The Ninth Circuit Clarifies the Law of Waiver Under ERISA as Applied to Anti-Assignment Defenses

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Benefit assignments are ubiquitous in the health care context, where doctors and other medical providers routinely ask new or existing patients to sign forms assigning their rights to insurance payments to the providers. These arrangements are as beneficial to all concerned as they are common. But anti-assignment clauses are also becoming increasingly common and are often held in reserve by insurance companies, either inadvertently or as part of an attempt to deny claims under a moving target of rationales. The Ninth Circuit has just clarified, or more accurately reiterated, that such practices will not be tolerated in the context of plans governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Background

"[A]n administrator may not hold in reserve a known or reasonably knowable reason for denying a claim, and give that reason for the first time when the claimant challenges a benefits denial in court." *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1297 (9th Cir. 2014). In *Spinedex*, the Ninth Circuit merely summarized—in the context of an anti-assignment defense—the same rule that it had described two years earlier in *Harlick v. Blue Shield of California*, 686 F.3d 699, 719-20 (9th Cir. 2012). While the court stopped short of holding that the insurer there had waived the anti-assignment defense, it left no doubt as to whether waiver applies.[1]

Nonetheless, after *Spinedex*, multiple district courts have concluded that anti-assignment is a "litigation defense" that is not waived when a claims administrator fails to raise it during the administrative process.[2] Each of the decisions relied on two unpublished Ninth Circuit decisions holding that waiver was inapplicable under the facts of those cases.[3]

The Ninth Circuit, however, recently confirmed the vitality of *Spinedex* and *Harlick*, and clarified their applicability to anti-assignment defenses with its reversal in *California Spine & Neurosurgery Institute v. Blue Cross of California*, 811 Fed. App'x 429 (9th Cir. June 30, 2020). The decision is significant because it should put an end in the Ninth Circuit to misinterpretations by lower courts about the nature of anti-assignment defenses. It is also a good outcome for plan participants and medical providers alike, as evidenced by the support that the appellant California Spine and

Read more on page 17

The Ninth... continued from page 5

Neurosurgery Institute (the "Neurosurgery Institute") received from *amici curiae* United Policyholders and the Association of American Physicians & Surgeons.

The Ninth Circuit Revisits Waiver in an Unpublished Disposition

The Neurosurgery Institute specializes in sophisticated surgical procedures, including minimally invasive spinal decompressive and complex spinal reconstruction. It obtained an assignment of rights and benefits and performed surgery services as an out-of-network provider for a participant in an employer-sponsored medical plan.

When the Neurosurgery Institute submitted a claim to Blue Cross of California ("Blue Cross") on a 1500 Health Insurance Claim Form ("HCFA"), Blue Cross paid a small portion of the claim. According to the complaint, the insurer denied the remainder on the purported basis that the unpaid portion "exceeded [the] maximum allowable amount." Despite the fact that the Neurosurgery Institute had made a pre-service inquiry about out-of-network services and had checked a box on the HCFA indicating that it accepted assignments, Blue Cross failed to inform the Neurosurgery Institute of an anti-assignment clause in the medical plan during the claims process.

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Nevertheless, Blue Cross raised the anti-assignment provision for the first time on a motion to dismiss after the Neurosurgery Institute brought a claim for benefits pursuant to ERISA § 502(a)(1)(B). Although the district court considered *Spinedex* and *Harlick*, it held that anti-assignment was a litigation defense that could not be waived, explaining the following:

Plaintiff's reading would overextend *Spinedex*'s holding [regarding waiver] to reach beyond the factual scenario that court considered . . . . Instead, this court reads *Spinedex* in concert with the subsequent Ninth Circuit decisions that are directly on point with the issue presented here. In doing so, the court notes that all three opinions rely on *Harlick*; *Brand Tarzana* itself relies on *Spinedex*; and Judge Bybee sat on the panels that decided both *Spinedex* in 2014 and *Eden Surgical Center* less than four years later. This court—like the three opinions themselves and Judge Bybee—reads their holdings harmoniously. This conclusion cannot be overcome by an amended pleading.[4]

