

No. 23-55019

**IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

BRISTOL SL HOLDINGS, INC.,

Plaintiff-Appellant,

v.

CIGNA HEALTH AND LIFE INSURANCE COMPANY and CIGNA
BEHAVIORAL HEALTH, INC.,

Defendants-Appellees.

On Appeal from the United States District Court
for the Central District of California
No. 8:19-cv-00709 | Hon. Philip S. Gutierrez

**BRIEF FOR THE ERISA INDUSTRY COMMITTEE,
THE AMERICAN BENEFITS COUNCIL, AND
THE CALIFORNIA ASSOCIATION OF HEALTH PLANS
AS *AMICI CURIAE*
IN SUPPORT OF APPELLEES AND AFFIRMANCE**

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, the undersigned counsel state that:

1. The ERISA Industry Committee has no parent corporation, and no publicly held corporation owns 10% or more of its stock.
2. The American Benefits Council has no parent corporation, and no publicly held corporation owns 10% or more of its stock.
3. The California Association of Health Plans has no parent corporation, and no publicly held corporation owns 10% or more of its stock.

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IDENTITY AND INTEREST OF *AMICI CURIAE*¹

The ERISA Industry Committee (“ERIC”) is a national non-profit business trade association representing approximately 100 of the nation’s largest employers in their capacity as sponsors of employee benefit plans for their workers, retirees, and families. ERIC member companies are leaders in every sector of the economy. As the voice of large employer plan sponsors regarding public policies that impact their ability to sponsor benefit plans for their nationwide workforces, ERIC frequently participates as *amicus curiae* in cases that have the potential for far-reaching effects on employee benefit plan design or administration and initiates litigation to protect ERISA preemption against state mandates.

The American Benefits Council (the “Council”) is a national non-profit organization dedicated to protecting and fostering privately sponsored employee benefit plans. The Council’s more than 430 members are primarily large, multi-state employers that provide employee benefits to active and retired workers and their families. The Council’s membership also includes organizations that provide employee benefit services to employers of all sizes. Collectively, the Council’s mem-

¹ No counsel for a party authored this brief in whole or in part, and no counsel or party contributed money intended to fund its preparation or submission. No person other than *amici*, their members, and their counsel contributed money intended to fund the preparation or submission of this brief.

bers either directly sponsor or provide services to retirement and health plans covering virtually all Americans who participate in employer-sponsored programs. The Council regularly participates as *amicus curiae* in cases affecting employee benefits.

The California Association of Health Plans (“CAHP”) is a statewide trade association representing 43 full-service healthcare plans licensed in California that provide coverage to nearly 28 million Californians. CAHP’s member health plans provide this coverage through a variety of mechanisms—health maintenance organizations, preferred provider organizations, and commercial for-profit and not-for-profit health plans.

Amici submit this brief in support of the district court’s determination that ERISA preempts Plaintiff’s state-law claims. Plaintiff seeks to impose contractual obligations on Cigna to pay for coverage of healthcare services beyond the terms of the ERISA health benefit plans that Cigna administers, based solely on routine activities that are critical to plan administration. Allowing those claims to proceed would fundamentally interfere with the design and administration of those plans, to the great detriment of employers that offer those plans and employees that rely on them for coverage. More generally, by forcing entities like Cigna either to alter the way they administer those plans (were that even possible) or to risk contractual liability beyond the applicable plan terms, Plaintiff’s contract-based theories threaten

to undermine the managed care model of healthcare that for decades has helped employer plan sponsors offer high-quality, affordable healthcare, including by disincentivizing low-quality, high-cost out-of-network services. Preventing that outcome and protecting the ability of employers to offer high-value healthcare is critically important to *amici* and their members.

INTRODUCTION AND SUMMARY OF ARGUMENT

Plaintiff's state-law claims allege that its predecessor-in-interest—Sure Haven, Inc., an out-of-network healthcare provider—contacted Cigna to verify coverage and obtain preapproval of specific healthcare services for 106 beneficiaries of ERISA health benefit plans administered by Cigna. 1-ER-2-3. Plaintiff claims that during these contacts, Cigna representatives authorized out-of-network treatment and quoted applicable plan terms and rates. 2-ER-21, 33; Cigna Br. 12-13; Bristol Br. 4-6. Based on these routine communications alone, Plaintiff alleges that Cigna “entered into enforceable oral contracts” with Sure Haven (which Cigna purportedly breached) whereby Cigna promised payment for the services without regard to the terms of the beneficiaries' ERISA plans. 2-ER-40, 46-47, 49. Plaintiff also alleges that Cigna's representations regarding payment amounted to “specific promise[s]” on which Sure Haven relied to its detriment. 2-ER-50-51.

Though this Court has sometimes allowed contract-based claims to survive ERISA's broad preemption provision, Plaintiff's breach of contract and promissory

estoppel claims are different because they seek to establish an enforceable contractual obligation merely because Cigna engaged in routine activities critical to the administration of an ERISA health benefit plan—namely, preauthorizing healthcare services and verifying the terms of coverage. In a prior appeal, this Court found those actions “sufficient” (on the then-existing record) “for a reasonable factfinder to conclude that an enforceable contract had been formed under governing California law.” *Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co.*, 2022 WL 137547, at *1 (9th Cir. Jan. 14, 2022). But the Court expressly reserved the question whether ERISA preempted state law from inferring an enforceable contract on that basis. *Id.* at *1 n.3. On remand, the district court correctly held that Plaintiff’s claims are preempted. 1-ER-11-13. It is critical for this Court to affirm that ruling.

