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Client Alert

Managed Care Lawsuit Watch - March 2016

March 29, 2016

This summary of key lawsuits affecting managed care is provided by the Health Care Group of Crowell & Moring. If you have questions or need assistance on managed care law matters, please contact Chris Flynn, Peter Roan, or any member of the Health Care Group.

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Helfrich v. Blue Cross & Blue Shield Ass'n
804 F.3d 1090 (10th Cir. 2015)

The U.S. Court of Appeals for the Tenth Circuit affirmed a judgment requiring a federal-employee health-insurance plan member to reimburse Blue Cross and Blue Shield Association and Blue Cross and Blue Shield of Kansas City (Blue Cross) for benefits paid for an injury caused by a third party, holding that federal common law displaces the relevant state regulation prohibiting subrogation and reimbursement (the anti-subrogation regulation) and that 5 U.S.C. § 8902(m)(1), the Federal Employees Health Benefits Act (FEHBA)'s preemption provision, overrides the regulation.

The plaintiff, Lee Ann Helfrich, was a federal employee enrolled in a federal-employee health-insurance plan (the Plan) administered by the defendants, Blue Cross. Helfrich received benefits under the Plan after sustaining injuries in a car accident caused by another driver. When Helfrich later settled with the driver's insurer, Blue Cross sought reimbursement for the benefits paid according to the reimbursement provision of the Plan. In response, Helfrich filed a petition against Blue Cross in Kansas state court seeking a declaration that the

subrogation clause in the Plan was enforceable under Kansas law and that FEHBA does not preempt the Kansas anti-subrogation regulation.

Blue Cross removed the case to federal court and filed a counterclaim seeking reimbursement for the amount of Helfrich's settlement with the driver's insurer. Blue Cross moved for judgment on the pleadings on the ground that the Kansas anti-subrogation law was preempted under 5 U.S.C. § 8902(m)(1) and, alternatively, that federal common law displaced the application of the Kansas regulation.

The Tenth Circuit held that federal common law displaced the Kansas anti-subrogation regulation. The court first determined that the contract between Blue Cross and the government as well as the provision of affordable quality healthcare to government employees were both matters of "uniquely federal" interest. The court then concluded that a government official's negotiation of the reimbursement provision into the Plan was "assuredly a discretionary function." After thus finding a sufficient federal interest existed, the court explained that the anti-subrogation regulation undermined the important purposes served by the Plan's reimbursement provision. For example, Blue Cross, as an experience-rated carrier, acted as a service agent between the federal government and its employees, and the money recovered through subrogation or reimbursement would be used to either reduce premiums or to increase coverage. Additionally, the government has a strong federal interest in uniformity that would be frustrated by allowing state law to override the subrogation and reimbursement requirements of the federal contract. Because the Kansas anti-subrogation regulation prohibited Blue Cross from fulfilling its contractual obligation to bring a reimbursement claim, the court determined that the state regulation was displaced by federal common law.

The court also held that § 8902(m)(1)'s directive that "terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits shall supersede and preempt any State law…which relates to health insurance or plans" preempted Kansas's anti-subrogation regulation. The usual presumption against preemption was determined by the court to be inapplicable because of the existence of a significant federal interest in federal employment. Next, the court concluded that preemption was proper, finding support in § 8902(m)(1)'s legislative history and giving weight to the views of the Office of Personnel Management—the agency responsible for administering FEHBA—regarding its interpretation of § 8902(m)(1).

Judge Lucero concurred in the judgment but disagreed with the majority that the government's decision to include subrogation clauses in FEHBA contracts involved sufficient agency discretion to warrant federal common law preemption.

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King v. CompPartners, Inc.
243 Cal. App. 4th 685 (2016), review filed (Feb. 16, 2016)

Kirk King sustained a back injury while at work. He later suffered anxiety and depression due to chronic back pain, which prompted his treating physician to prescribe a psychotropic medication known as Klonopin. Dr. Naresh Sharma, a utilization review physician at CompPartners Inc. (CompPartners), conducted a workers' compensation utilization review and determined that Klonopin was not medically necessary. Dr. Sharma did not warn Kirk about the consequences of abruptly withdrawing from Klonopin. Kirk stopped taking the drug and consequently suffered four seizures.