On appeal, the Ninth Circuit quickly disposed of the issue. In a decision issued only weeks after the video-conferenced oral argument, the court held that the "district court erred in determining waiver was inapplicable."[5] Citing *Spinedex* and *Harlick*, the Ninth Circuit also ruled that the Neurosurgery Institute had adequately pleaded waiver.[6] In explanatory parentheticals, the court recognized that *Spinedex* had directly considered waiver in the context of an anti-assignment provision and *Harlick* had articulated waiver principles based on "ERISA and its implementing regulations."[7]

The Impact of the *California Spine* Decision

This case was not only correctly decided under existing Ninth Circuit case law, but it makes sense as a practical matter. When a doctor's office with an assignment calls the insurance company to confirm coverage prior to performing surgery or providing other treatment and is not told until too late that the insurance company will not accept the assignment, it would be patently unfair to both the doctor and the patient to allow the insurance company to escape its obligation to pay on that basis. Yet that is exactly what the district court's decision had condoned.

More broadly, if this had become the rule in the Ninth Circuit, medical providers, like the Neurosurgery Institute, and their patients would have been left with only bad choices. One choice for providers would have been to attempt to have patients prepay for all services, including expensive surgery, which few are likely to have the wherewithal to do. Alternatively, doctors could attempt to recover the costs from the patient after the fact. But as with prepayment, this is problematic from the patient's point of view and costly and inefficient from the doctor's. Indeed, this alternative would often be tantamount to asking doctors to simply absorb the costs of medical treatment provided to patients. Already, doctors and hospitals are burdened with tens of billions of dollars in uncompensated medical costs every year.[8] There is a limit, of course, to the amount of uncompensated costs that any one medical provider can absorb without going out of business. Which leads back to the growing trend of doctors demanding prepayment from their patients because of unnecessary obstacles erected by insurance companies.[9] Because many patients would be unable to come up with the required cash to pay for needed surgery or other expensive medical procedures, they would have to forego such procedures, to the detriment of their health, despite being participants in medical plans that promise to cover medically necessary treatment. The Ninth Circuit's elegant decision avoids these adverse consequences by correctly applying its existing precedent to prevent insurance companies from lying in wait before asserting plan anti-assignment provisions.

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Notably, the Neurosurgery Institute has requested publication of the unpublished disposition.

Endnotes

1 *See Spinedex*, 770 F.3d at 1297 (emphasizing that there was "no evidence that United was aware, or should have been aware, during the administrative process" that the medical provider was an assignee).

2 *See, e.g.*, *Cal. Spine & Neurosurgery Inst. v. Blue Cross of Cal.*, 358 F. Supp. 3d 949, 953-55 (N.D. Cal. 2019), *rev'd in part, vacated in part*, 811 F. App'x 429 (9th Cir. June 30, 2020); *Korman v. ILWU-PMA Claims Office*, 2019 U.S. Dist. LEXIS 117605, at *20-22 (C.D. Cal. July 23, 2019); *Cal. Surgical Inst., Inc. v. Aetna Life & Cas. Bermuda*, 2019 U.S. Dist. LEXIS 151849, at *14-15 (C.D. Cal. Mar. 26, 2019); *Beverly Oaks Physicians Surgical Ctr., LLC v. Blue Cross Blue Shield of Ill.*, 2018 U.S. Dist. LEXIS 191527, at *11-13 (C.D. Cal. Nov. 8, 2018).

3 *See Eden Surgical Ctr. v. Cognizant Tech. Sols. Corp.*, 720 F. App'x 862, 863 (9th Cir. 2018); *Brand Tarzana Surgical Inst., Inc. v. Int'l Longshore & Warehouse Union-Pac. Mar. Ass'n Welfare Plan*, 706 F. App'x 442, 443 (9th Cir. 2017).

4 *Cal. Spine & Neurosurgery Inst.*, 358 F. Supp. 3d at 954-55.

5 *Cal. Spine & Neurosurgery Inst.*, 811 Fed. App'x at 429.

6 *Id.* at 429-30.

7 *Id.*

8 *See* American Hosp. Ass'n, Uncompensated Hospital Care Cost Fact Sheet (Dec. 2017), available at, https://www.aha.org/system/files/2018-01/2017- uncompensated-care-factsheet.pdf.

9 *See* Barbara Martinez, Cash Before Chemo, Wall St. J., April 28, 2018.