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Maybe There's a Leg to Stand on After All: U.S. Court of Appeals for the Ninth Circuit Allows Non-Health Care Providers to Assert Derivative Standing to Bring Out-of-Network ERISA Claims

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For years, health insurance companies and plans have faced large numbers of ERISA suits by health care providers regarding out-of-network coverage, typically seeking reimbursement in the form of usual, reasonable, and customary rates, known as UCRs.[1] These lawsuits typically follow an assignment of rights from the patient to the provider, allowing the provider to assert derivative standing to bring the ERISA claim.

Although courts have tended to limit derivative standing to health care provider assignees, a recent decision by the U.S. Court of Appeals for the Ninth Circuit expands the scope of derivative standing to a successor in interest arising out of the provider's bankruptcy.

This column provides a background on out-of-network provider claims, discusses the courts' treatment of health care provider derivative standing, and examines the recent Ninth Circuit case that expands that standing, although modestly.

In conclusion, we provide some key takeaways and best practices.

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OUT-OF-NETWORK PROVIDER CLAIMS

Out-of-network providers continue to bring claims against health insurance companies and ERISA plan entities in high volumes.[2] Hundreds of cases involving out-of-network provider claims have been filed in recent years alone.[3]

The allegations in these cases follow a typical pattern. Before treating a prospective patient on an out-of-network basis, the health care provider contacts the patient's insurance company to verify that the patient has coverage for the treatment at issue. The dispute in many case arises from the contention that the insurer or plan orally promises to pay for treatment "at the usual, reasonable, and customary rate," or UCR[4] (or sometimes at another, similar rate[5]). Once the out-of-network provider provides treatment, however, the insurer "allegedly refuse[s] to live up to its end of the bargain" and reimburses the provider at rates far lower than anticipated, or declines to reimburse at all.[6] The medical provider eventually sues some contingent of the plan – typically the insurer, plan sponsor, plan administrator, or plan service provider – to recoup the difference.

In these lawsuits, a provider may seek additional reimbursement through a variety of federal law and state law claims. Frequently, the provider brings a claim for wrongful denial of benefits under ERISA § 502(a), which provides a cause of action "to recover benefits due . . . under the terms of [an ERISA] plan."[7] Other commonly asserted ERISA claims are for breach of fiduciary duty under ERISA § 404[8] and failure to provide "a full and fair review" of the claim under ERISA § 503(2)[9] based on an alleged provision of misinformation about the patient's coverage or the procedures for determining the UCR.[10]

Providers may also assert state law claims. These include, most commonly, breach of an express or implied contract, promissory estoppel, unjust enrichment, negligent or fraudulent misrepresentation, fraudulent concealment, and violations of state unfair competition statutes.[11]

Although ERISA broadly preempts state law claims "relat[ing] to any employee benefit plan,"[12] some courts have concluded that state law claims seeking reimbursement for out-of-network services are not preempted when they arise solely out of an oral promise or representation. The reasoning used to allow such state law claims is that they depend not on the existence or terms of the patient's ERISA plan, but rather on the alleged extracontractual statement.[13]

By contrast, where the alleged oral promise or representation regarding reimbursement for out-of-network services clearly refer to the terms of an ERISA plan, courts have often found state law claims preempted.[14]

MEDICAL PROVIDERS' DERIVATIVE STANDING TO PURSUE OUT-OF-NETWORK CLAIMS

Claims involving out-of-network coverage that are brought by the health care provider itself, as opposed to the patient or beneficiary, implicate the theory of "derivative standing" under ERISA. Although ERISA § 502(a) grants a cause of action to recover benefits due only to "a participant or beneficiary" of an ERISA plan,[15] so-called "derivative standing" allows a health care provider "to sue under ERISA by obtaining a written assignment from a 'participant' or 'beneficiary' of his right to payment of medical benefits."[16] To date, it appears that every federal circuit court to have considered the question has agreed that "when a patient assigns payment of insurance benefits to a healthcare provider, that provider gains standing to sue for that payment under ERISA § 502(a)."[17]

In articulating the theory of derivative standing, courts have drawn guidance from, on the one hand, "Congress's intent that ERISA 'protect . . . the interests of participants in employee benefit plans,'"[18] and, on the other, the notion "that the assignment of ERISA claims to providers 'serves the interests of patients by increasing their access to care.'"[19] As the Third Circuit has explained, "[t]he value of such assignments lies in the fact that providers, confident in their right to reimbursement and ability to enforce that right against insurers, can treat patients without demanding they prove their ability to pay up front," allowing patients to "increase their access to healthcare and transfer responsibility for litigating unpaid claims to the provider, which will ordinarily be better positioned to pursue those claims."[20]

