15-2144

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

MCCULLOCH ORTHOPAEDIC SURGICAL SERVICES, PLLC,
AKA DR. KENNETH E. MCCULLOCH,
Plaintiff-Appellant,

v.

UNITED HEALTHCARE INSURANCE COMPANY, OF NEW YORK,
AKA OXFORD (PATIENT MARY BETH YARROW),
Defendant-Appellee.

On Appeal from the United States District Court
for the Southern District of New York

BRIEF FOR THE SECRETARY OF LABOR AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF-APPELLANT,

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QUESTION PRESENTED

Whether ERISA completely preempts the state-law promissory estoppel claim of a healthcare provider, which had no contractual relationship with an ERISA plan or its insurer, based on the insurer's promise of a specified rate of payment.

THE SECRETARY'S INTEREST

The Secretary of Labor bears primary responsibility for interpreting and enforcing Title I of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq. Sec'y of Labor v. Fitzsimmons, 805 F.2d 682, 698 (7th Cir. 1986) (en banc). In this capacity, he has a strong interest in ensuring that courts correctly apply ERISA's preemption provisions. In prior ERISA preemption decisions, this Court has considered the Secretary's views as expressed in amicus briefs. E.g., Gerosa v. Savasta & Co. Inc., 329 F.3d 317, 320 (2d Cir. 2003).

STATEMENT OF THE CASE

Plaintiff-appellant McCulloch Orthopedic Surgical Services ("McCulloch") is a surgical center and a healthcare provider that has no contract with defendant-appellee United Healthcare, a/k/a Oxford ("UHC") to provide medical services.

McCulloch is thus considered an "out-of-network"[1] provider for patients insured by UHC. Summons and Verified Complaint, dated July 3, 2014 ("Compl."), at A16. Patient Mary Beth Yarrow was a participant in an ERISA plan insured and administered by UHC. Compl., at A17. As the plan administrator, UHC processes the plan participant's claims for health benefits. Id. Yarrow sought McCulloch's services for an arthroscopic knee surgery. Id. Prior to performing the surgery, McCulloch contacted UHC and UHC assured McCulloch that Yarrow's plan "provided for payment to out-of-network physicians," covered Yarrow's surgical procedures, and that UHC "would reimburse [McCulloch] at 70% of UCR [usual, customary, and reasonable] rates for such procedures." Id. McCulloch asserts that UHC should have paid $15,479.80 for the surgery pursuant to those assurances but paid only $641.66. Id. The parties do not dispute that Yarrow's plan did not provide reimbursement at 70% of UCR for the services provided by McCulloch.[2]

McCulloch sought to recover the amount of payment allegedly promised for the surgery so it sued UHC for promissory estoppel in New York state court.

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[1] An "in-network" provider to an ERISA Plan is "a health care provider who is in the network of providers with whom the [ERISA Plan] has specially contracted to provide services to its members." Montefiore Med. Ctr. v. Teamsters Local 272, 642 F.3d 321, 325 (2d Cir. 2011). An "out-of-network" provider is a health care provider outside of that network.

[2] See Defendant's Memorandum of Law in Support of Motion to Dismiss, McCulloch v. United Healthcare, No. 1:14-cv-06989-JPO, Dkt. No. 5, at *10 (S.D.N.Y. filed Sept. 3, 2014) (quoting plan document's reimbursement methodologies).

Opinion and Order, June 8, 2015, ("Op."), at A491. The complaint filed in state court asserted a right to payment pursuant to UHC's promise and not a right to payment pursuant to the ERISA plan terms. Compl., at A21. UHC removed the case to federal court. Id. McCulloch then moved for a remand to state court. Op., at A491. The district court denied McCulloch's motion, concluding that ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), completely preempts McCulloch's state law claims. Id. Section 502(a)(1)(B) provides that a "plan participant or beneficiary" may bring a civil action to "recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the plan."

The district court applied the two-prong analysis for complete preemption by ERISA section 502(a)(1)(B) established by Aetna Health Inc. v. Davila, 542 U.S. 200 (2004). Op., at A496-99. The court also relied on this Court's decision in Montefiore Med. Ctr. v. Teamsters Local 272, 642 F.3d 321, 324 (2d Cir. 2011), which applied Davila to a factually different dispute between a healthcare provider and a self-insured plan. Op., at A496, 500-01.

For prong one, this Court identified two steps in Montefiore, 642 F.3d at 328. Under prong one, step one, the court asks "whether the plaintiff is the type of party that can bring a claim pursuant to § 502(a)(1)(B)." Id. Under prong one, step two, the court asks "whether the actual claim that the plaintiff asserts can be

construed as a colorable claim for benefits pursuant to § 502(a)(1)(B)." Id. Under prong two, the court asks, "whether there is an independent legal duty that is implicated by the defendant's actions." Id. The "test is conjunctive; a state-law cause of action is preempted only if both prongs of the test are satisfied." Id.

