3.

<sup>147</sup> *Id.*

<sup>148</sup> *Id.* at 4.

<sup>149</sup> *Id.*

<sup>150</sup> *Id.* at 5.

<sup>151</sup> *Id.*

<sup>152</sup> *Id.* at 22.

the treatment she received was not a ‘covered service’ because a preexisting condition exclusion applied. The Plan’s obligation to pay for the services St. Luke’s provided [the beneficiary] depends on, and derives from, the ERISA Plan terms . . . Much like *Radiology Associates of San Antonio*, determining eligibility and coverage for the services rendered in this case depends on the...ERISA-regulated Plan terms.<sup>153</sup>

Thus, the court held that the breach of contract claim and the claims brought under the Texas Insurance Code were completely preempted by ERISA and denied the provider’s Motion to Remand.<sup>154</sup> The court concluded that the negligent misrepresentation claim, on the other hand, was not completely preempted by ERISA because it was not dependent on the terms of the ERISA plan.<sup>155</sup> The Court held that St. Luke’s “provided treatment to [the beneficiary] based on [the TPA’s] alleged promise that St. Luke’s would be compensated for its work, regardless of—not because of—the Plan’s ‘preexisting condition’ exclusion.”<sup>156</sup> Because that claim could be advanced even if coverage was correctly denied, the court reasoned that it did not “derive from the Plan or depend wholly on the Plan terms.”<sup>157</sup>

Ultimately, the Southern District of Texas’ decision in *St. Luke’s* may provide a more workable interpretation of *Davila* and complete preemption in PPO and participating provider disputes. It is important to keep in mind, however, that *St. Luke’s* did not involve the array of disparate billing disputes that were at the heart of the litigation in *Radiology Associates*. The provider in *Radiology Associates* argued that the

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<sup>153</sup> *Id.* at 21-22.

<sup>154</sup> *Id.* at 25.

<sup>155</sup> *Id.* at 29 (having denied the provider’s Motion to Remand, the court exercised supplemental jurisdiction over the negligent misrepresentation claim).

<sup>156</sup> *Id.*

<sup>157</sup> *Id.*

payor “repeatedly underpaid, delayed, or improperly denied payment” on its claims.<sup>158</sup>

Thus, while some of the provider’s claims were mere “coverage” disputes hinging on an interpretation of ERISA plans, some of the claims were not.<sup>159</sup> Nevertheless, the U.S. District Court for the Western District of Texas held that the provider’s contract was “tethered to” the ERISA plans at issue, and the provider’s breach of contract claim was therefore preempted. It remains to be seen whether other district courts will adopt the broader view of complete preemption described in *Radiology Associates*.

### III. CONCLUSION

Unfortunately, the recent flurry of provider reimbursement litigation has not greatly clarified the applicability of ERISA to reimbursement claims. It remains difficult to determine whether nonparticipating providers can avoid preemption by disclaiming their ability to recover as assignees of ERISA plan benefits. Some courts have interpreted corollary claims for unjust enrichment or promissory estoppel as impermissible remedies that would “duplicate, supplement, or supplant” those established by ERISA, but some courts have indicated that such claims are grounded on “independent” legal duties. It is also unclear the extent to which participating provider disputes fall within the scope of § 1132(a). While *St. Luke’s* drew a relatively workable distinction between contract claims that are predicated on “coverage” or “eligibility” and those that are not, opinions like *Radiology Associates* provide support for a much broader reading of complete preemption. That being said, clear trends have emerged. The PPO cases recently decided in the U.S. District Court for the District of

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<sup>158</sup> *Radiology Assocs.*, No. 03-1152, Notice for Removal by Aetna Health (W.D. Tex. Nov. 20, 2003) (attaching a copy of Plaintiff’s Petition, which contains the quoted language on page 4).

<sup>159</sup> See *id.* (containing a spreadsheet of the provider’s claims).

New Jersey demonstrate that district judges have been reluctant to find complete preemption where a provider alleges that the payor failed to abide by the terms of a PPO subscriber agreement. Such cases have bolstered the *dicta* in *Pascack*, and raised more questions about the viability of the sweeping “tethered to” principle applied in *Radiology Associates*. Ultimately, this is an area of the law that is constantly evolving and taking shape around the complexities of provider reimbursement arrangements. As a result, it is unlikely that all aspects of it will ever be comprehensively resolved.

***ERISA Preemption in Provider Reimbursement Litigation: Recent Cases & Current Trends***

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