Conversely, "if their status as assignees d[id] not entitle them to federal standing against the plan, providers would either have to rely on the beneficiary to maintain an ERISA suit, or they would have to sue the beneficiary. Either alternative . . . would discourage providers from . . . helping beneficiaries who were unable to pay them 'up-front.'"[21] "For these reasons," courts have generally determined that "the interests of ERISA plan participants and beneficiaries are better served by allowing provider-assignees to sue ERISA plans."[22]

However, the ability to pursue such claims, as a matter of fact, is by no means a foregone conclusion. One of the main defenses that health insurers and plan entities can raise against such claims – again, facts permitting – is that the provider lacks derivative standing because the ERISA plan contains an anti-assignment provision. Just as federal circuit courts have universally held that an out-of-network health care provider has derivative standing to assert claims as an assignee of the patient, so, too, have circuit courts agreed "that an assignment is ineffectual if the plan contains an unambiguous anti-assignment provision.[23]

Thus, while ERISA itself does not contain an anti-assignment clause, the statute's "silence on the issue of the assignability of insurance benefits leaves the matter to the agreement of the contracting parties."[24]

COURTS TEND TO LIMIT STANDING TO MEDICAL PROVIDERS

While courts have (absent an anti-assignment provision) generally permitted out-of-network providers to bring suit in their capacity as assignees of patients or beneficiaries with claims for benefits due, they have historically drawn the line at permitting suit by "the assignee of other assignees."[25] For example, in Simon, the plaintiff sought to assert claims under ERISA and other federal statutes on behalf of over 600 mental health patients who had assigned their benefit claims to a handful of out-of-network providers, "who later reassigned them to Simon."[26]

Agreeing with the district court, the Ninth Circuit held that Simon "lack[ed] standing under derivative standing theory," distinguishing between "health care providers," which can assert derivative standing, and "the assignee[s] of health care providers," which cannot.[27] The court reasoned that, whereas "the assignment of benefit claims to health care providers . . . facilitate[s] the receipt of health care benefits by beneficiaries," the same is not true of subsequent assignments.[28]

To the contrary, permitting sub-assignees to assert derivate standing "would be tantamount to transforming health benefit claims into a freely tradable commodity," leading "to endless reassignment of claims" and allowing "third parties with no relationship to the beneficiary to acquire claims solely for the purpose of litigating them."[29] Because such an outcome would not further ERISA's purpose, and found no support in ERISA's text or legislative history, the court "decline[d] to extend derivative standing."[30]

Following in the Ninth Circuit's wake, other courts have likewise held that sub-assignees or assignees other than health care providers cannot take advantage of derivative standing theory – often in cases involving the same plaintiff, who pursued his claims in many courts.[31] At least two circuits, however, have held otherwise and allowed sub-assignees to assert derivative standing, while declining to decide whether sub-assignees can always do so.[32]

THE NINTH CIRCUIT "CRACKS" THE STANDING DOOR FOR NON-MEDICAL PROVIDERS AND SUB-ASSIGNEES

In a recent Ninth Circuit case, however, the court "cracked" the standing door for non-health care providers to bring claims for out-of-network benefits. In Bristol SL Holdings, Inc. v. Cigna Health and

Life Insurance Company,[33] the health care provider, Sure Haven, was an accredited mental health and substance abuse treatment center. According to the complaint, Sure Haven went out of business and filed for bankruptcy when Cigna stopped reimbursing $8.6 million worth of out-of-network services that Sure Haven had provided to Cigna insureds.[34]

In accord with the typical fact pattern discussed above, the case contained a factual dispute over what was said during pre-service authorization and verification phone calls. Bristol claimed that a percentage reimbursement of the UCR was established.[35] Cigna disagreed, asserting that all calls included a disclaimer that, among other things, "pre-approval is not a guarantee of coverage,"[36] that written disclaimers appeared on a plan participant's Explanation of Benefits report, and that the Cigna employees on the calls "could not have entered into binding commitments . . . because they were not authorized to do so."[37]

Defendant Bristol purchased Sure Haven's claims against Cigna in Sure Haven's bankruptcy.[38] Bristol then sued Cigna, bringing an ERISA claim for benefits under 29 U.S.C. § 1132(a)(1)(b) and ten state law claims.[39] The district court dismissed the ERISA cause of action, citing to Simon for the proposition that the Ninth Circuit has declined to extend derivative standing to assignees of health care providers.[40]