Preauthorization and verification of benefits are common and vital components of the managed care system through which ERISA plans and health insurers promote high-quality, affordable healthcare by steering patients away from low-value care. Preauthorization promotes these goals by ensuring that providers—especially out-of-network providers like Sure Haven, whose rates typically are not known or negotiated in advance of treatment—deliver only care that is medically necessary. Many ERISA health plans thus require preauthorization as a condition of coverage for certain healthcare services, especially out-of-network services. Plans also offer verification of benefits as a critical service to plan beneficiaries,

whereby patients and their providers can consult with plan administrators to seek information about plan terms and the scope of coverage. But preauthorization and verification of benefits are not the only requirements for coverage, and they are only steps in determining the extent to which an ERISA plan covers the particular mix of services that a provider may ultimately provide in the course of an approved treatment and seek to have reimbursed by the plan. Other key aspects of coverage—for example, which billed services were necessary for the approved treatment, the appropriate reimbursement rate for each necessary service, the member’s appropriate cost share, and whether the provider engaged in activities that preclude coverage under plan terms—can be assessed only *after* treatment is provided.

Plaintiff nonetheless seeks to turn preauthorization and verification of benefits into a contractual commitment to pay for all services billed for a preauthorized treatment, irrespective of the terms of coverage and the claims administrator’s discretion to interpret and apply those terms. That position, if accepted, would undercut plans’ ability to enforce key plan terms, and risk removing preauthorized claims from the ordinary ERISA framework, stripping plans that engage in preauthorization and verification of benefits services from the critical protections that this framework provides to employer plan sponsors and beneficiaries—such as administrator discretion and requirements to exhaust administrative remedies. Plaintiff’s theory would thus force a choice on plans that could unravel the managed care system: either abandon

preauthorization requirements and refuse to verify benefits (assuming that were even possible for a particular plan) or risk contractual liability for preauthorized claims beyond plan terms and outside of ERISA’s “comprehensive and reticulated” framework for determining which claims are covered. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993).

Plaintiff’s state-law claims are preempted because forcing this choice on plans would interfere with these central aspects of plan design and administration. It is irrelevant that, as Plaintiff contends, Plaintiff is bringing claims on behalf of a third-party healthcare provider, because the effect of Plaintiff’s theory, if accepted, would not be limited to the relationship between plans and providers. Instead, that theory would directly impact the core ERISA relationship between plans, claims administrators, and beneficiaries by undercutting central aspects of plan administration. Moreover, allowing Plaintiff’s claims to proceed would sanction a patchwork of state common law that would preclude uniform national coverage, decrease efficiency, and increase plan costs—not just in the context here, but in numerous others involving different aspects of plan administration.

ARGUMENT

I. Plaintiff’s State-Law Claims Are Preempted Because They Interfere With Plan Design And Administration By Imposing Contractual Obligations Beyond Plan Terms Based On Routine Plan Administration

Section 514(a) of ERISA expressly preempts “any and all State laws” that “relate to” employee benefit plans. 29 U.S.C. § 1144(a). The plain language of this express-preemption provision is broad, and the Supreme Court has long held that it applies in two circumstances: “A law ‘relates to’ an employee benefit plan,” and is preempted, “if it has a [(1)] connection with or [(2)] reference to such a plan.” *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983).

The district court correctly held that Plaintiff’s claims are preempted under both standards, 1-ER-12-13, but *amici* here focus on the “connection with” standard because preemption under that standard turns on the impact of state law on plan design and administration—issues uniquely within *amici*’s expertise. A state law “has an impermissible ‘connection with’ ERISA plans” if it “‘governs ... a central matter of plan administration,’” “‘interferes with nationally uniform plan administration,’” or imposes “‘acute, albeit indirect, economic effects’” that “‘force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers.’” *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320 (2016). Plaintiff’s state-law claims are preempted under that standard because they force plans to choose between eliminating preauthorization and verification of benefits

services (to the extent that were even possible) or sacrificing other critical aspects of plan design and administration.

A. Plaintiff’s Claims Burden Plans’ Ability To Use Preauthorization And Provide Verification Of Benefits, Which Are Essential Components Of Administering Health Benefits In The Managed Care System

Preauthorization and verification of benefits are essential tools of managed care. The managed care system—the prevailing method of administering health benefits in the United States—seeks “to provide quality care at reduced costs to the public.” J. Scott Andresen, *Is Utilization Review the Practice of Medicine? Implications for Managed Care Administrators*, 19 J. Legal Med. 431, 431-32 (1998). One way plans achieve that goal is by contracting with selected healthcare providers “to create exclusive ‘provider networks.’” *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 332 (2003). Providers in these networks “agree to render health-care services” to plan beneficiaries “at discounted rates and to comply with other contractual requirements” in exchange for “the benefit of patient volume higher than that achieved by nonnetwork providers.” *Id.* By routing plan beneficiaries to these preferred providers, plans ensure that beneficiaries are receiving higher-quality care at lower cost. See Karen A. Jordan, *Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through a Responsibility to Select Quality Network Physicians*, 27 Ariz. St. L.J. 875, 917-20 (1995).