The district court concluded that under prong one, step one, the question turned on whether McCulloch received an assignment of Yarrow's right to benefits under the plan from Yarrow, and therefore became a "type of party" that can sue under ERISA section 502(a)(1)(B). Op., at A497. McCulloch argued that its assignment from Yarrow was invalid because her plan had an anti-assignment clause. Id. UHC conceded that the assignment was invalid. Id. ("[UHC] does not dispute that the assignment was invalid."). Nevertheless, the court found this fact to be irrelevant, because McCulloch had the ability to sue derivatively under ERISA based on its assignment even though "the purported assignment may have been ineffective under the terms of the benefit plan." Op., at A498.

On prong one, step two, the district court concluded that this step turns on whether McCulloch's claim concerned a "right to payment" under the ERISA plan rather than the "amount of payment" pursuant to an "independent contractual obligation[]." Op., at A498-99. The court held that McCulloch's claim implicated a right to payment under the plan because the claim concerned "alleged

representations *about the plan*" and what the plans covered in the form of reimbursements. Op., at A499 (emphasis in original).

On Davila's prong two, the court rejected McCulloch's argument that the insurer's actions implicated a legal duty independent of the insurer's obligations under the benefits plan. Op., at A500. The court acknowledged that at least four circuit courts have concluded that there is no complete preemption where the phone call was "a confirmatory confirmation [that]. . . create[s] a basis for an independent legal duty, even if it is evident that the communication is plan-related." Op., at A500-501. Yet, the court read Montefiore, 642 F.3d at 328, to break with these other circuit decisions and, instead, "specifically reject[ ] the argument that confirmatory phone calls create an independent legal duty." Op., at A501.

Accordingly, the court concluded that McCulloch's claim satisfied both prongs and was completely preempted by ERISA section 502(a)(1)(B). Op., at A501. McCulloch conceded that it could not state a claim for benefits under ERISA section 502(a)(1)(B), so the court dismissed the case. Op. at A502. McCulloch then timely appealed.

SUMMARY OF THE ARGUMENT

1. A state law claim is completely preempted and thus removable to federal court under ERISA only if the action satisfies both prongs of a two-pronged

test: (1) the plaintiff could have brought the suit under ERISA, and (2) the claim does not implicate an independent duty of the defendant. McCulloch's claim for promissory estoppel does not satisfy either prong. Its claim against UHC therefore should be remanded to state court.

2. McCulloch could not have brought its suit as a claim for benefits under ERISA section 502(a)(1)(B) for two reasons. First, McCulloch is not a plan participant or beneficiary with an independent right to sue for benefits, nor did it have a valid assignment of this right from the participant. Second, even if McCulloch could have brought suit under ERISA, its state-law claim of promissory estoppel turns on the oral communication between the defendant and McCulloch, and does not implicate an ERISA plan or depend on its terms. McCulloch's suit is thus not a claim for benefits under ERISA.

Moreover, McCulloch's promissory estoppel claim is based on a legal duty independent of any duty UHC may have to pay benefits to plan participants. UHC's promises to McCulloch created an independent legal obligation under state law, an obligation independent from the ERISA plan terms. This Court's decision in Montefiore is not to the contrary because, in that case, the provider's suit concerned ERISA plan terms integrated into its contract arrangements with the plan and its agents. Here, in contrast, McCulloch has no pre-existing relationship

with the insurer or the ERISA plan, and any dispute centers solely on the insurer's broken promise.

3. Both the Seventh and Ninth Circuits have concluded that ERISA does not completely preempt similar claims. Other circuits have applied the same reasoning in finding no preemption of similar claims under ERISA's express preemption provision. This Court has applied similar reasoning and found claims not completely preempted.

4. Finally, if this Court were to find McCulloch's claims completely preempted, this would leave McCulloch, an independent medical provider with no relationship to the plan, without any remedy to enforce the insurer's promise to reimburse it at 70% of UCR. This significant risk of non-payment may well lead McCulloch and other medical providers to decide not to treat, or to otherwise screen patients who are participants in certain plans, or to increase its fees, thus hurting the plan participants whom ERISA was designed to protect. Furthermore, this likely harm to plan participants (and certain harm to medical providers like McCulloch who are the recipients of broken promises) is not counterbalanced by any increase in uniformity for those administering the plans. Ultimately, complete preemption is not only unjustified under the relevant legal authorities but also undermines ERISA's principal purpose to protect the plan beneficiaries and participants.

ARGUMENT

ERISA DOES NOT COMPLETELY PREEMPT MCCULLOCH'S STATE LAW PROMISSORY ESTOPPEL CLAIM BECAUSE IT COULD NOT HAVE BEEN BROUGHT AS AN ERISA CLAIM FOR BENEFITS AND IT IS BASED ON THE INSURER'S INDEPENDENT DUTY UNDER STATE LAW TO COMPLY WITH ITS PROMISE TO PAY FOR SERVICES

A. BACKGROUND LEGAL PRINCIPLES

1. ERISA's Complete Preemption Framework under *Davila*

ERISA's "complete preemption" doctrine is a removal doctrine that turns on whether "a plaintiff's 'state cause of action [may be recast] as a federal claim for relief, making [its] removal [by the defendant] proper on the basis of federal question jurisdiction.'" Wurtz v. Rawlings Co., LLC, 761 F.3d 232, 238 (2d Cir. 2014) (citation omitted), cert. denied, 135 S. Ct. 1400 (2015).

