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How the HCFA Form 1500 Can Make or Break ERISA Standing in Health Plan Disputes

By Henry E. Norwood and Justin Russell

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In the course of seeking reimbursement for services rendered to patients, healthcare providers often face challenges to their claims from their patients' insurers. If the insurers' appeal processes do not resolve the disputes, providers may choose to bring suit in state or federal courts. Providers may find themselves at a disadvantage from the outset, however, because insurer defendants frequently leverage the very industry-standard forms that providers use to submit their claims in the first place as a potential defense. In a bid to create federal jurisdiction over a provider's state law causes of action, insurers sometimes point to information that a provider has submitted on industry-standard health insurance claim forms indicating that the provider received an assignment of their patient's claims. The issue has been addressed in several court decisions, which are explored in this article.

The Health Insurance Claim Reimbursement Process and ERISA

Several steps are involved in the health insurance claim reimbursement process. The process begins when the patient requests services from a health provider. The provider routinely obtains the patient's health insurance information and, often, requests that the patient sign an assignment of benefits (AOB) form, permitting the provider to seek reimbursement directly from the patient's health insurer and assigning the patient's right to sue for plan benefits to the provider. Upon receiving care, the patient or their provider will submit claims for reimbursement to the patient's insurer, often on a pre-approved form, such as the CMS-1500 Health Insurance Claim Form (HCFA). [1] Once the insurer receives the submitted claims, the insurer will consider and render a decision regarding the requested reimbursement by applying the terms of the patient's health plan to the services received.

Many health plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA) which provides a framework regarding necessary plan provisions and requirements for members to recover benefits under the plan. ERISA is a federal law and supersedes state laws applicable to health plans. Among the requirements imposed by ERISA are those governing who may enforce the provisions of an ERISA health plan.

Standing to Enforce ERISA Rights

ERISA authorizes civil actions to recover benefits due under a health plan to be brought by plan participants and beneficiaries. [2] Healthcare providers are generally not authorized under ERISA to sue on their own behalf, even if they are entitled to direct payment from the plan administrator, because the provider is not itself a plan participant or beneficiary. [3] For a provider to sue under ERISA 29 U.S.C. § 1132, it must do so through an assignment or as a representative of a plan beneficiary. [4] When a medical provider pursues the claims of a patient via an AOB, the provider stands in the shoes of the patient, with the ability to raise the same claims and being subject to the same defenses as the patient. [5]

Courts have recognized a narrow exception to the ERISA standing requirements when a healthcare provider is assigned the beneficiaries' claim

via an AOB in exchange for healthcare. [6] If the court determines that the Summary Plan Document (SPD) provisions allow for such assignment, healthcare providers are granted standing to bring claims under section 502(a)(1)(B) for a recovery of benefits as the patient's assignee. [7] ERISA § 502(a)(1)(B) provides that a participant or beneficiary may bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." [8]

However, providers asserting an action to recover benefits as an assignee must also establish that the ERISA beneficiary "assigned his right [to reimbursement] in accordance with the terms of the ERISA plan." [9] In determining whether an ERISA plan's anti-assignment renders such assignment unenforceable, courts will look to the plan provisions and "where plan language unambiguously prohibits assignment, an attempted assignment will be ineffectual," [10] and the healthcare provider purporting to be an assignee will lack statutory standing to sue for benefits.

The other consideration that courts will evaluate to determine standing is whether the assignee exhausted all administrative remedies required by plan participants under the SPD. While "ERISA itself does not require a participant or beneficiary to exhaust administrative remedies in order to bring an action under § 502 of ERISA," [11] as a general rule for a claimant to assert Article III standing under ERISA, they "must exhaust available administrative remedies before bringing a claim in federal court." [12] However, even if the plan expressly requires exhaustion of administrative remedies, 29 C.F.R. § 2560.503–1(l) provides that where a plan fails "to establish or follow claims procedures consistent with the requirements of this section," claimants are "deemed to have exhausted [their] administrative remedies." [13] Providers need to evaluate all provisions of the SPD prior to attempting to assert Article III standing as an assignee under ERISA § 502(a)(1)(B).

Without standing to enforce the terms of a patient's health plan, providers must find alternative causes of action to seek reimbursement for their claims.

These causes of action typically are based in common law. Frequently used causes of action include unjust enrichment, breach of implied contract, and, when representations by the insurer have been made to the provider, promissory estoppel, or negligent misrepresentation. [14] When providers raise these alternative causes of action, insurers typically argue the action really falls under ERISA and the provider is simply trying to circumvent federal law and, in particular, avoid removal to federal court or dismissal via ERISA preemption.