Kirk sued CompPartners and Dr. Sharma for professional negligence, negligence, intentional infliction of emotional distress, and negligent infliction of emotional distress. His wife Sara (collectively the Kings) also sued CompPartners and Dr. Sharma for loss of consortium. CompPartners and Dr. Sharma brought a demurrer, arguing that the Kings' claims were preempted by the Workers' Compensation Act (WCA) since the WCA already set forth a procedure for objecting to a utilization review decision. CompPartners and Dr. Sharma alternatively argued that they did not owe Kirk a duty of care because they did not personally examine him and did not treat him. The trial court sustained the demurrer without leave to amend.

The Court of Appeal disagreed — at least in part. It found that the trial court correctly sustained the demurrer, but erred by not providing the Kings with an opportunity to amend their complaint. The Court concluded that the Kings' claims were not necessarily preempted by the WCA. The Court explained that injuries arising in the course of the workers' compensation claims process are preempted by the WCA because this process is tethered to a compensable injury. But if a new injury arises, or the prior injury is aggravated due to a mishap during the claims process, preemption might not apply. The Complaint alleged two ways in which Dr. Sharma was potentially responsible for the seizures. One option is that Dr. Sharma incorrectly determined that Klonopin was not medically necessary since a reduced dosage was necessary until Kirk was properly weaned off the drug. The other suggests that Dr. Sharma was at fault only because he failed to warn Kirk about the consequences of abruptly withdrawing from Klonopin. The Court of Appeal found that the Kings' first theory would be preempted since it directly challenged Dr. Sharma's medical necessity determination. But the Court explained that the WCA did not preempt the Kings' allegations to the extent the Kings faulted Dr. Sharma only for his failure to warn Kirk about the consequences of his decision. The Court reasoned that the warning went beyond the "medical necessity" determination that Dr. Sharma had made.

The Court of Appeal also found that the trial court erred by concluding that Dr. Sharma and CompPartners did not owe Kirk a duty of care. The Court acknowledged that as a utilization review doctor, Dr. Sharma's relationship with Kirk is distinct from that of a treating physician who conducts in-person examinations. But the Court noted that a medical director's utilization review decisions amounts to medical care because it has to be conducted by medical professionals who exercise medical judgment and apply clinical standards. The distinct nature of the relationship that a utilization management review doctor has with the patient changes the scope of the duty owed. It does not mean no duty of care is owed at all.

Finally, the Court of Appeal concluded that the trial court correctly sustained the demurrer. The Kings did not plead enough factual allegations to determine the nature of the duty Dr. Sharma owed. The Court nevertheless found that the trial court erred by not granting the Kings leave to amend. The Court reasoned that additional facts might cure the problems presented by the complaint. The Kings had explained that, if given leave to

amend, they could plead that seizures are a known consequence of abruptly ceasing Klonopin and that Dr. Sharma knew that his decision would lead to the immediate denial of more Klonopin without any review by Kirk's prescribing doctor.

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Unilab Corp. v. Angeles-IPA
No. B255136, 2016 WL 374988 (Cal. Ct. App. Feb. 1, 2016)

The California Court of Appeal, Second Appellate District, affirmed summary judgment for Angeles, an independent physician association (IPA), finding that it was not liable to Unilab Corporation, doing business as Quest Diagnostics (Quest), an out-of-network clinical laboratory, for the cost of laboratory tests on specimens mistakenly ordered by physicians for Angeles patients. Quest presented several theories, including an agency theory, unjust enrichment, and *quantum meruit*.