To encourage plan beneficiaries to remain in-network—and to manage quality and cost when beneficiaries do use out-of-network providers—many plans, like the employer plans administered by Cigna here, require that out-of-network services be “preauthorized” as a precondition for coverage and payment. *See* 1-ER-3; Cigna Br. 12-13; Andresen, *supra*, at 432. Preauthorization refers to the process by which providers “establish eligibility and obtain approval from the patient’s health plan before care is delivered.” Ani Turner et al., *Impacts of Prior Authorization on Health Care Costs and Quality: A Review of the Evidence*, at 4 (Nov. 2019), <https://tinyurl.com/5ykft56y>. The process generally involves a plan’s clinical professionals determining whether the patient’s circumstances match the criteria for authorization, including whether the service is medically necessary. Wendy Warring & Lauren E. M. Bedel, *Streamlining Prior Authorization: Final Report & Recommendations*, Network for Excellence in Health Innovation, at 11-12 (Sept. 30, 2021), <https://tinyurl.com/38pnyc43>.

Preauthorization is a routine, but vital, administrative process that yields several benefits for plan beneficiaries. A determination of “medical necessity” commonly involves consideration of whether a treatment accords with generally accepted standards of care, is clinically appropriate, is not primarily for convenience, and is not more costly than an equally effective alternative. *See, e.g., Medical Necessity Definitions*, Cigna Healthcare, <https://tinyurl.com/ysvmrk9t> (last visited

June 27, 2023). By verifying that the proposed healthcare services meet these criteria, plans root out care that is not safe, high-quality, evidence-based, or necessary. Warring & Bedel, *supra*, at 12-13. As a result, preauthorization “clearly contains costs.” *Id.* at 13. By promoting safe and high-quality care—and routing patients to in-network providers more likely to provide such care—preauthorization “eliminat[es] ... unnecessary and high-cost care in favor of less expensive options.” *Id.* And by curtailing high-cost care, preauthorization has “proven effective in reducing” the overall costs of health insurance, which translates to lower premiums and lower cost-sharing obligations for plan beneficiaries. Andresen, *supra*, at 432 & n.13, 434 & n.26.

The federal government has acknowledged these benefits, recognizing that the preauthorization process “used by private insurers” “reduce[s] expenditures, unnecessary utilization, and improper payments.” Gov’t Accountability Off., *Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending* (Apr. 2018), <https://tinyurl.com/3bbmt9dz>. Indeed, the government itself uses preauthorization in programs like Medicare. *Id.*

Preauthorization therefore functions as an important precondition that must be satisfied *before* a beneficiary can obtain coverage or payment for out-of-network services. *See* Turner, *supra*, at 4. But preauthorization is *not* designed to establish

a contractual relationship between plans and providers that *governs* coverage or payment. Instead, under the terms of the applicable plan, coverage can ultimately be denied for reasons independent of the determinations made during the preauthorization process. Indeed, many essential coverage-related determinations necessarily cannot be made until *after* services have been preauthorized, rendered, and submitted for reimbursement. *See infra*, at 14-15.

Verification of benefits also is a routine service that plans offer their beneficiaries by authorizing claims administrators to convey information to patients and providers about plan terms and the scope of coverage. *See Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co.*, 22 F.4th 1086, 1088 (9th Cir. 2022); 1-ER-3; Cigna Br. 12. Plans have a duty under ERISA to disclose “eligibility requirements and claims-processing procedures” to plan participants. *Gobeille*, 577 U.S. at 321 (citing 29 U.S.C. §§ 1021(a)(1), 1022, 1024(b)(1)); *see* 29 C.F.R. pt. 2520. Like preauthorization, however, carrying out this duty by providing routine information about plan terms to providers is not intended to expand coverage, resolve all requirements for coverage, or bind a plan to payment. *See Advanced Ambulatory Surgical Ctr., Inc. v. Conn. Gen. Life Ins. Co.*, 261 F. Supp. 3d 889, 897 (N.D. Ill. 2017) (“confirming the availability and details of a patient’s insurance benefits is not a concomitant promise of payment”).

Plaintiff's theory, however, would deeply burden the use of preauthorization and verification of benefits by seeking to impose contractual liability based on nothing more than the act of speaking with a provider to preauthorize out-of-network treatment and verify plan benefits, and accurately quoting applicable plan terms in doing so. If that theory were accepted, many plans "would doubtless cease offering th[ese] valuable service[s]" instead of trying to defend against common-law claims in 50 different states. *Advanced Ambulatory Surgical Ctr., Inc.*, 261 F. Supp. 3d at 897. And if that were to happen, the advantages of preauthorization and verification of benefits would be lost for those plans, which would be unable to ensure the safety, quality, and cost-effectiveness of care offered by out-of-network providers and would see increased costs from losing a powerful means of routing beneficiaries to preferred, lower-cost in-network providers. *See supra*, at 8-10; *see also* Zarek Brot-Goldberg et al., *Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare*, at 2 (Becker Friedman Inst., Working Paper No. 2023-08, Jan. 2023), <https://tinyurl.com/mry4x7dc> (finding that "eliminating prior authorization would be cost-increasing rather than cost-decreasing"). Indeed, many plans could find it difficult if not impossible to cease preauthorization and verification of benefits services altogether given how entrenched those services are in routine plan administration.