On appeal, the Ninth Circuit reversed, holding that Bristol had derivative standing. First, it distinguished Simon on the facts, pointing out that unlike Bristol, Simon was an attorney "who aggregated hundreds of unrelated claims from numerous different health facilities" and had no relationship to the beneficiaries, whereas "Bristol . . . is the bankruptcy successor-in-interest to Sure Haven."[41] The court reasoned that allowing standing here aligned with the ERISA's goal of protecting access to care and also found support in cases from the Fourth, Fifth, and Eleventh Circuits.[42] The court, however, was explicit about the confines of its ruling:

> Our ruling today is a modest one: We hold only that the first assignee as a successor-in-interest through bankruptcy proceedings who owns all of one healthcare provider's health benefit claims has derivative standing.[43]

To date, one case has examined the "Bristol exception" to the prohibition on derivative standing to non-health care providers and kept that exception narrow. ABC Services Group., Inc. v. Health Net of California, Inc.,[44] like Bristol, involved a treatment facility, Morningside, which offered services to patients suffering from mental health and substance use disorders.[45] Morningside patients assigned their rights to receive benefits owed under various insurance plans to Morningside, and Morningside subsequently executed a written assignment of the same to Plaintiff ABC Services Group, Inc.[46] Prior to the Ninth Circuit's holding

in Bristol, the district court relied on Simon to conclude that ABC, as an assignee of a health care provider, did not have standing to bring its ERISA claims.[47]

On appeal, and after the Ninth Circuit's Bristol ruling, the Ninth Circuit reversed and remanded ABC Services Group for the district court to consider the standing issue in light of Bristol.[48] On remand, the district court concluded that ABC Services Group was distinguishable from Bristol and in light of the distinguishing facts, the "Bristol exception" did not apply to give ABC standing. In particular, the court underscored that Bristol involved a dispute with a single insurance company, whereas ABC brought suit against numerous insurance companies; and Bristol was the first assignee, whereas ABC was the second assignee.[49]

The opinion also emphasized the importance of why the claims have been assigned to a non-health care provider. Unlike in Bristol, where it was alleged that the insurer stopped paying on $8.6 million in claims to a mental health facility which drove that facility into bankruptcy, Morningside's closing "appeared to be result of Morningside's own actions. As referenced at argument, the Department of Justice indicted Morningside's owner for a 'scheme to defraud several state Affordable Care Act programs of millions of dollars.'"[50]

Under these facts, the court held that the case was more analogous to Simon than Bristol. Bristol, it explained, "is not an affirmative enumeration of all the instances where derivative standing is acceptable. Instead, Bristol merely rejects Simon's complete bar to derivative standing."[51] More to come, however, as the plaintiffs have appealed, giving the Ninth Circuit a chance to weigh in again.

KEY TAKEAWAYS

There are several important takeaways for plan sponsors from the above line of cases. Perhaps most importantly, plan sponsors may be able to avoid these claims in the first place. One way is to be cognizant of the depth and breadth of your plans' in-network providers. Ensuring your plans have a robust network of providers, including in the mental health space, will minimize the need for participants to seek care from out-of-network providers.

Plan sponsors should also consider putting an anti-assignment provision in their ERISA plans. While it is important to always check the jurisdictions where a plan may be challenged, courts have denied health care providers standing based on unambiguous anti-assignment provisions.

When it comes to verification and authorization calls, pay attention to how the plans' service providers are authorizing or verifying coverage for out-of-network services over the phone. Doing so in a way that makes reference to the plan's terms increases the likelihood that state-law claims based on oral statements will be completely preempted by claims that depends only on the written terms of the plan.

Finally, if the claims are assigned to a non-health care provider, facts will matter when assessing the viability of a challenge to derivative standing. For example, the facts surrounding why the claims were assigned, and whether it was due to the plan's failure to pay the claims or some extraneous circumstance, matter. It is important, from both a litigation and also an employee-relations perspective, to do your best to ensure the actions of your plans' administrators and fiduciaries, and your policies, won't be viewed as contrary to ERISA's goal of ensuring access to care. Moreover, while often out of the plan's control, courts also find significant the type of plaintiff and their relationship to the health care provider.

Insurers, plans, and plan sponsors will no doubt continue to face ERISA claims for benefits brought by out-of-network providers. And while, so far, it appears that Bristol only "cracked" the standing door for non-medical providers, subsequent cases will have to explore how wide that door opens.