The Supreme Court addressed complete preemption under ERISA most recently in Davila, which held that ERISA completely preempted ERISA plan participants' state law claims that their insurers had violated duties of ordinary care in refusing to cover certain medical services. 542 U.S. at 214. The Davila Court held that these malpractice claims could have been brought as claims for benefits under ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and were thus completely preempted by ERISA. Id. The Court reasoned that ERISA's comprehensive civil enforcement scheme set out in section 502 completely preempts any state-law claim that "duplicates, supplements, or supplants" an

ERISA remedy. Id. at 209, 210. The Court established a two-pronged test for making this determination: (1) the plaintiff, "at some point in time could have brought his claim under ERISA" section 502, and (2) "there is no other independent duty that is implicated by a defendant's actions." Id. at 210.

Complete preemption under ERISA section 502 is distinct from preemption under ERISA's express preemption provision, section 514, 29 U.S.C. § 1144, which turns on whether a state law "relates to" an ERISA plan. Section 514 preemption does not support federal subject-matter jurisdiction but is a form of "defensive preemption" used by defendants as an affirmative defense against state law claims. Wurtz, 761 F.3d at 238. Complete preemption, on the other hand, addresses whether federal subject-matter jurisdiction exists over a claim brought under state law. Nevertheless, there is considerable overlap in the analysis. See, e.g., Franciscan Skemp Healthcare, Inc. v. Cent. States Bd. Health & Welfare Trust Fund, 538 F.3d 594, 600 (7th Cir. 2008).

2. This Court's Application of the *Davila* Test in *Montefiore*

The district court relied extensively on this Court's interpretation and application of Davila to a dispute between a hospital and a self-insured ERISA plan[3] in Montefiore, 642 F.3d at 326, 328. In Montefiore, the hospital asserted

[3] A self-insured plan is one in which the plan sponsor pays claims out of its own assets or from a trust, rather than contracting with an insurance company to pay claims under an insurance policy.

state-law contract and quasi-contract claims against a self-insured plan for improperly reimbursing medical services provided to ERISA plan participants. Id. at 326, 328.

In Montefiore, this Court disaggregated Davila's prong one into two steps. 642 F.3d at 330. Under prong one, courts must first determine "whether the plaintiff was the *type* of party that could bring a claim pursuant to § 502(a)(1)(B); and second, [the court must] consider whether the *actual claim* that the plaintiff asserts can be construed as a colorable claim for benefits pursuant to § 502(a)(1)(B)." Id. at 328 (emphasis in original).

With regard to the first step in prong one, this Court in Montefiore noted that plaintiff hospital had obtained valid assignments from the patients to pursue their claims for plan benefits; therefore, the hospital was "the type of party that can bring a claim against the [ERISA plan] regarding benefits pursuant to § 502(a)(1)(B)." Id. at 329, 330. With regard to the second step of the first prong, this Court concluded that at least some of the asserted claims were for benefits covered under the plan since they concerned benefit coverage determinations rather than "underpayment or untimely payment, where the basic right to payment has already been established and the remaining dispute only involves obligations from a source other than the Plan." Id. at 331.

With regard to the second prong of Davila, plaintiff hospital argued that because it made phone calls to the plan to confirm coverage, these oral confirmations "gave rise to an independent duty" between the hospital and the plan. Id. at 332. This Court rejected this argument, and concluded that the phone conversations between the in-network provider and the Plan "did not create a sufficiently independent duty under Davila." Id. Instead, the oral communications were part of a "pre-approval process . . . expressly required by the terms of the Plan itself and therefore inextricably intertwined with the interpretation of the Plan coverage and benefits." Id. (emphasis added). This Court held that "[w]hatever legal significance these phone conversations may have had, see Appendix A, they did not create a sufficiently independent duty under Davila . . . ." Id. (emphasis added). In Appendix A, this Court diagrammed the factual context that led to this holding: the provider had called the plan pursuant to plan terms and the provider's pre-existing contractual arrangements with the preferred provider organization ("PPO") and the self-insured plan. For these reasons, this Court found the hospital's claims were completely preempted.

As discussed below, the factual circumstances here are distinguishable from those in Montefiore. Unlike the hospital in that case, McCulloch was an out-of-network provider with no existing contractual arrangements with the plan or the insurer and it did not have a valid assignment of plan benefits from the patient. It

called to verify that the plan would pay for out-of-network services at an acceptable rate. McCulloch then relied on the insurer's assurances before proceeding with those services. The significant factual differences compel an opposite result in this case.