Plaintiff's theory is therefore preempted by ERISA. Plan-imposed preauthorization and verification of benefits requirements are plainly “a central matter of plan administration” that ERISA protects from state interference. *Gobeille*, 577 U.S. at 320; *cf. Ky. Ass’n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 362-63 (6th Cir. 2000) (“any willing provider” law that “eliminated an insurer’s ability to choose limited provider networks” “directly affect[ed] the administration of the plans” and was preempted by Section 514), *aff’d sub nom. Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. at 332-34.² To the extent state-law claims like Plaintiff’s could have the “effect” of forcing plans to abandon these requirements, those claims have an impermissible “connection with” health plans and are preempted under Section 514. *Cal. Div. of Lab. Standards Enf’t v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997).

B. Plaintiff’s Claims Interfere With Other Central Aspects Of Plan Design And Administration By Imposing Contractual Liability In Excess Of Plan Terms

The flip side if plans and claims administrators continue providing these indispensable preauthorization and verification of benefits services is that Plaintiff’s

² The question presented to the Supreme Court in *Miller* was whether the state law was “saved from pre-emption” under ERISA’s insurance savings clause, 29 U.S.C. § 1144(b)(2)(A)—making clear that the law would otherwise be preempted, 538 U.S. at 334, as the Solicitor General acknowledged, *see* Br. for U.S. as Amicus Curiae, *Miller*, 2002 WL 31477704, at 5, 9-10 (U.S. Oct. 31, 2002). The savings clause is not at issue here.

theory would burden them by imposing contractual liability beyond plan terms and outside of the ordinary framework for determining coverage under ERISA. Forcing such liability on plans and their claims administrators would undermine several additional aspects of plan design and administration, including plan terms dictating *whether* benefits are paid, *how* those determinations are made, *who* can sue for benefits, and *when* suit can be brought. These features are central to the relationship between plans and plan beneficiaries—and are designed to protect both. If state law governs instead, however, each of these protections would be lost for preauthorized claims.

First, plans often include exclusions that limit coverage even where services are medically necessary and preauthorized. Enforcement of these plan terms is an important component of plan design and administration. Several key aspects of coverage necessarily cannot be evaluated until *after* services are rendered. In this case, for example, Sure Haven submitted reimbursement requests to Cigna that included unnecessary toxicology screens and double billing—services that Cigna never specifically approved. Cigna Br. 10. Until these services were itemized, Cigna could not have assessed whether they were necessary for the treatment Cigna preauthorized. Nor could Cigna have determined whether the provider engaged in conduct that precluded coverage under plan terms, or what the appropriate reimbursement rate or member cost share was for each necessary service. *Id.* at 10-11. By locking

plans into an enforceable agreement regarding payment for billed services before any services are rendered, Plaintiff's theory would effectively nullify plan exclusions and coverage limitations that cannot be applied until after services are provided.

This case presents a stark example of the disruption to plan administration that would result if Plaintiff's theory were to prevail. Cigna asserts that it denied all the preauthorized claims here because of a "fee-forgiving" exclusion in the plans. Cigna Br. 8-9, 17. This exclusion—common in many plans—authorizes the administrator to deny benefits when a provider improperly waives a patient's cost-sharing obligation. *Id.* at 6, 22. It thus operates independently of whether a particular service is medically necessary or otherwise appropriate for preauthorization.

Fee-forgiving exclusions, like preauthorization and verification of benefits, are vital to sound plan administration in the managed care system. As discussed, provider networks are an essential feature of that system because they facilitate higher-quality care and lower costs. *See supra*, at 8. A plan's leverage for negotiating discounted rates with in-network providers depends on the plan being able to credibly offer those providers a higher volume of patients. Plans therefore must be able to provide meaningful financial incentives for beneficiaries to use in-network providers. *See* John L. Utz, *Network Viability and the Emboldened Out-of-Network Provider*, 23 No. 2 ERISA Litig. Rep. 11 (2015). In particular, plans often require

beneficiaries to pay a substantially higher cost-share when they obtain services from out-of-network providers. Cigna Br. 12. Cost-sharing requirements give patients skin in the game that “sensitize[s] [them] to the costs of health care, leading them not only to use less but also to seek out providers with lower fees.” *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 699 (7th Cir. 1991).

A “fee-forgiving” scheme—such as the one that Sure Haven allegedly carried out here—destroys a patient’s financial incentive to choose in-network providers. Cigna Br. 12. These schemes generally involve out-of-network providers refusing to collect all or part of patients’ cost-sharing obligations. *See N. Cypress Med. Ctr. Operating Co. v. Aetna Life Ins. Co.*, 898 F.3d 461, 470 (5th Cir. 2018). Because patients no longer owe more than they would if they received care from an in-network provider, they have no financial reason to choose an in-network provider, or even to consider cost in choosing between out-of-network providers. And in the aggregate, this means a reduced stream of patients to in-network providers and fewer providers willing to go in network, all of which undermines plans’ ability to disincentivize low-value care. That, in turn, leads to lower-quality care and forces insurers to increase premiums and cost-sharing obligations—outcomes that are antithetical to the managed care model.