Removal to Federal Court

In ERISA litigation, defendants routinely seek removal of plaintiffs' state court complaints to federal court. Civil actions that arise under the U.S. Constitution, treaties, or laws of the U.S. are removable pursuant to federal question jurisdiction. [15] The well-pleaded allegations of the complaint are examined to determine if federal question jurisdiction exists. [16] However, when a federal statute, such as ERISA, completely preempts alternative, state law causes of action, the well-pleaded complaint rule does not apply and the complaint is viewed as stating causes of action under federal law, making removal to federal court proper. [17]

ERISA Section 502(a)(1)(B) permits an ERISA plan beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." [18] In *Aetna Health Inc. v. Davila*, [19] the U.S. Supreme Court set forth the well-recognized test to determine whether a plaintiff's purported state law causes of action are preempted by ERISA. [20] Under the *Davila* test, a plaintiff's claims are preempted by ERISA: (1) if the plaintiff would have standing to bring their claims under 502(a)(1)(B) and (2) there is no other independent legal duty raised by the plaintiff's complaint. [21] While both prongs of the *Davila* test are frequently contested, the first prong puts providers in the difficult position of having to deny they would have standing to bring their claims under ERISA when their denial is arguably contradicted by a box they may have checked on the HCFA forms they previously submitted.

HCFA Item Number 27

A HCFA is the provider's means of telling an insurer they are entitled to payment for the treatment of one of the insurer's members. It can be seen as the document that links the provider to the insurer. Because the HCFA is generally the best evidence establishing that the provider sought reimbursement from the insurer, the HCFA is frequently attached to, or at least referenced in, complaints for reimbursement filed in court. [22] This potentially presents a problem for plaintiff-providers when a defendant-insurer seeks removal to federal court or dismissal pursuant to ERISA preemption, because the HCFA includes a possible representation that the provider may have obtained an assignment of benefits from the patient sufficient to give rise to standing to bring their claims under ERISA. The relevant box is Item Number 27 of the HCFA form. [23]

HCFA Item Number 27 simply states "ACCEPT ASSIGNMENT?" [24] The provider is only given the option of selecting "YES" or "NO." [25] The National Uniform Claim Committee's Reference Instruction Manual for the HCFA-1500 claim form explains Item Number 27 as follows: "[t]he accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program." [26] No further detail is provided in the manual as to what it means for a provider to "accept" an assignment "under the terms of the payer's program," or whether a provider must actually have obtained a signed assignment of benefits from their patient in order to validly check the box. Some courts, however, have taken the view that if a provider answers "yes" to Item Number 27, they have represented to the payor that they admit that the patient has executed an assignment of benefits in favor of the provider and that the provider is thus an assignee of the patient's health plan reimbursement rights. As an assignee, the provider would have standing to bring suit against the insurer under ERISA. [27] The first prong of the *Davila* test would therefore be satisfied, and if the second prong is also satisfied (which is beyond the scope of this article), the insurer may establish that federal jurisdiction exists over the action. [28]

Item Number 13 of the HCFA form should also be noted. Item Number 13 states: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below." [29] If a patient or another authorized person signs Item Number 13, the insurer is told that payment under the health plan is to be directed to the provider. Given the "broad consensus" in the federal circuit courts that the assignment of the right to payment conveys the right to sue for plan benefits, [30] courts may view a signed Item Number 13 as an indication the provider has an AOB and would have standing to bring suit under ERISA. Several courts in the Fifth and Eleventh Circuits have interpreted plaintiff-providers "yes" responses to Item Number 27 as it relates to ERISA standing and the *Davila* test and have generally ruled in favor of insurers.

How Courts Have Viewed the HCFA Item Number 27 Standing Issue

In *Apex Toxicology, LLC v. United Healthcare Ins. Co.*, [31] the U.S. District Court for the Southern District of Florida heard a classic ERISA standing scenario involving HCFA Item Number 27. The case involved a plaintiff-toxicology laboratory provider that provided services to several patients who were members of health plans issued by the defendant-insurer. [32] The provider submitted numerous claims to the insurer for reimbursement, and the insurer denied the claims. [33] The provider filed suit against the insurer in state court, raising several common law and state statutory causes of action. [34] The insurer successfully removed the action to federal court on the basis of ERISA preemption. [35] The provider sought to remand the matter back to state court, arguing the provider's claims arose under state law—not ERISA—and the insurer simultaneously filed a motion to dismiss on the bases of complete and defensive preemption. [36] The court applied the *Davila* test and determined, in relevant part, that the provider had standing to bring a claim under ERISA. [37] The court reached its conclusion despite the fact that the provider's complaint included no allegations regarding submitted claim forms or any reference to the patients' health plans. [38] The court found persuasive the insurer's argument that the provider did, in fact, submit

