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Don't Quote Me on This: Are Pre-Verification Calls Binding in ERISA Health Plan Litigation?

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In this article, the authors explain that although most of the recent court decisions are trending toward ERISA preemption of pre-verification call claims, the law in this area is evolving and diverse across jurisdictions, warranting continued attention by health plans, providers, and patients in the future.

When a patient makes the decision to undergo a medical procedure, one of the first questions that often comes to mind is: will my insurance cover this? Healthcare providers often have this same question, along with another question: how much will insurance pay? The answers to these questions are vital to patients and providers seeking the greatest coverage possible under the patient's health insurance plan. Several factors determine how these questions are answered.

The first factor is whether the medical procedure is specifically excluded or included under the terms of the health insurance plan. A procedure that is specifically excluded typically ends the inquiry and a procedure that is specifically included can lead to the question of how much coverage is available. Most medical services and procedures,

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however, are not specifically excluded or included in the health plan. Instead, the plan often includes language that may or may not cover certain procedures. For example, the plan may state the insurer will provide coverage for medically necessary procedures. This language is broad, but also vague, which often leads patients and providers to reach out to a patient's insurer to ensure certain procedures are covered.

The next factor is whether the provider is in-network or out-of-network with the health plan. If the provider is in-network, the insurer and the in-network provider have contractually agreed to rates of payment for various procedures and services. As a result, there is typically no dispute as to the amount owed by an insurer to an in-network provider for services provided to an insured.

On the other hand, out-of-network providers have no contractual agreement with the insurer, so the amount the insurer is willing to pay for services is not immediately clear.

The patient's health plan will often specify how the insurer will reimburse out-of-network providers. Common examples of out-of-network reimbursement are payment based on Medicare rates or payments based on the usual, customary, and reasonable (UCR) rates. Medicare rates are set by the Centers for Medicare and Medicaid Services, while UCR rates are more subjective, set by the insurers, and may be calculated using a variety of different methods. UCR rates seek to calculate a reimbursement rate that would be customary for services provided by similar providers in the same geographic location as the out-of-network provider.

With these factors in mind, patients and providers often seek greater clarity and certainty to determine whether and to what extent services rendered by an out-of-network provider will be covered. Pre-verification calls occur when patients or providers call the patient's insurer to determine coverage for a planned service. This practice has become so common that medical offices often train their staff on specific questions to ask insurers. These questions frequently track the factors to determine the existence and scope of coverage discussed above. Providers ask: whether a service is covered; whether the provider is in or out-of-network; and how the insurer bases its reimbursement of out-of-network providers. When the information provided by the insurance agent is in line with the terms of the health plan and the provider is ultimately reimbursed in line with the agent's representations, there is no issue. However, when a provider is not reimbursed to the extent the agent represents on the pre-verification call, the provider may sue the insurer for the difference between the amount paid and the amount "promised" by the insurance agent. The causes of action available to the provider are subject to dispute in the courts.

ERISA VERSUS STATE LAW CAUSES OF ACTION

Many health plans are governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA affords insureds certain rights in enforcing the terms of their health plans and imposes various requirements on health insurers. For health plans that fall within its scope, ERISA is intended to provide the sole causes of action for lawsuits to enforce the terms of the plan. ERISA Section 502(a)(1)(B)¹ provides a mechanism for insureds and beneficiaries to sue to recover benefits, enforce plan terms, or clarify their rights to future benefits under an ERISA health plan. When an insurance agent represents the coverage available for a service under a health plan during a pre-verification call and the plan pays according to these representations, the patient or provider may bring an action under Section 502(a)(1)(B) for plan benefits. Importantly, Section 502(a)(1)(B) is tied to the terms of the health plan.

Aside from causes of action under ERISA, patients and providers have tried raising causes of action under state common law to enforce promises of coverage made during a pre-verification call. Generally, these causes of action include: promissory estoppel, negligent misrepresentation, breach of oral contract, and breach of a state statutory unfair competition law.

At times, plaintiffs will bring state law causes of action along with a cause of action under Section 502(a)(1)(B), but more frequently, plaintiffs choose to either bring common law causes of action under state law or through an ERISA cause of action under federal law. When a plaintiff alleges state common law causes of action and the patient's health plan is governed by ERISA, preemption issues arise.

ERISA PREEMPTION AND REMOVAL TO FEDERAL COURT

Often, the first legal battle in ERISA health plan disputes pertains to which court will hear the dispute – state or federal court. Typically, patient or provider plaintiffs prefer to, and do, file suit in state court, while health plan defendants prefer federal court and will often remove state court lawsuits to federal court. Civil actions that arise under the U.S. Constitution, treaties, or U.S. laws are removable pursuant to federal question jurisdiction.² The well-pleaded allegations of the complaint are examined to determine if federal question jurisdiction exists.³ 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.⁴

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.”⁵

In *Aetna Health Inc. v. Davila*,⁶ 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.⁷ 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.⁸ In pre-verification call disputes, the second prong of *Davila* is most scrutinized by courts.