Enforceable fee-forgiving exclusions are thus important components of the managed care system. They also are an important term of ERISA plans. Plaintiff’s

claims, however, would make this critical aspect of plan design and administration effectively meaningless. If preauthorization and verification of benefits were enough to establish an enforceable contract under state law, plans could face liability beyond plan terms even where evidence of a fee-forgiving scheme provides a legitimate basis under the plan for denying benefits.

Second, many plans—including those administered by Cigna here—grant claims administrators “discretionary authority” to interpret plan terms, including terms governing reimbursement, and to make judgments about medical necessity. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *see* 1-ER-4-5. Thus, when an administrator with that authority is presented with a claim for coverage after services have been preauthorized and rendered, it retains discretion to deny that claim if a plan term excludes benefits. *See supra*, at 14-15. And those discretionary determinations are subject only to abuse of discretion review in court. *See Lehman v. Nelson*, 943 F.3d 891, 897 (9th Cir. 2019).

But if claims under ERISA were instead routed through state law, plans would lose their discretion in evaluating coverage. In a breach of contract suit under state law, even assuming that state law excluded damages for unnecessary billed services provided in the course of a preauthorized treatment, the necessity of the services would likely be decided *de novo* rather than reviewed under abuse of discretion review. *See, e.g., Ameron Int’l Corp. v. Ins. Co. of Pa.*, 50 Cal. 4th 1370, 1377 (2010)

(“interpretation of an insurance policy is a question of law and is reviewed de novo”). Plaintiff also seeks to apply a *de novo* standard to the measure of damages, claiming that it is entitled to the usual, customary, and reasonable rate (“UCR”) for the billed services, as determined by a jury. 2-ER-20, 25, 47, 49, 51, 54-55. But under the ERISA framework, the UCR, if applicable, would be determined by Cigna, and reviewed deferentially by a court under an abuse of discretion standard where the plan has granted such discretion to Cigna. *See N. Cypress Med. Ctr.*, 898 F.3d at 483.

Third, ERISA authorizes only plan members to sue for benefits due. *See* 29 U.S.C. § 1132(a)(1)(B). Plan members can sometimes assign their claims—and thus the right to sue—to providers under a separate contract. But plans retain authority to prohibit such assignments through “[a]nti-assignment clauses,” which this Court has recognized as “valid and enforceable” when used “in ERISA plans.” *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1296 (9th Cir. 2014). Plans use these provisions to “decrease their exposure to out-of-network claims, and encourage providers to come in network,” lowering the cost of coverage for employers and plan beneficiaries. *Plastic Surgery Ctr., PA v. Aetna Life Ins. Co.*, 967 F.3d 218, 228 (3d Cir. 2020). Under Plaintiff’s theory, however, providers could sue under state law to recover benefits (in the form of ordinary damages) without obtaining an assignment from the beneficiary, even if the beneficiary’s plan has an anti-assignment clause.

Fourth, though ERISA does not specify a statute of limitations for bringing a claim for benefits under 29 U.S.C. § 1132(a)(1)(B), limitations periods imposed by plans are enforceable. *See Heimeshoff v. Hartford Life & Accident Ins. Co.*, 571 U.S. 99, 102 (2013). Plan provisions requiring that plan members exhaust their administrative remedies before filing suit are likewise enforceable. *See Wit v. United Behavioral Health*, 58 F.4th 1080, 1098 (9th Cir. 2023). These limitations and exhaustion requirements are enforceable under ERISA’s framework because “[t]he plan ... is at the center of ERISA.” *Heimeshoff*, 571 U.S. at 108. Plans rely on these requirements to provide certainty and repose, lowering the risk of unexpected expenses and thus making it easier and more attractive for employers to provide greater benefits to their employees. By suing under state laws that do not honor plan terms in the same way that ERISA’s framework does, providers could sue long after any plan limitations periods have expired, and without having to adhere to any plan exhaustion requirements.

Plaintiff’s theory of state-law contract formation thus would give providers an end-run around the entire federal framework for preauthorized claims. Accordingly, Plaintiff’s claims arising from preauthorization services, verification of benefits, and accurate quoting of plan terms are preempted because they force plans to sacrifice

at least one important aspect of plan administration that serves to protect beneficiaries: either preauthorization and verification of benefits services or all the other managed-care tools that plans can deploy under the ERISA framework.

II. The District Court’s Holding That Plaintiff’s Claims Are Preempted By Section 514 Of ERISA Is Fully Consistent With Precedent

Plaintiff mainly tries to avoid preemption by arguing that claims brought by a “third-party provide[r]” like Sure Haven are exempt from ERISA’s express-preemption provision because the relationship between plans and providers is not one of the core “relationships regulated by ERISA.” Bristol Br. 21-22. That argument fundamentally misunderstands this Court’s “relationship test” for ERISA preemption, *id.* at 21, which focuses on whether an ERISA relationship is *affected* by state law, not on which party brings the claim.

