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Third Circuit Rules State Law Reimbursement Claims Brought by Out-of-Network Medical Provider Not Precluded by ERISA

October 4, 2020
The LHD/ERISA Advisor

In *Plastic Surgery Center, P.A. v. Aetna Life Ins. Co.*, 2020 U.S. App. LEXIS 22274 (July 17, 2020), the Third Circuit held that an out-of-network medical provider's state law claims against an insurer were not precluded by ERISA where the insurer agreed to pay for procedures before they were performed, but, after the procedures were completed, determined that it would not reimburse the provider for the full billed amount.

The Third Circuit determined that the out-of-network provider's state law causes of action for breach of contract and promissory estoppel were not pre-empted by ERISA and were permitted to go forward, potentially requiring the insurer to pay higher rates than those provided for in the insureds' ERISA plans.

The dispute first arose because two patients—who did not have out-of-network coverage under their ERISA healthcare plan—each required niche plastic surgery procedures. It was determined that the in-network providers did not perform the specialized procedures that were needed and the patients were referred to the Plastic Surgery Center ("Surgery Center"), an out-of-network provider. The patients alleged that prior to performing the procedures, the Surgery Center contacted Aetna Life Insurance Company ("Aetna"), the insurer for the healthcare plans at issue, by phone and received confirmation that Aetna would pay for the two procedures. For one of the procedures, Aetna agreed to make payment at the "highest in-network level" for similar procedures. As to the other, Aetna agreed to pay "a reasonable amount for those services" according to the terms of the Plan. Based on those assurances, the Surgery Center agreed to perform those procedures.

After the procedures were completed and billed, Aetna determined that it was only responsible for a portion of the billed amounts under the terms of the insureds' plans' payment rates. In response, the Surgery Center filed a complaint asserting three causes of action: breach of contract, promissory estoppel, and unjust enrichment.

Aetna responded with a motion to dismiss asserting that each of the three state law causes of action were preempted by ERISA because the claims "related to" the insureds' ERISA-governed health insurance plans. The U.S. District Court for the District of New Jersey agreed with Aetna and dismissed the Surgery Center's complaint in it is entirety.

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The Surgery Center appealed on the basis that the ERISA plans were not essential to its claims against Aetna. In response, Aetna argued that the Surgery Center agreed to be bound by all terms and conditions of the ERISA-governed plans—in other words, it agreed to be paid as if it were an in-network provider. Importantly, because the court was presented with the issue on a motion to dismiss, it had to accept the allegations in the complaint as true, which did not include allegations of an agreement by the Plastic Surgery Center to be bound by the terms of the plans.

The Third Circuit reversed the district court's decision to dismiss. In doing so, it determined that the breach of contract and promissory estoppel claims did not require "reference to" the ERISA plans. The court further held that those two claims could be interpreted as seeking to enforce obligations separate from the ERISA plan—i.e., that the assurance of payment was its own independent obligation—and thus did not require interpretation or construction of ERISA plans. After accepting the allegations of the complaint as true, the Third Circuit found that the claims did not relate to the ERISA plans:

> The claims here, on the other hand, arose precisely because there was no coverage under the plans for services performed by an out-of-network provider like the Center.
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> …
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> Thus, absent a separate agreement between Aetna and the Center, there was no obligation for the center to provide services to the plan participants, no obligation for Aetna to pay the Center for its services, and no agreement that compensation would be limited to benefits covered under the plan.

Therefore, the court held that Aetna's promise to pay the Plastic Surgery Center for the out-of-network procedures fell outside the bounds of the ERISA-governed plan, so the breach of contract and promissory estoppel claims were not barred by ERISA.

With regard to the unjust enrichment claim, the Third Circuit determined that it was pre-empted by ERISA because the "enrichment" conferred upon Aetna was its discharge of the obligation that it owed to the insureds. And because the obligation to the insureds arose out of the ERISA-governed plans, that claim was precluded by ERISA.

Plastic Surgery Center serves as a reminder for healthcare insurers that they may be obligated to pay higher rates than called for by the insured's plan when authorizing out-of-network treatment if they do not first negotiate and memorialize the rates that they will pay before authorizing the treatment. As such, if health insurers want to ensure they will only be liable for the rates provided for in insureds' plans, that should be communicated and memorialized in writing—and perhaps, when feasible, enter into a separate written agreement with the provider incorporating the specific payment rates.