Whether a plaintiff can raise state court causes of action is significant because Section 502(a)(1)(B) allows recovery of benefits due under the insured’s health plan. Accordingly, if the amount promised on a pre-verification call exceeds the amount actually due under the health plan, a Section 502(a)(1)(B) cause of action should only permit recovery of the lesser amount due under the health plan. Recovery of the amounts promised on pre-verification calls should only be available through state law causes of action, which is why plaintiffs prefer state law to govern the dispute and insurers prefer ERISA to govern the dispute. There is a trend in recent years toward ERISA preemption over state law causes of action with fewer courts trending away from preemption.

COURTS TRENDING TOWARD ERISA PREEMPTION

Prior to 2024, federal courts in the U.S. Court of Appeals for the Ninth Circuit varied in their rulings on the pre-verification call ERISA preemption issue. This changed when the Ninth Circuit issued its ruling in *Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co., et. al.*⁹

In *Bristol*, a drug substance provider treated a number of Cigna health plan insureds as an out-of-network provider.¹⁰ Prior to rendering services to the insureds, the provider allegedly called the insurer and requested the insurer’s agent to confirm whether the insurer would reimburse the provider at an out-of-network rate.¹¹ The agent allegedly confirmed this and represented that the provider would be reimbursed at a specific percentage of UCR.¹² After several years of pre-verification calls and reimbursements, the insurer began to suspect the provider was forgiving insured’s cost sharing obligations.¹³ When the insurer obtained evidence it believed confirmed its’ suspicions, the insurer refused to continue reimbursing the provider, including refusing to pay for more than one-hundred claims submitted by the provider for services rendered to insureds.¹⁴ On many of these claims,

the provider had placed pre-verification calls with the insurer and the insurer represented it would reimburse the provider at a specified rate.¹⁵

The provider's successor in interest sued the insurer in federal court, asserting a claim for plan benefits under Section 502(a)(1)(B) and several state law causes of action, including breach of oral contract, breach of implied contract, and promissory estoppel.¹⁶ The district court granted the insurer's motion for summary judgment as to the recovery of plan benefits claim, leaving the state law claims.¹⁷ The insurer then sought summary judgment on the state law claims under ERISA preemption, arguing the state law claims arose from each insured's health plan, which were governed by ERISA.¹⁸ The provider countered that it was seeking to enforce the oral representations of the insurer's agents, which allegedly created obligations separate from the health plans.¹⁹ The district court granted the insurer's motion, and the provider appealed.²⁰

On review by the Ninth Circuit, the appellate court affirmed the district court's ruling, reasoning that insurers' practice of encouraging providers and insureds to call to verify coverage is an essential element of most health plans and imposing an independent obligation based on pre-verification calls would discourage this practice, while enabling providers to skirt the ERISA framework if the insurer does not pay in accordance with the agent's representations.²¹ The Ninth Circuit affirmed the summary judgment ruling on this basis.²²

Since *Bristol* was decided, several courts, particularly in California, have followed its reasoning in finding ERISA preemption applies to pre-verification call cases, demonstrating a trend in this direction.²³ The impact of *Bristol* is not contained within California or even the Ninth Circuit.

A federal district court in Illinois followed suit in *Northwestern Memorial Healthcare v. Anthem Blue Cross and Blue Shield, LLC f/k/a Empire BlueCross and BlueShield*,²⁴ and a New Jersey appellate court did as well in *Princeton Neurological Surgery, P.C. v. Horizon Blue Cross Blue Shield of New Jersey*.²⁵ is a recent pre-verification call case weighing in favor of ERISA preemption of state law claims, and it produced a significant ruling on the issue of disclaimers by insurance agents on pre-verification calls. The case involved an out-of-network surgical provider that contacted Horizon Blue Cross, the insurer for several insureds seeking treatment from the provider, to verify coverage and reimbursement for the surgeries it intended to provide.²⁶ The insurance agent verified coverage and reimbursement methodology (80% FAIR Health), but also disclaimed that the representations on the pre-verification call were not guarantees of coverage.²⁷ When the provider rendered services to the insureds and was reimbursed at a lower rate than

allegedly represented, the provider sued the insurer in state court, raising claims for promissory estoppel and negligent misrepresentation.²⁸ The insurer successfully moved for summary judgment on ERISA preemption grounds, and the provider appealed.²⁹

On appeal, the appellate court affirmed the trial court's summary judgment ruling.³⁰ The appellate court reasoned that the provider's state law claims arose out of the ERISA health plans because the pre-verification calls did not create independent obligations apart from the health plans, particularly because of the disclaimers made by the insurance agents.³¹