Notes

1. "The UCR rate is a term of art in the healthcare industry and refers to the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical services." In re EthiCare Advisors, Inc., No. Civ. A. 20-1886, 2020 WL 4670914, at *1 (D.N.J. Aug. 12, 2020).

2. See, e.g., Nicholas Bullard & Andrew Holly, The "War" Between Out-of-Network Providers and Insurers Spreads Into COVID-19 Territory, JD Supra (Apr. 30, 2020) (discussing the phenomenon and its spread to the COVID-19 context).

3. Id. A Westlaw search reveals nearly 300 out-of-network provider cases in the past three years and nearly 1,000 in the past ten years.

4. Summit Estate, Inc. v. United Healthcare Ins. Co., No. 4:19-CV-06724 YGR, 2020 WL 5436655, at *1 (N.D. Cal. Sept. 10, 2020); see also, e.g., Mid-Town Surgical Ctr., LLP v. Humana Health Plan of Tex., Inc., 16 F. Supp. 3d 767, 772 (S.D. Tex. 2014); In re WellPoint, Inc. Out-of-Network UCR Rates Litig., 903 F. Supp. 2d 880, 892 (C.D. Cal. 2012).

5. See, e.g., Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 232 (3d Cir. 2020) (addressing oral promise for reimbursement "at the highest in-network level").

6. Plastic Surgery Ctr., 967 F.3d at 224; see also Summit Estate, 2020 WL 5436655, at *1; Mid-Town Surgical, 16 F. Supp. 3d at 772; In re WellPoint, 903 F. Supp. 2d at 892.

7. 29 U.S.C. § 1132(a)(1)(B).

8. Id. § 1104.

9. Id. § 1133(2).

10. See, e.g., In re WellPoint, 903 F. Supp. 2d at 920; Mid-Town Surgical, 16 F. Supp. 3d at 773.

11. See, e.g., Summit Estate, 2020 WL 5436655, at *3-8; Mid-Town Surgical, 16 F. Supp. 3d at 781–82.

12. 29 U.S.C. § 1144(a).

13. E.g., Plastic Surgery Ctr., 967 F.3d at 230-34; Access Mediquip LLC v. UnitedHealthcare Ins. Co., 662 F.3d 376, 383 (5th Cir. 2011), adhered to on reh'g en banc, 698 F.3d 229 (5th Cir. 2012); Marin Gen. Hosp. v. Modesto & Empire Traction Co., 581 F.3d 941, 947 (9th Cir. 2009).

14. See, e.g., Pac. Recovery Sols. v. United Behav. Health, 508 F. Supp. 3d 606, 621 (N.D. Cal. 2020) (holding that claims based on oral promises of reimbursement at UCR were preempted where UCR was alleged to be based on plan terms); Star Multi Care Servs., Inc. v. Empire Blue Cross Blue Shield, 6 F. Supp. 3d 275, 288 (E.D.N.Y. 2014) (holding that claims based on provision of "authorization" implicitly made reference to plan terms and were preempted).

15. 29 U.S.C. § 1132(a)(1)

16. Conn. State Dental Ass'n v. Anthem Health Plans, Inc., 591 F.3d 1337, 1347 (11th Cir. 2009); accord, e.g., I.V. Servs. of Am., Inc. v. Inn Dev. & Mgmt., Inc., 182 F.3d 51, 54 n.3 (1st Cir. 1999); Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272, 1277 (6th Cir. 1991).

17. See N. Jersey Brain & Spine Ctr. v. Aetna, Inc., 801 F.3d 369, 373 (3d Cir. 2015) (noting unanimous authority amongst federal circuit courts as of 2015).

18. Id. (quoting 29 U.S.C. § 1001(b)).

19. Id. (quoting CardioNet, Inc. v. Cigna Health Corp., 751 F.3d 165, 179 n.13 (3d Cir. 2014)); see also Hermann Hosp. v. MEBA Med. & Benefits Plan, 845 F.2d 1286, 1290 (5th Cir. 1988) ("To deny standing to health care providers as assignees of beneficiaries of ERISA plans might undermine Congress' goal of enhancing employees' health and welfare benefit coverage."), abrogated on other grounds by Access Mediquip, LLC v. UnitedHealthcare Ins. Co., 698 F.3d 229 (5th Cir. 2012).

20. N. Jersey Brain & Spine, 801 F.3d at 373; accord Misic v. Bldg. Serv. Emps. Health & Welfare Tr., 789 F.2d 1374, 1377 (9th Cir. 1986).

