HEALTH CARE PROVIDER V. PAYOR DISPUTES SIMPLIFIED: GETTING AROUND ERISA PREEMPTION

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In this article, I try to provide a simplified distillation of *Crescent City Surgical Centre v. United Healthcare of La., Inc.*, [1] a recent dispute between a health care provider and a payor. For ease of reading, anything that might slow the reader down is relegated to a footnote.

INTRODUCTION

This case illustrates how certain claims by a Provider against an out-of-network ("OON") Payor might be kept in state court and not preempted by ERISA, [2] if the Provider desires.

FACTS

Provider [3] sued Payor [4] in state court seeking reimbursement on certain claims. Provider is OON with Payor (i.e., they have no managed care-type contract between them to cover payment of all claims). Provider's complaint alleged that Payor preauthorized certain treatments at agreed upon rates through Payor's online portal, thus creating a contract between the parties as to those treatments. Provider also alleged that Payor failed to make those agreed-upon payments.

Payor removed the case to federal court, claiming that this was an ERISA case and thus properly in federal court (because ERISA preempted the state law claims). [5]

Provider responded, saying it was only suing in state court over the agreed-upon (i.e., contracted) payments and not suing on any noncontract claims that required derivative standing under ERISA. [6] On that basis, Provider asked the Federal District Court Judge [7] to remand the case back to state court. The court agreed with Provider and remanded the case to state court.

COURT'S RATIONALE

In remanding, the court emphasized several points:

1. In determining ERISA preemption, courts focus specifically on the rights that a provider is seeking to enforce.

2. Because many potential claims here could be enforced under ERISA (derivatively through patients' assigning benefits), those claims would be completely preempted by ERISA and properly in federal court if Provider were seeking to enforce such claims.
3. Here, Provider was not seeking to enforce such derivative-only ERISA claims. [8]

ANALYSIS

In most OON situations, payors will try to shift providers' claims into federal court under the rationale that, absent an overarching managed care contract between the parties, all state law claims are preempted by ERISA. Payors appear to do this for two main reasons:

4. ERISA payment disputes are sometimes harder for a provider to prove than disputes based on state law claims (proving patient-based derivative standing is replete with procedural traps that have nothing to do with the merits).
5. State law claims can offer providers more effective relief in many instances.

Thus, if providers can identify a direct contractual relationship with a payor in what is otherwise an OON relationship, and that relationship imposes on the payor a non-ERISA-based legal duty to pay, the provider can assert state court jurisdiction with more favorable state court remedies and fewer unnecessary procedural roadblocks as to those claims.

NOTES:

[1] The full citation is *Crescent City Surgical Centre v. United Healthcare of La., Inc.* (E.D. La., Civil Action No. 19-12586), issued November 19, 2019.
[2] The Employee Retirement Income Security Act of 1974, 29 U.S.C. ch. 18 § 1001 et seq.
[3] Crescent City Surgical Centre.
[4] United Healthcare of Louisiana, Inc.
[5] The court explained the interplay between federal court pleading rules and presumptive ERISA preemption as follows:

> Normally, the “well-pleaded complaint rule” allows the plaintiff to avoid federal jurisdiction by exclusive reliance on state law. Caterpillar Inc. v. Williams, 482 U.S. 386 , 392 (1987). However, that rule is limited by the doctrine of “complete preemption,” which acknowledges that “Congress may so completely preempt a particular area of the law that any civil complaint raising this select group of claims is necessarily federal in character.” Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58 , 63–64 (1987). Under this doctrine, a case may be removed on grounds that the plaintiff has asserted claims that are preempted by § 514(a) of ERISA. Metropolitan Life Ins. Co. v. Taylor, 481 U.S. at 66. Under that provision, ERISA “shall supersede any state causes of action insofar as they may now or hereafter relate to any employee benefit plan.” 29 U.S.C. § 1144(a).

[6] In most instances, providers do not have a direct right to sue a payor under ERISA. Therefore, providers sue payors under ERISA derivatively on behalf of their patients, under benefit assignments from such patients.
[7] Mary Ann Vial Lemmon, U.S. District Court for the Eastern District of Louisiana.
[8] The court provided the following explanation:

> "One possibility is that a third-party health care provider can seek to enforce its patient's rights to reimbursement pursuant to the terms of the ERISA plan, in a derivative capacity pursuant to an assignment of the patient's rights." Center for Restorative Breast Surgery, 2011 U.S. Dist. LEXIS 36709, 2011 WL 1103760. In that case, the claim is a derivative one and completely preempted by ERISA. Id. In contrast, "if a health care provider can assert a right to payment based on some separate agreement between itself and an ERISA defendant (such as a provider agreement or an alleged verification of reimbursement prior to providing medical services), that direct claim is not completely preempted by ERISA." Id. (citations omitted). Thus, "a health care provider may also have both a valid assignment of its patient's rights and a direct claim arising under state law and can elect to assert either or both of those claims." Id. (citations omitted). Under that scenario, "the mere existence of an assignment of the patient's rights under the ERISA plan is jurisdictionally irrelevant so long as the provider is not actually seeking to enforce that derivative claim." Id.

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