B. MCCULLOCH'S CLAIM FAILS TO SATISFY EITHER PRONG OF THE COMPLETE PREEMPTION TEST

1. Prong One, Step One: McCulloch Is Not a "Type of Party" That Can Bring a Claim Under ERISA Section 502

Under Montefiore, healthcare providers who obtain "valid" assignments of a benefit claim from a plan participant are the types of parties that can bring benefit claims under section 502(a)(1)(B). 642 F.3d at 329. Without a valid assignment from the plan participant, a healthcare provider may not independently sue under ERISA section 502 because it is not a participant or beneficiary. See Montefiore, 642 F.3d at 329.

The parties in Montefiore disputed the validity of the provider's assignment. This Court in Montefiore rejected the provider's argument that as an "in-network" provider it could not receive a valid assignment of benefits. Montefiore, 642 F.3d at 330. In reaching its decision, this Court in Montefiore clearly recognized that the validity of the assignment is not only relevant to the prong one, step one

analysis, but a court also needs to assess the validity of a party's assignment based on the specific facts in each case.[4] Id. at 321 nn.8-10.

In this case, McCulloch is an out-of-network provider suing to enforce promises made by an insurer of an ERISA plan with an anti-assignment provision. Unlike Montefiore, the parties here do not dispute that the assignment was invalid by operation of the anti-assignment clause. Op., at A498-500. Nevertheless, the district court still held that McCulloch was a "type of party" that could bring a claim pursuant to § 502(a)(1)(B). Id. The district court erred by ignoring both Montefiore's clear language that a provider's assignment must be "valid" for the provider to sue under 502(a)(1)(B), and the undisputed invalidity of McCulloch's assignment. Without a valid assignment, McCulloch is not the type of party that can sue for benefits under section 502(a)(1)(B) and clearly does not satisfy prong one, step one.

2. Prong One, Step Two: McCulloch's Promissory Estoppel Claim Cannot be Brought as a Benefits Claim Under ERISA Section 502

The district court also erred in its analysis of prong one, step two. In this prong, the court must determine "whether the actual claims that [plaintiff] asserts can be construed as colorable claims for benefits pursuant to § 502(a)(1)(B)."

[4] The inquiry here is not a full merits inquiry into an assignment's validity or the scope of an anti-assignment clause. Nevertheless, as Montefiore held, courts under this prong one, step one, must still address whether an assignment was "valid." 642 F.3d at 330. The scope of this inquiry will depend on the pleadings in each case. Here, the assignment's invalidity was undisputed. Op., at A498-500.

Montefiore, 642 F.2d at 330. In other words, the court must determine whether the "claims . . . implicate coverage and benefits established by the terms of the ERISA benefit plan." Id. McCulloch's claim does not depend on the coverage and benefits under the ERISA plan. In fact, the parties do not dispute that the plan did not provide for McCulloch to be reimbursed at 70% of UCR. Instead, McCulloch's claim is based on UHC's oral promise to reimburse at that rate, a promise that was entirely outside the plan provisions. For that reason, McCulloch's claim is not a colorable claim for benefits pursuant to ERISA section 502(a)(1)(B).

In reaching the contrary conclusion, the district court relied on a distinction between a claim based on a "right to payment" under the plan versus a claim based on the "amount of payment" due under obligations outside the plan as discussed in Montefiore. Op., at A498-500. As explained below, the district court misapplied this distinction and erroneously concluded that UHC's oral representations concerned a "right to payment" under the plan simply because these oral communications were "about the plan." Id.

In Montefiore, the plaintiff-provider had a pre-existing contract with the preferred provider organization serving the ERISA plan and that contract incorporated the ERISA plan's terms. 642 F.2d at 326. The plaintiff-provider then raised both contractual claims with respect to the contract and also quasi-

contractual claims based on oral communications with plan agents. Id. at 331-32. With respect to the contractual claims, this Court in Montefiore found these claims were based on the plan terms as incorporated into the contract and, therefore, depended on the plan's coverage and benefits, or, stated differently, a "right to payment" under the plan. Id. at 331 & n.13. These claims were based on plan terms, so they were completely preempted. Id. at 331. Montefiore suggested that other claims solely concerning the amount and timeliness of payment to the provider would not be preempted because these contractual claims do not implicate incorporated plan terms. Id. (characterizing these claims as "independent contractual obligations between the provider and the PPO"). The distinction between "right to payment" and "amount of payment" has been specifically applied only to claims concerning contracts between providers and insurers that incorporate plan terms. See Montefiore, 642 F.2d at 331 (citing Lone Star OB/GYN Assocs. v. Aetna Health Inc., 579 F.3d 525, 530–31 (5th Cir. 2009); Pascack Valley Hosp., Inc. v. Local 464A UFCW Welfare Reimbursement Plan, 388 F.3d 393, 403-04 (3d Cir. 2004); Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., 187 F.3d 1045, 1051 (9th Cir. 1999)). Montefiore's analysis in this prong one, step two, therefore, derives from the specific contractual arrangement in that case. Here, McCulloch does not have a contractual arrangement with the plan or its agents, so McCulloch's suit does not concern any

plan terms or a "right to payment" incorporated into such an arrangement. The district court erroneously applied this distinction to UHC's oral promises, which are untethered to any pre-existing contractual relationship with McCulloch.