A. Under the relationship test, “a state law [claim] is preempted ... [if] it encroaches on the relationships regulated by ERISA,” *Gen. Am. Life Ins. Co. v. Castonguay*, 984 F.2d 1518, 1522 (9th Cir. 1993), such as “the relationship between plan and plan member, between plan and employer, [or] between employer and employee,” *Paulsen v. CNF Inc.*, 559 F.3d 1061, 1082 (9th Cir. 2009). But to satisfy this test, a state law need not “regulat[e] the relationship directly.” *Castonguay*, 984 F.2d at 1522. Instead, a state law is also preempted if it affects an ERISA-regulated relationship “indirectly,” “by imposing on the parties extra duties that flow from their conduct in this relationship.” *Id.* The state-law claim need only “encroac[h],”

id., ““bea[r] on,” *Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 666 (9th Cir. 2019), or “affect” the relationship between plan principals, *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1276 (6th Cir. 1991).

The “critical” question, therefore, “is not whether the parties to a claim are traditional ERISA entities, but whether the claims affect an aspect of a *relationship* that is comprehensively regulated by ERISA.” *Access Mediquip LLC v. UnitedHealthcare Ins. Co.*, 662 F.3d 376, 385 (5th Cir. 2011). It is “irrelevan[t]” whether the parties are ““ERISA entit[ies]”” if, as here, the claims “would ‘affect relations among [such] entities.’” *Am. ’s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1331 (11th Cir. 2014). What matters is the “aspect of plan administration” or design regulated, *Gobeille*, 577 U.S. at 324, and the “nature of the effect ... on ERISA plans,” *Dillingham*, 519 U.S. at 325, not the entity nominally regulated. That is the only mode of preemption analysis that sensibly accounts for the “administrative realities of employee benefit plans” with which ERISA is concerned. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). A state law directing plans to pay *providers* for certain types of treatment, for example, is no different in practice than a law requiring plans to cover such treatment for *beneficiaries*, which clearly “relates to” ERISA plans, as the Supreme Court has held. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985).

The Supreme Court in *Gobeille* confronted an analogous question regarding the relevance of third parties in ERISA preemption, concluding that ERISA preempted Vermont’s reporting law even though that law imposed direct requirements only on the respondent plan’s “third-party administrator,” *Blue Cross*. 577 U.S. at 317. The position that a state-law claim avoids preemption if its “burden of compliance falls on” a plan’s third-party administrator garnered only two dissenting votes, *id.* at 341 (Ginsburg, J., dissenting), and was rejected by the majority, *id.* at 317.

In *Rutledge v. PCMA*, 141 S. Ct. 474 (2020), the Court again refused to embrace an exception to ERISA preemption for laws regulating third parties. Arkansas’s pricing law purported to regulate the relationship between third-party agents of plans—called pharmacy benefit managers (“PBMs”)—and pharmacies, rather than the relationship between plans and beneficiaries. *Id.* at 481. But the Court still applied standard ERISA preemption doctrine. The Court concluded that the Arkansas law did not actually “gover[n] a central matter of plan administration or interfer[e] with nationally uniform plan administration,” *id.* at 480, and so was not preempted. The Court did not dispute, however, that a law regulating the relationship between PBMs and pharmacies that *did* intrude on those areas *would* be subject to connection-with preemption. *See id.* at 479. Notably, the United States submitted a brief urging that state regulation is not preempted where it “imposes obligations on PBMs,

not plans.” Br. for U.S. as Amicus Curiae, *Rutledge*, 2020 WL 1190622, at 27 (U.S. Mar. 2, 2020). But at oral argument, the government conceded that ERISA preemption “focuse[s] on *what* is being regulated”—*i.e.*, “plan administration”—rather than “who.” Tr. 25:21-27:14, <https://tinyurl.com/z3wwnzvs> (emphasis added). In keeping with that concession, the Court declined to endorse any third-party exception to ERISA preemption.

Other circuits have likewise recognized that “ERISA’s overarching purpose of uniform regulation of plan benefits overshadows [any] distinction” based on which entities are the “focus” of a state law. *Hudgens*, 742 F.3d at 1331. In *Hudgens*, for example, the Eleventh Circuit held that ERISA preempted a Georgia prompt pay law that purported to regulate “payments made by ‘administrators’ and ‘insurers’ to health care providers and facilities claiming benefits under health benefit plans”—including in-network providers that had a contractual relationship with the health plan. *Id.* at 1325-26. Similarly, in *Cromwell*, the Sixth Circuit held that a provider’s claims were “[c]learly” preempted because, “if allowed, [they] would affect the relationship between plan principals by extending coverage beyond the terms of the plan.” 944 F.2d at 1276. And in *Mayeaux v. Louisiana Health Service & Indemnity Co.*, 376 F.3d 420 (5th Cir. 2004), the Fifth Circuit rejected a provider’s argument that his claim against an insurer was not preempted because, as a provider, he was not a traditional ERISA entity. The provider’s claim was preempted, the

court ruled, because it concerned ““handling, review, and disposition of a request for coverage,”” which “go to the very heart of the ERISA administration process,” and thus necessarily affected ERISA fiduciaries and beneficiaries. *Id.* at 432-33.