HCFA forms to the insurer, in which the provider selected "yes" to Item Number 27 and payment was authorized to the provider via Item Number 13. [39] The insurer introduced exemplar HCFA claim forms submitted by the provider in support of its argument. [40] The Southern District of Florida denied the provider's motion to remand and granted the insurer's motion to dismiss. [41]

Similarly, in *Bailey v. Blue Cross & Blue Shield of Tex., Inc.*, [42] the U.S. District Court in the Southern District of Texas handled another ERISA standing claim that turned on the Item Number 27 argument. The plaintiff in *Bailey* was a surgical provider who sought reimbursement from several defendant-insurers for services provided to the insurers' members. [43] The provider alleged the insurers underpaid for several of the submitted claims and filed suit in state court, raising state statutory and common law causes of action. [44] The case bounced back and forth from state to federal court until the federal court was faced with the provider's second motion to remand the case to state court. [45] Applying the *Davila* test, the court found the insurers' argument persuasive that the HCFA claim forms submitted by the provider with Item Number 27 marked "yes" sufficiently indicated the provider would have standing to sue under ERISA even though the AOBs themselves were not submitted to the court. [46]

The U.S. District Court for the Middle District of Louisiana has also weighed in on the issue and ruled in favor of the insurer in *Sadeghi v. Aetna Life Ins. Co.* [47] The case involved out-of-network plastic surgeons who provided services to several members of the defendant-insurer. [48] The providers sought reimbursement and alleged the insurer underpaid various submitted claims. [49] As in the previous cases discussed, the providers filed suit, raising common law causes of action. [50] The provider sought summary judgment on the basis of ERISA preemption. [51] The court applied the *Davila* test and considered the arguments of both sides regarding the first prong. [52] The providers argued, in relevant part, that although it had received AOBs from the members at issue, the providers had no intention of relying on those AOBs in the present lawsuit. [53] The insurers countered that the providers had held

themselves out as assignees throughout the entire claims process prior to filing suit and only sought to disregard the AOBs at the present time to avoid ERISA preemption. [54] The court agreed with the insurer's argument and found particularly persuasive the fact that the providers had marked "yes" on Item Numbers 13 and 27 on the HCFA forms they submitted to the insurers, thus holding themselves out as assignees with standing to sue under ERISA. [55]

Conclusion

While only a handful of courts have addressed the issue, most of which are located in the Fifth and Eleventh districts, those courts overwhelmingly favor the typical insurer position on the import of checking Item Number 27 on the HCFA-1500 claim reimbursement form. Providers, insurers, and their counsel should be aware of how courts have dealt with this scenario before they arrive in court to argue the ERISA standing issue.

Authors

Henry E. Norwood
Kaufman Dolowich LLP, Orlando, FL

Henry Norwood is an associate with Kaufman Dolowich. He represents clients in ERISA litigation and compliance, general liability, commercial litigation, and managed care litigation and compliance. He defends clients in claims arising from disputes in defined benefit plans and defined contribution plans, including benefits claims by participants, claims for breach of fiduciary duty, and multi-employer welfare administrators in benefit payment. He may be reached at henry.norwood@kaufmandolowich.com.

Justin Russell
Kaufman Dolowich LLP, Orlando, FL

Justin Russell is of counsel with Kaufman Dolowich. He defends clients in claims recovery, subrogation, healthcare liability, Health Insurance Portability and Accountability Act, and ERISA matters. He also handles matters pertaining to financial services, corporate governance, and related commercial litigation and counseling. He may be reached at justin.russell@kaufmandolowich.com.

Endnotes

1. The HCFA form 1500 was created by the Health Care Financing Administration (hence its name), which, in 2001, was renamed to the current Centers for Medicare & Medicaid Services.

2. *See* 29 U.S.C. § 1132(a)(1).

3. *See Grasso Enters., LLC v. Express Scripts, Inc.*, 809 F.3d 1033, 1040 (8th Cir. 2016).

4. *Id.* at 1039–41.

5. *Connecticut State Dental Assoc. v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 2009 WL 512636, at *12 (11th Cir. 2009).

6. *See Cromwell v. Equicor–Equitable HCA Corp.,* 944 F.2d 1272, 1277 (6th Cir.1991); *Kennedy v. Connecticut Gen. Life Ins. Co.,* 924 F.2d 698, 700 (7th Cir.1991); *I.V. Servs. of Am., Inc. v. Trustees of Am. Consulting Eng'rs Council Ins. Trust Fund,* 136 F.3d 114, 117 n. 2 (2d Cir.1998).

7. *See N. Jersey Plastic Surgery Ctr., LLC v. 1199SEUI Nat'l Benefit Fund*, No. 22-CV-6087 (PKC), 2023 WL 5956142, 4 (S.D.N.Y. Sept. 13, 2023).