Other recent cases finding ERISA preemption in the pre-verification call context include *Rowe Plastic Surgery of New Jersey, L.L.C. & East Coast Plastic Surgery, P.C. v. Aetna Life Ins. Co.*³² and *Mapsong, PC v. Aetna Life Ins. Co.*³³

COURTS TRENDING AWAY FROM ERISA PREEMPTION

One case going against ERISA preemption on pre-verification calls, is *Jenkins v. Aetna Health, Inc.*³⁴ *Jenkins* involved a neurosurgeon treating several insured patients.³⁵ Prior to rendering services, the provider's office would call the insurer, which confirmed coverage and represented it would reimburse the provider at a percentage of the UCR.³⁶ When the provider treated certain insureds however, the insurer allegedly reimbursed the provider at a rate lower than that represented.³⁷ The provider sued the insurer in state court, alleging causes of action for unjust enrichment, promissory estoppel, breach of implied contract, and negligent misrepresentation.³⁸ The insurer successfully removed the case to federal court on ERISA grounds, and the provider sought to remand the case back to state court.³⁹

The New York federal court agreed with the provider, holding that the provider's claims were based on the representations that the provider would be reimbursed at a percentage of UCR – not based on the health plans.⁴⁰ On this basis, the court granted the provider's motion to remand the case back to state court, likely saving their claims from summary judgment on ERISA preemption in federal court.

*Moda Health Plan, Inc. v. New Life Treatment Ctr.*⁴¹ is another recent case finding ERISA preemption does not apply in the pre-verification call context

CONCLUSION

While most of the recent court decisions are trending toward preemption of pre-verification call claims, this is far from a settled

issue. Several courts do find promises of coverage on pre-verification calls may constitute an independent legal duty apart from the health plan.

Further, even the courts that lean toward preemption may leave the door open to allowing state law claims if the plaintiff can demonstrate their claims are based on more than mere pre-verification promises of coverage, such as a course of dealing between the parties in the past or some other basis inducing the plaintiff's reliance. The law in this area is evolving and diverse across jurisdictions, warranting continued attention by health plans, providers, and patients in the future.

NOTES

1. 29 U.S.C. § 1132(a)(1)(B).
2. 28 U.S.C. § 1441(b).
3. *Beneficial Nat. Bank, et al. v. Anderson*, 539 U.S. 1, 6 (2003).
4. *Id.* at 8.
5. 29 U.S.C. § 1132(a)(1)(b).
6. 542 U.S. 200 (2004).
7. *Id.* at 209.
8. *Id.* at 201.
9. *Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co., et. al*, 103 F.4th 597 (9th Cir. May 31, 2024).
10. *Id.* at 599-600.
11. *Id.* at 600.
12. *Id.*
13. *Id.*
14. *Id.* at 601.
15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.*
20. *Id.*
21. *Id.* at 603-04.
22. *Id.* at 607.

23. See e.g. Keith Feder, M.D., Inc. v. Amazon.com, Inc., 2024 WL 5275521 (C.D. Cal. Oct. 31, 2024); Coast Surgery Center v. United Healthcare Ins. Co., et. al., 2024 WL 5679158 (C.D. Cal. Oct. 25, 2024); Dedicato Treatment Ctr., Inc. v. Aetna Life Ins. Co., 2024 WL 3346241 (C.D. Cal. July 8, 2024); Aetna Life Ins. Co. v. Young, 2025 WL 1357427 (C.D. Cal. April 15, 2025).

24. Northwestern Memorial Healthcare. Anthem Blue Cross and Blue Shield, LLC f/k/a Empire BlueCross and BlueShield, 2025 WL 1455823 (N.D. IL May 21, 2025).

25. Princeton Neurological Surgery, P.C. v. Horizon Blue Cross Blue Shield of New Jersey, 2024 WL 178220 (App. Div. Jan. 17, 2024).

26. Id. at *1.

27. Id.

28. Id. at *4.

29. Id.

30. Id. at *8.

31. Id. at *6.

32. Rowe Plastic Surgery of New Jersey, L.L.C. & East Coast Plastic Surgery, P.C. v. Aetna Life Ins. Co., 2025 WL 1907005, *6 (E.D. NY July 10, 2025).

33. Mapsong, PC v. Aetna Life Ins. Co., 2025 WL 757820, *8-9 (C.D. Cal. Feb. 7, 2025)..

34. Jenkins v. Aetna Health, Inc., 2024 WL 1795488 (S.D. NY April 25, 2024).

35. Id. at *2.

36. Id.

37. Id.

38. Id.

39. Id. at *3.

40. Id. at *6.

41. Moda Health Plan, Inc. v. New Life Treatment Ctr., 2025 WL 404913, *10 (D. AK Feb. 5, 2025).

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