Here too, the same concerns underlying ERISA preemption still apply even though no plan beneficiary is a party to Plaintiff’s claims. What matters is that those claims plainly still *affect* the relationship between plan beneficiaries and plans.

B. Nor can Plaintiff escape preemption merely by alleging that Cigna undertook a ““contractual obligatio[n]”” to provide coverage beyond the terms of the relevant plans. Bristol Br. 22. While Plaintiff points to decisions in which this Court and other courts have at times allowed certain contract-based state-law claims to escape preemption, none of those decisions permits state law to recognize a contractual duty to expand coverage for a plan beneficiary based solely on routine preauthorization and verification of benefits activities and accurate quoting of plan terms.

Instead, in the vast majority of Plaintiff’s cases, a provider’s state-law claims evaded preemption because the patient had no relevant coverage at all at the time of treatment. In *The Meadows v. Employers Health Insurance*, 47 F.3d 1006 (9th Cir. 1995), for example, this Court found that the claims at issue were not preempted “because neither [the provider] nor [the patient] had any existing ties to the ERISA plan” when treatment was provided. *Id.* at 1009; *see* Cigna Br. 46-47. “[T]he claims arose” independent of the plan precisely “because there was no plan coverage.” *The*

Meadows, 47 F.3d at 1010; see also *Cedars-Sinai Med. Ctr. v. Nat’l League of Postmasters*, 497 F.3d 972, 974 (9th Cir. 2007) (finding no preemption under the Federal Employees Health Benefits Act on the same basis). District courts in this Circuit have distinguished *The Meadows* and *Cedars-Sinai* on this basis. See *Fast Access Specialty Therapeutics, LLC v. UnitedHealth Grp., Inc.*, 532 F. Supp. 3d 956, 972-73 (S.D. Cal. 2021).³

Most of Plaintiff’s out-of-circuit cases are distinguishable on similar grounds: The patient did not in fact have the relevant coverage under the plan despite the plan’s contrary representations. The “provider’s state law action” thus arose “precisely because there [wa]s no ERISA plan coverage.” *Mem’l Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 246 (5th Cir. 1990); accord *Plastic Surgery Ctr., PA*, 967 F.3d at 231; *Franciscan Skemp Healthcare, Inc. v. Cent. States Joint Bd. Health & Welfare Tr. Fund*, 538 F.3d 594, 596 (7th Cir. 2008); *In Home Health, Inc. v. Prudential Ins. Co. of Am.*, 101 F.3d 600, 602, 605 (8th Cir. 1996); *Lordmann*

³ Similarly, in *Catholic Healthcare West-Bay Area v. Seafarers Health & Benefits Plan*, 321 F. App’x 563 (9th Cir. 2008), the provider asserted claims based on alleged “misrepresentations” about “eligibility” for coverage. *Id.* at 564-65. Here, by contrast, Plaintiff’s claims are based on the mere *fact* that Cigna engaged in preauthorization and verification of benefits services, and there is no allegation that Cigna made any misrepresentations about a patient’s eligibility for coverage when doing so. 2-ER-24, 40-51; Cigna Br. 45; Bristol Br. 21-22. All patients had coverage for out-of-network benefits, 2-ER-24, and Cigna denied benefits because of a fee-for-giving exclusion that operated independently of coverage, 1-ER-4-5; Cigna Br. 18.

Enters., Inc. v. Equicor, Inc., 32 F.3d 1529, 1531, 1533 (11th Cir. 1994); *Hospice of Metro Denver, Inc. v. Grp. Health Ins. of Okla., Inc.*, 944 F.2d 752, 753-55 (10th Cir. 1991) (per curiam). Plaintiff's other case dealt with a retirement plan and involved neither a healthcare provider nor preauthorization or verification of benefits services. *See Gerosa v. Savasta & Co.*, 329 F.3d 317, 319-20 (2d Cir. 2003); *see also* Cigna Br. 50-52 (distinguishing Plaintiff's out-of-circuit authorities).

Several of Plaintiff's cases also are inapposite and unpersuasive for the additional reason that they involved (or required) an analysis of preemption under Section 502 of ERISA, not Section 514. The question in *The Meadows* and *Catholic Healthcare*, for example, was whether a provider's state-law claims were properly removed to federal court. *The Meadows*, 47 F.3d at 1008; *Cath. Healthcare West-Bay Area v. Seafarers Health & Benefits Plan*, 321 F. App'x 563, 565 (9th Cir. 2008); *see also Franciscan Skemp*, 538 F.3d at 601; *Home Health, Inc.*, 101 F.3d at 602. As this Court has subsequently made clear, the removal question is a jurisdictional inquiry that requires an analysis of whether the state-law claims are "completely preempted" under Section 502 (29 U.S.C. § 1132(a)(1)(B)), *not* any analysis of ERISA's conflict-preemption provision, Section 514. *See Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 943-46 (9th Cir. 2009). Preemption under Section 514 is not a jurisdictional issue but rather a defense on the merits. *See id.* at 945.