21. Hermann Hosp., 845 F.2d at 1290 n.13.

22. Cagle v. Bruner, 112 F.3d 1510, 1515 (11th Cir. 1997).

23. Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc., 371 F.3d 1291, 1295 (11th Cir. 2004); accord Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield, 890 F.3d 445, 453 (3d Cir. 2018) (noting that every circuit court to have considered this issue has held that "nothing in ERISA forecloses plan administrators from freely negotiating anti-assignment clauses").

24. St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc., 49 F.3d 1460, 1465 (10th Cir. 1995); accord see also City of Hope Nat. Med. Ctr. v. HealthPlus, Inc., 156 F.3d 223, 229 (1st Cir. 1998).

25. Simon v. Value Behavioral Health, Inc., 208 F.3d 1073, 1080-81 (9th Cir. 2000), amended, 234 F.3d 428 (9th Cir. 2000), cert. denied, 531 U.S. 1104 (2001), abrogated on other grounds by Odom v. Microsoft Corp., 486 F.3d 541 (9th Cir. 2007).

26. Id. at 1080.

27. Id. at 1081.

28. Id.

29. Id.

30. Id. at 1081-82.

31. See Simon v. Gen. Elec. Co., 263 F.3d 176, 178 (2d Cir. 2001) ("This narrow exception [i.e., derivative standing theory] grants standing only to healthcare providers to whom a beneficiary has assigned his claim in exchange for health care. Simon is not a healthcare provider assignee. Accordingly, and for the reasons given by the several circuit courts, we conclude that Simon does not have standing to sue under the terms of ERISA." (internal citation and footnote omitted)); Simon v. Cyprus Amax Mins. Health Care Plan, 12 F. App'x 839, 841 (10th Cir. 2001) (same); see also Brown v. Sikora & Assocs., Inc., No. CIV.A.6:04-579, 2007 WL 1068241, at *4 (D.S.C. Mar. 30, 2007) (declining "to adopt the theory of derivative standing to allow an employee organization to bring an action as an assignee of participants and beneficiaries of an ERISA plan"), aff'd, 311 F. App'x 568 (4th Cir. 2008); Chesters v. Welles-Snowden, 444 F. Supp. 2d 342, 346 (D. Md. 2006) ("Because Ms. Chesters is not health care provider to whom Ms. Welles-Snowden assigned her claims under a plan in exchange for health care, she lacks derivative standing to sue under ERISA.").

32. See Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Fla., Inc., 813 F.3d 1333, 1340 (11th Cir. 2015); Tango Transp. v. Healthcare Fin. Servs. LLC, 322 F.3d 888, 894 (5th Cir. 2003).

33. 22 F.4th 1086, 1088 (9th Cir. 2022).

34. Id. at 1087-88.

35. Id. at 1088.

36. Id.

37. Bristol SL Holdings, Inc. v. Cigna Health Life Ins. Co. et al., 2020 WL 6489324, at *1-2, 6 (C.D. Cal. Sept. 9, 2020), aff'd in part, rev'd in part, and remanded sub. nom. Bristol SL Holdings, Inc. v. Cinga Health and Life Ins. Co., 22 F.4th 1086 (9th Cir. 2022).

38. Bristol SL Holdings, Inc., 22 F.4th at 1089.

39. See Bristol SL Holdings, Inc. v. Cigna Health Life Ins. Co., 2020 WL 2027955, at *1 (C.D. Cal. Jan. 6, 2020), aff'd in part, rev'd in part, and remanded sub. nom. Bristol SL Holdings, Inc. v. Cinga Health and Life Ins. Co., 22 F.4th 1086 (9th Cir. 2022).

40. Id. at *5; see also 22 F.4th at 1089.

41. 22 F. 4th at 1090.

42. See id. at 1090-91 (citing Brown v. Sikora & Assocs., Inc., 311 Fed. App'x 568, 570 (4th Cir. 2008); Gables Ins. Recovery, Inc., 813 F.3d 1333; Tango Transp., 332 F.3d 888).

43. 22 F. 4th at 1092.

44. No. 8:19-CV-00243, 2022 WL 2348062 (C.D. Cal. June 13, 2022).

45. Id. at *1.

46. Id. at *1, *3.

47. ABC Servs. Grp., Inc. v. Aetna Health and Life Ins. Co., No. 20-55821, 2022 WL 187849, at *1 (9th Cir. Jan. 20, 2022).

48. Id.

49. ABC Servs. Grp., Inc., 2022 WL 2348062, at *3.

50. Id.

51. Id.

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