This Court also rejected the provider's "quasi-contract" claims based on oral communications in a pre-approval process because these communications were required by the plan under its contractual relationship with the provider. Montefiore, 642 F.3d at 322. As a plan requirement, ERISA preempted these claims because these claims were "intertwined" with an interpretation of plan coverage and benefits. Id. at 322 ("this pre-approval process was expressly required by the terms of the Plan itself and is therefore inextricably intertwined with the interpretation of Plan coverage and benefits"). This Court specifically emphasized the specific factual context, i.e., a web of contractual arrangements, for these communications in preempting these claims. Id. at 332, 334 & n.5 (tying these oral communications and the plan's pre-approval process to Montefiore's pre-existing contractual relationships with a preferred provider organization or "PPO," the plan, and its beneficiaries as diagrammed in Appendix A).

Here, unlike the hospital in Montefiore, McCulloch only asserts a claim of promissory estoppel based on oral communications with an unrelated insurer; this claim is not based on any alleged entitlement under the plan terms or any written contractual arrangement with the insurer or the plan. Furthermore, unlike

Montefiore, these communications were not required under the plan terms or a part of an intertwined contractual arrangement with the insurer and the plan. McCulloch, unlike the provider in Montefiore, therefore does not base his claim on plan terms or a contractual arrangement with incorporated plan terms. Accordingly, Montefiore's reliance on the plaintiff's contractual arrangement and plan terms to reach its decision on both the contractual and quasi-contractual claims renders its holding wholly inapt to McCulloch's claim.

Other circuit courts have correctly found similar claims not completely preempted in analogous factual circumstances. The Ninth Circuit's holding in Marin General Hospital v. Modesto & Empire Traction Co., 581 F.3d 941 (9th Cir. 2009), is instructive. Marin General Hospital held that the type of state law claim asserted by McCulloch, which is based on a plan administrator's oral representation to a provider and not based on the terms of the plan documents (or those incorporated into contracts), does not meet Davila prong one. 581 F.3d at 947. The court reasoned that a provider's state law claims based on an "oral contract" were unlike those in Davila which "complain[ed] only about denials of coverage promised under the terms of an ERISA plan." Id. The Seventh Circuit reached the same conclusion in Franciscan Skemp, 538 F.3d at 598 ("Franciscan Skemp is seeking damages arising from alleged misrepresentations made by [the plan] to Franciscan Skemp in response to its inquiry – a wrong not within § 502's scope").

In these disputes, the provider is "not arguing about plan terms. It is not seeking to recover plan benefits . . . ." Id. at 601. Instead, the provider, like McCulloch, "is bringing state-law claims based on the alleged shortcomings in the communications between it and" the insurer or the plan. Id.

Even if this Court should agree with the district court that McCulloch has a valid assignment for prong one, step one, a valid assignment does not affect the analysis under prong one, step two. In both the Seventh and Ninth Circuit cases, the provider was a valid assignee of a participant's or beneficiary's benefit claim and could have brought a claim for benefits under ERISA as an assignee. Nevertheless, for both courts, the assignment did not convert the third party provider's claim based on an oral contract into claims to recover benefits under an ERISA plan. E.g., Marin Gen. Hosp., 581 F.3d at 950. Both courts rejected the insurer's arguments that an assignment supplants or restricts the provider's right to sue based on the provider's own independent rights. See id. at 949 (rejecting the argument that "because the [provider] could have brought a suit under § 502(a)(1)(B) for payments owed to the patient by virtue of the terms of the ERISA plan, this is the only suit the [provider] could bring"); Franciscan Skemp, 538 F.3d at 598 ("Simply because at one point in time [the provider] acknowledged an assignment from [the patient] does not mean that it simultaneously and implicitly gave up any claim(s) it had against [the plan] apart from that assignment."). The

Seventh Circuit observed that the provider "is not and could not be 'standing in her shoes' or asserting [the patient's] rights" because "[the provider] is basing its claims on a conversation to which [the patient] was not even a party." Id. at 598.

Both circuit courts correctly concluded that state law claims based solely on the oral communications between the provider and an insurer to an ERISA plan or the ERISA plan itself are not completely preempted. As both circuits recognized, such a suit is different from a claim to recover benefits under the plan terms. In reaching the opposite conclusion, the district court's decision erroneously departs from the well-reasoned decisions from these two circuits and from a proper understanding of Montefiore.