8. 29 U.S.C. § 1132(a)(1)(B).

9. *See Neurological Surgery, P.C. v. Travelers Co.*, 243 F. Supp. 3d 318, 325-26 (E.D.N.Y. 2017).

10. *See Neurological Surgery, P.C. v. Aetna Health Inc.*, 511 F. Supp. 3d 267, 282 (E.D.N.Y. 2021).

11. *See Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 626 (9th Cir. 2008) (*citing* 29 U.S.C. § 1132).

12. *See Barboza v. Cal. Ass'n of Prof'l Firefighters*, 651 F.3d 1073, 1076 (9th Cir.2011).

13. *Id.*

14. *See e.g. Apex Toxicology, LLC v. United Healthcare Ins. Co.*, 2017 WL 7806152, at *1 (S.D. Fla. 2017).

15. 28 U.S.C. § 1441(b).

16. *Beneficial Nat. Bank, et al. v. Anderson*, 539 U.S. 1, 6 (2003).

17. *Id.* at 8.

18. 29 U.S.C. § 1132(a)(1)(b).

19. 542 U.S. 200 (2004).

20. *Id.* at 209.

21. *Id.* at 201.

22. In fact, it could be argued that the existence of a submitted HCFA is an established fact when referenced by a complaint under the incorporation by reference doctrine. *See e.g. Brooks v. Blue Cross & Blue Shield of Fla., Inc.*, 116 F.3d 1364, 1369 (11th Cir. 1997).

23. *See* National Uniform Claim Committee, Health Insurance Claim Form 1500, *available at:* CMSLC WITH DIMENSIONS.pdf (nucc.org).

24. *Id.*

25. *Id.*

26. *See* National Uniform Claim Committee, 1500 Health Insurance Claim Form Instruction Manual, *available at:* National Uniform Claim Committee CMS-1500 Claim (nucc.org).

27. *See Grasso Enters., LLC v. Express Scripts, Inc.*, 809 F.3d 1033 1039-41 (8th Cir. 2016.

28. *Davila*, 542 U.S. at 201.

29. *Supra* n. 23.

30. *Coast Specialty Surgery Ctr., Inc. v. Blue Cross of Cal.*, 90 F.4th 953, 960 (9th Cir. 2024) (quoting *Brown v. BlueCross BlueShield of Tenn., Inc*, 827 F.3d 543, 546 (6th Cir. 2016) and collecting cases).

31. 2017 WL 7806152 (S.D. Fla. 2017).

32. *Id.* at *1.

33. *Id.* at *1-2.

34. *Id.* at *1.

35. *Id.*

36. *Id.* at *1, 7-8.

37. *Id.* at *6.

38. *Id.*

39. *Id.* at *6, fn. 8.

40. *Id.* at *6.

41. *Id.* at *10. The Southern District of Florida has also found Item Number 27 as sufficient evidence of an assignment for ERISA standing purposes in *Gables Ins. Recovery v. United Healthcare Ins. Co.*, 39 F. Supp. 3d 1377, 1384 (S.D. Fla. 2013), *Apex Toxicology, LLC v. United Healthcare Servs., Inc.*, 2020 WL 13551296, at *2 (S.D. Fla. 2020), and *Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Fla., Inc.*, 2015 WL 12778385, at * 2-3 (S.D. Fla. 2015). The Middle District of Florida has held similarly in *Lee Memorial Health System v. Blue Cross and Blue Shield of Fla., Inc.*, 248 F.Supp.3d 1304, 1311-12 (M.D. Fla. 2017), as did the Eleventh Circuit Court of Appeals in *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1343 (11th Cir. 2009).

42. 2022 WL 1216308 (S.D. Tex 2022).

43. *Id.* at *2.

44. *Id.*

45. *Id.* at *2-3.

46. *Id.* at *5. The Southern District of Texas also found Item Number 27 sufficient for ERISA standing purposes in *Found. Ancillary Servs., L.L.C. v. United Healthcare Ins. Co.*, 2011 WL 4944040, at *2 (S.D. Tex. 2011), *Spring ER LLC v. Aetna Life Ins. Co.*, 2010 WL 598748, at *3 (S.D. Tex. 2010), and *Chu v. First Health Life & Health Ins. Co.*, 2007 WL 7216760, at *2 (S.D. Tex. 2007).

47. 564 F.Supp.3d 429 (M.D. La. 2021).

48. *Id.* at 433.

49. *Id.*

50. *Id.* at 449.

51. *Id.*

52. *Id.* at 454-56.

53. *Id.*

54. *Id.*

55. *Id.* at 455-56.

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