These two forms of preemption mandate distinct analytical inquiries. Complete preemption under Section 502 focuses on whether to preempt “claims.” *The Meadows*, 47 F.3d at 1008. That focus makes sense because the relevant question for complete preemption is whether the claims themselves are “‘necessarily federal in character.’” *Marin*, 581 F.3d at 945. But in the Section 514 context, the relevant question is whether ERISA preempts the applicable *duty* that is the basis of the state-law claim. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (Section 514 preemption focuses on the “substantive standards” that state courts “develop” through “their common law powers”); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987) (Section 514 preemption focuses on what duties “common law causes of action” are “based on”). Thus, while state-law claims premised on “independent legal dut[ies]” may escape complete preemption under Section 502, *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004), courts routinely find duties arising independently under state law to be preempted by Section 514 when they interfere with ERISA plan design and administration, *see, e.g., Concha v. London*, 62 F.3d 1493, 1504-05 (9th Cir. 1995); *Powell v. Chesapeake & Potomac Tel. Co. of Va.*, 780 F.2d 419, 422 (4th Cir. 1985) (collecting cases).

Here, the question is whether Section 514 preempts state law holding that mere performance of routine administration of an ERISA plan (including providing

preauthorization and verification of benefits services and accurately quoting applicable plan terms) can result in the formation of a contract between the administrator and the provider. Section 514 does preempt such a law, because the formation of that contract would encroach on the administrator's relationship with the beneficiary by impeding the administrator's ability to perform its administrative duties without having to alter its payment obligations under the terms of the plan. As this Court recognized in *Marin*, *that* analytical inquiry—whether ERISA preempts the formation of a contractual or other common-law duty—was never addressed in *The Meadows* or *Catholic Healthcare*, both because it was not legally relevant in the complete preemption context, and because no one ever made that argument. *Marin*, 581 F.3d at 945-46. Those cases therefore are not controlling or persuasive here.

III. Plaintiff's Narrow Approach To Preemption Would Undermine Uniform Coverage And Plan Administration In Areas Far Beyond This Case

Reversing the district court's preemption ruling could threaten basic preemption principles and significantly undermine Congress's objectives across many contexts extending well beyond this case. "ERISA's goal, [the Supreme] Court has emphasized, is 'uniform national treatment of [plan] benefits.'" *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 17 (2004). Allowing state common law to dictate the design and administration of plans, as Plaintiff seeks to do, would subject ERISA plans to a thicket of conflicting state rules that will defeat

Congress’s objectives, preclude plans from offering uniform national coverage, and raise costs of plan administration. The resulting burden on plans will ultimately harm beneficiaries by barring them from accessing the full range of benefits offered in other states, by increasing their cost-sharing obligations, and by “lead[ing] those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them.” *Fort Halifax*, 482 U.S. at 11.

More than 178 million Americans, or 54% of the U.S. population, receive health insurance through employment-based benefit plans. Katherine Keisler-Starkey & Lisa N. Bunch, *Health Insurance Coverage in the United States: 2021*, U.S. Census Bureau, at 4 (Sept. 2022), <https://tinyurl.com/354bjaxf>. Congress enacted ERISA to safeguard “the continued well-being and security” of the “millions of employees and their dependents [who] are directly affected by these plans.” 29 U.S.C. § 1001(a).

By the time of ERISA’s enactment, “the operational scope and economic impact of such plans [was] increasingly interstate,” 29 U.S.C. § 1001(a), and today most plans operate across multiple states. ERISA accordingly employs broad preemption of related state laws as a principal means to accomplish Congress’s “primary” goal of “ensur[ing] that plans and plan sponsors would be subject to a uniform body of benefits law.” *Rutledge*, 141 S. Ct. at 480. Preemption also serves the related “congressional goal of ‘minimiz[ing] the administrative and financial

burden[s]’ on plan administrators” of complying with divergent state laws and precedents—“burdens ultimately borne by the beneficiaries” in the form of higher premiums or reduced benefits. *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 149-50 (2001) (alterations in original).

The burdens imposed by conflicting state common law are no mere theoretical concern. They have concrete consequences for the many Americans who depend on ERISA plans. Evidence shows that “each one percent increase in ... plans’ costs ... results in a potential loss of insurance coverage for about 315,000 individuals.” Health Economics Practice, Barents Group, LLC, *Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003*, at iii (1998). The cumulative effect of “[r]equiring ERISA administrators to master the relevant laws of 50 States” is to massively increase the costs of maintaining and operating a multi-state employee benefits plan. *Egelhoff*, 532 U.S. at 149.

Direct conflict between state laws is not the only burden ERISA guards against. Rather, “the central design of ERISA ... is to provide a single uniform national scheme for the administration of ERISA plans without interference from laws of the several States even when those laws, to a large extent, impose parallel requirements.” *Gobeille*, 577 U.S. at 326-27. If allowed to take root, the mish-mash of varying state law will only grow and threaten to wipe out the efficiency gains that

uniform plan administration offers large, nationwide plans and their participants and beneficiaries.

Plaintiff's unduly narrow approach to ERISA preemption thus threatens to disrupt uniform national coverage and plan administration, reduce efficiency, and increase costs for plans and participants in areas extending far beyond this particular case.

CONCLUSION

This Court should affirm the district court's ruling that Section 514 of ERISA preempts Plaintiff's state-law claims.

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Respectfully submitted.

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