3. Prong Two: McCulloch's Promissory Estoppel Claim Arises from an Independent Legal Duty Implicated by UHC's Actions

The district court also erred in its analysis of the second prong: "whether there is an independent legal duty that is implicated by the defendant's actions." Montefiore, 642 F.3d at 328. As with prong one, the district court erred in concluding that McCulloch's claim was analogous to the claims in Montefiore because McCulloch failed to implicate an independent legal duty. Unlike the provider in Montefiore, McCulloch was unrelated to the plan or its insurer; McCulloch was an out-of-network provider that called an insurer for assurance that it would pay out-of-network providers at an acceptable rate. McCulloch had no pre-existing contractual obligations with the insurer or the plan that would

implicate an ERISA plan's terms. UHC's assurances to McCulloch that it would pay McCulloch for its services allegedly created an independent legal duty to pay the amount promised under the state law rule of promissory estoppel.

McCulloch's claims are similar to the claims in Stevenson v. Bank of New York Co., 609 F.3d 56, 60 (2d Cir. 2010), and the district court's decision is contrary to this Court's decision in that case. In Stevenson, plaintiff asserted state law claims, including promissory estoppel, based on his employer's promises that his pension benefits would be maintained after an international move, which would otherwise make him ineligible for benefits. 609 F.3d at 60. This Court found those claims were not completely preempted, reasoning that "[b]ecause Stevenson's state law claims derive from [a] promise rather than from an ERISA benefits plan, their resolution does not require a court to review the propriety of an administrator's or employer's determination of benefits under such a plan." Id. at 60-61. Though these representations "reference[d]" the terms of the benefit plan, the claims were not completely preempted because the representations constituted a "separate promise" from which the state law claims were derived. Id. In Stevenson, this Court concluded that the participant was asserting an independent state law claim, not a claim based on the terms of the ERISA plan. 609 F.3d at 60.

Here, as in Stevenson, McCulloch's claim depends solely on UHC's representations and oral promises to McCulloch, a legal basis independent from the

plan terms. See Davila, 542 U.S. at 215 ("'the wording of [respondents'] plans is immaterial to their claims"). Unlike claims completely preempted by ERISA, the claim alleged here does not arise from any rights or obligations established by ERISA or the terms of the ERISA plan but rather, if at all, from an independent state law duty when speaking to a third-party provider. See id. at 213. Accordingly, the claims as pleaded concern an "independent legal duty that is implicated by a defendant's actions" unrelated to the plan terms or the ERISA remedies designed to remedy violations of those terms. Id. at 210.

Again, this Court's decision in Montefiore is inapposite. The phone conversations in Montefiore were expressly required by the pre-approval process pursuant to plan terms and were held within a contractual web connecting the provider, the ERISA plan, an organization of providers or PPOs, and the plan beneficiaries. 642 F.3d at 332, 326 n.5, 334, Appendix A. Because of this tangle of interconnected relationships, the oral communications between the plan and the provider were governed and required by the "terms of the Plan itself" and "therefore inextricably intertwined with the interpretation of Plan coverage and benefits." Id. at 332. Accordingly, the provider's claims did not appear to be claims that concerned "obligations derived from a source other than the Plan." Id. at 331. Unlike Montefiore, the obligations here arise from an independent source, the insurer's oral promise, and not on plan terms or a contractual arrangement that

incorporated those terms. Because McCulloch's state law claim derives from an independent promise rather than from the terms of an ERISA benefits plan, its claim is not be completely preempted by ERISA. See Stevenson, 609 F.3d at 61.

In accord, the Seventh and Ninth Circuits both concluded that similar state law claims based on an oral promise from the plan or insurer to a provider may constitute an independent duty under prong two. The Ninth Circuit, for example, concluded that "[t]he question under the second prong of Davila is whether the complaint relies on a legal duty that arises independently of ERISA. Since the state-law claims asserted in this case are in no way based on an obligation under an ERISA plan, and since they would exist whether or not an ERISA plan existed, they are based on 'other independent legal dut[ies]' within the meaning of Davila." Marin Gen. Hosp., 581 F.3d at 950. As in Marin General Hospital, the obligation here arises from UHC's oral promises and these promises "exist whether or not" the patient had an ERISA plan. See id. Reaching the same conclusion, the Seventh Circuit, in Franciscan Skemp, 538 F.3d at 599, stated that "the relevant legal duties, logically implicated by these facts, are entirely independent from ERISA and any plan terms."

It is important to note that just as in prong one, step two, having a valid assignment does not change the analysis for prong two. See Franciscan Skemp, 538 F.3d at 598; Marin Gen. Hosp., 581 F.3d at 950; see also, supra pp. 18-19. The

state-law claim of a provider with a valid assignment is still not completely preempted if the claim is based on an independent legal duty stemming from the insurer's oral promises. McCulloch "is not suing defendants based on any assignment from the patient of his rights under his ERISA plan pursuant to § 502(a)(1)(B); rather, it is suing in its own right pursuant to an independent obligation." Marin Gen. Hospital, 581 F.3d at 948.

4. The District Court's Conclusion that ERISA Preempts McCulloch's Promissory Estoppel Claim is Contrary to Other Circuit Court Decisions

There is an overwhelming and persuasive consensus that state law claims similar to the one in this appeal are not completely preempted under ERISA section 502 or preempted under section 514. As discussed earlier, two circuit courts in Franciscan Skemp and Marin General Hospital have rejected complete preemption under ERISA 502 in circumstances similar to this case.

In so holding, the Seventh Circuit relied on other decisions from the Eighth, Ninth, Tenth, and Eleventh Circuits, all of which have held similar claims with analogous factual circumstances not preempted under ERISA section 514 using similar reasoning. See Franciscan Skemp, 538 F.3d at 599 (citing In Home Health, Inc. v. Prudential Ins. Co., 101 F.3d 600, 602 (8th Cir. 1996); The Meadows v. Employers Health Insurance, 47 F.3d 1006, 1009 (9th Cir. 1995); Lordmann Enterprises, Inc. v. Equicor, Inc., 32 F.3d 1529, 1533 (11th Cir.1994), cert. denied,

516 U.S. 930 (1995); and Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc., 944 F.2d 752, 753 (10th Cir. 1991)); accord Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co., 662 F.3d 376, 387 (5th Cir. 2011), opinion reinstated, 698 F.3d 229 (5th Cir. 2012) (en banc).[5] While many of these cases are pre-Davila and most deal with preemption under ERISA section 514, the Seventh Circuit in Franciscan Skemp recognized that "similar underlying policy considerations," i.e., the independence of these claims from the patient's claims for ERISA plan benefits, inform both types of ERISA preemption analyses in these cases and the court "do[es] not find any concrete reason to suppose that the

[5] The contrary view is held solely by the Sixth Circuit in Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272 (1991). The Cromwell case involved a valid assignment, and the Sixth Circuit found that preemption was proper, because the substance of the "breach of contract claim was for benefits payable under an employee health insurance plan." Cromwell, 944 F.2d at 1276. The court found that the provider "clearly claimed to be entitled to benefits due them from the . . . plan as beneficiaries by virtue of the assignment of benefits clause." Id. at 1278-1279. The court then conflated the claims under the assignment with the independent state law claims, emphasizing plaintiffs' "repeated" reliance on the valid assignment. Id. The Cromwell opinion has been strongly criticized. As the Seventh Circuit pointed out in Franciscan Skemp, 538 F.3d at 600, the dissenting judge in Cromwell "criticized the majority's focus on the alleged 'assignment.'" The dissent concluded that the majority's opinion was "emblematic of what seems to be an overzealous readiness in the federal courts to bar all state-law claims which even smell of ERISA under the broad umbrella of preemption without engaging in the complex case-by-case analysis which the statute and precedent require." Cromwell, 944 F.2d at 1279; see also Franciscan Skemp, 538 F.3d at 601 ("Cromwell is a poorly reasoned outlier").

conclusions reached in these cases have been deemed incorrect by Davila." 538 F.3d at 600.[6]

The underlying rationale that governs the decisions of these six circuit courts is that the ERISA participant and the healthcare provider have independent and separate rights. As the Tenth Circuit in Hospice of Metro Denver succinctly concluded: "[a]n action brought by a health care provider to recover promised payment from an insurance carrier is distinct from an action brought by a plan participant against the insurer seeking recovery of benefits due under the terms of the insurance plan." 944 F.2d at 756. In short, the relationship between the healthcare providers with the insurer is a separate relationship with independent duties from the one between the insurer and the plan participants. See, e.g., Franciscan Skemp, 538 F.3d at 600-601; In Home Health, 944 F.2d at 1277-278; Lordmann Enterprises, 32 F.3d at 1534. Under this rationale, these claims implicate an independent duty under Davila's prong two analysis for complete preemption. This Court also cited with approval this rationale in Wurtz, 761 F.3d at 244-45, where it held that a plan participant's state right to enjoin an insurer's

[6] State appellate courts have endorsed the same rationale to hold that ERISA section 514 does not preempt similar claims. See, e.g., Alliance Health of Santa Teresa Inc. v. Nat'l Presto Ind., Inc., 113 P.3d 360, 371-73 (N.M. App. Ct. 2005); Weiser v. United Food and Commercial Workers Unions and Emp'rs Midwest Health Benefits Fund, 653 N.E.2d 51, 53 (Ill. App. Ct. 1995); Brookwood Med. Ctr. v. Celtic Life Ins., 637 So.2d 1385, 1387-390 (Ala. Civ. App. Ct. 1994); cf. St. Joseph's Hosp. & Med. Ctr v. Reserve Life Ins. Co., 742 P.2d 808, 817 (Ariz. 1987) (finding tort liability for insurer's oral promises to provider).

subrogation action against his tort settlement was not completely preempted under ERISA. This Court cited Marin General Hospital and Franciscan Skemp with approval in reaching this conclusion. Id.

Significantly, Montefiore itself also cited both Franciscan Skemp and Marin General Hospital with approval. 642 F.3d at 327-28. Far from expressing the intent to create a conflict with these decisions Montefiore recognized that Marin General Hospital properly held that "although plan beneficiaries had validly assigned their ERISA claims to the provider hospital, the actual claim brought by the hospital was based on a separate contractual obligation." 642 F.3d at 328. In Marin General Hospital, the "separate contractual obligation" was based on oral promises made over the phone, much like the claims here. 642 F.3d at 947. Accordingly, Montefiore cannot plausibly be read to conflict with these well-established holdings, which support no complete preemption of McCulloch's claim. The district court erred in relying on Montefiore in reaching the contrary conclusion that McCulloch's claim is completely preempted.

5. Completely Preempting McCulloch's Promissory Estoppel Claim Would Unfairly Leave An Independent Medical Provider Without any Remedy to Enforce an Insurer's Promises, Thereby Indirectly Harming Plan Participants Without Serving to Promote Uniformity in the Administration of the Patient's Medical Benefits Plan

The Supreme Court has stressed that "the starting presumption [is] that Congress does not intend to supplant state law," New York State Conference of

Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654 (1995), and has instructed the courts to look "to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive," id. at 655-656. This Court in Gerosa, 329 F.3d at 320, 329-330, described ERISA preemption in relation to two related purposes. First, ERISA's "principal goal" is to protect the interests of participant and beneficiaries. Id.; see also 29 U.S.C. § 1001 (purpose of ERISA is "to protect . . . the interests of participants in employee benefit plans and their beneficiaries"). Second, ERISA preemption is also concerned with "the planning interests and administrative burdens of employers and plan administrators," such as the uniformity of plan administration. Gerosa, 329 F.3d at 329; see also Davila, 542 U.S. at 208 ("The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans.").

Preemption here harms the interests of plan participants and beneficiaries. Preemption would unfairly leave third-party providers, like McCulloch, without any remedies for the insurer's oral assurances that caused detrimental reliance. As other circuit courts uniformly recognize, preemption of a provider's state law claims would leave them without any remedy because they lack standing to pursue those claims independently under ERISA. E.g., Hospice of Metro Denver, 944 F.2d at 755. Such a result harms beneficiaries and participants because the third-party providers might deny care, increase patient screening, or raise fees in order to

cover the risk of insurer misrepresentation or other errors. See, e.g., In Home Health, 101 F.3d at 606-07; The Meadows, 47 F.3d at 1011; cf. Gerosa, 329 F.3d at 320, 329-330 (relying on In Home Health, 101 F.3d at 606-07, which this Court favorably described as "holding that [a] rule leaving health-care providers with no remedy against [a] plan would be contrary to Congress's intentions because it would result in higher costs and other inconveniences to beneficiaries"). The Eleventh Circuit in Lordmann aptly summarized the harm to providers, like McCulloch, and the plan participants:

> The "commercial realities" of the health care industry require that health care providers [like McCulloch] be able to rely on insurers' representations as to coverage. . . . If ERISA preempts their potential causes of action for misrepresentation, health care providers can no longer rely as freely and must either deny care or raise fees to protect themselves against the risk of noncoverage. In that event, the employees whom Congress sought to protect would find medical treatment more difficult to obtain.

Lordmann, 32 F.3d at 1533.

Permitting McCulloch to sue under state law would not undermine the uniformity in the administration of benefits. This Court recognized in Stevenson that "because Stevenson's suit neither interferes with the relationships among core ERISA entities nor tends to control or supersede their functions, it poses no danger of undermining the uniformity of the administration of benefits that is ERISA's key concern." 609 F.3d at 61. In Stevenson, this Court found that ERISA Section 502(a) did not preempt Stevenson's state law claims, because the claims were "in

themselves neutral toward ERISA plans." Id. "These claims make reference to ERISA plans solely as a means of describing the consideration underlying an alleged contract that itself is separate from the terms of any plan; they will not affect the referenced plans, particularly not in a way that threatens ERISA's goal of uniformity." Id. Likewise, here, McCulloch's claims are based on a single oral communication with an unrelated insurer and is "neutral toward" the ERISA plan; the claim is based solely on the alleged oral promise between the insurer and the provider that "is separate from the terms of any plan," and "will not affect the referenced plans." See Stevenson, 609 F.3d. at 61. The claim here likewise does not "threaten[ ] ERISA's goal of uniformity" in plan administration. Id.

Preemption of McCulloch's claims would undermine ERISA's "principal goal" of protecting the interests of plan participants while permitting McCulloch to sue the insurer under state law does not interfere with ERISA's goal of uniformity.

CONCLUSION

For the reasons set forth above, the Secretary requests that this Court reverse the district court's ruling that plaintiff-provider's state law claims are completely preempted.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 29(d) and 32(a)(7)(B)-(C), I certify that this amicus brief uses a mono-spaced typeface of 14 characters per inch and contains 6,996 words.

Dated: October 22, 2015

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CERTIFICATE OF SERVICE

I hereby certify that on this 22nd day of October, 2015, I electronically filed the foregoing Brief of The Secretary, United States Department of Labor, as Amicus Curiae, in Support of Plaintiff-Appellant, with the Clerk of the Court for the United States Court of Appeals for the Second Circuit by using the CM/ECF system. I certify that all participants in this case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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