Angeles is an IPA that contracts with various health care plans to facilitate the delivery of health care services to enrollees of the plans. Under these contracts, the plans assign their enrollees to Angeles, and Angeles contracts with various health care providers to render covered services to Angeles patients. From 2005 through 2009, Angeles contracted with Quest for laboratory testing services for Angeles patients on a prepaid (*i.e.* capitation) basis. When that contract expired in November 2009, Angeles told its physicians to send all laboratory tests to a different contracted laboratory, and Angeles notified Quest that its services would no longer be authorized. When Angeles terminated its contract with Quest, some Angeles physicians, who belonged to other IPAs that had contracts with Quest, continued to maintain Quest drop boxes in their offices for their patients who belonged to a Quest-affiliated IPA. On occasion, these physicians erred in placing specimens from Angeles patients into the Quest drop box. Typically, when the specimen arrives at the Quest laboratory, it is tested prior to confirmation of the patient's IPA/payor information. Under this process, Quest tested specimens for Angeles patients without knowledge that Angeles was their IPA.

First, Quest argued that Angeles is liable for the post-contract tests ordered by its physicians under an agency theory. Specifically, Quest contended that Angeles implicitly authorized Quest to perform testing services when an Angeles physician placed a specimen inside a Quest drop box because the physician is the authorized agent of Angeles. The California Court of Appeal rejected this argument on the basis that the agreement between Angeles and the physician specifically defined the relationship as that of an independent contractor. The court held that even under Quest's theory that physicians can be both independent contractors and agents of an IPA, there was no evidence that Quest was misled by the conduct of the physicians to believe that Angeles would pay for the tests. Indeed, until Quest ferreted out the patient's IPA/payor information, it was unaware that the patient even belonged to Angeles.

Second, Quest argued that it is entitled to quasi-contract restitution based on unjust enrichment. In rejecting this argument, the court explained that unlike an implied-in-fact contract, an implied-in-law contract or quasi-

contract is not based on the intention of the parties, but arises from a legal obligation that is imposed on the defendant as a result of unjust enrichment, *i.e.*, where a person obtains a benefit that he or she may not justly retain. Quest argued that because it performed some of Angeles' required testing services, Angeles could pay its in-network laboratory a lower capitation rate. There was no evidence, however, that Angeles actually cut a deal with its in-network laboratory as a result of the misdirected work to Quest. The court found that the benefit conferred upon Angeles by the negligence of the physicians was unintended and did not cause the misdirection of the specimens. The court clarified that the fact that one party benefits from another is not itself sufficient to require restitution. The person receiving the benefit, rather, is only required to make restitution if the circumstances are such that, as between the two parties, it is *unjust* for the person to retain it.

The court summarily rejected Quest's *quantum meruit* argument on the basis that *quantum meruit* requires the services be rendered under some understanding or expectation of both parties that compensation therefore was to be made. Here, the court found that Quest had no understanding or expectation of payment for Angeles' unauthorized out-of-network tests.

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Kaiser Found. Health Plan, Inc. v. Burwell
No. 14 cv-05255-EMC (U.S. District Court, Northern District of California. November 30, 2015)

The U.S. District Court for the Northern District of California granted the Secretary's cross-motion for summary judgment, holding that the treating physician's stabilization determination is binding on Kaiser with respect to its financial obligation to pay for emergency care up until the point of stabilization. This case was heard on appeal from the Medicare Appeals Council (MAC), which ruled in favor of the Secretary.

Kaiser, a Medicare Advantage Organization (MAO) that provides Medicare-covered services to its enrollees, challenged whether a treating physician's determination that a patient is stabilized is binding on Kaiser under federal regulation 42 C.F.R. § 422.113(b)(3).

In this case, Kaiser's enrollee arrived at the Emergency Department complaining of high blood pressure and a headache. The attending physician determined that the patient was "unstable for transfer" and marked several reasons on a checklist. Accordingly, the physician admitted the patient. Kaiser refused to pay for inpatient services provided explaining that, "[p]er our physician review, the member was clinically stable for transfer in-plan after evaluation and treatment in the emergency room. We did not authorize the hospital to provide the post-stabilization inpatient care received after that." Kaiser refused to pay the hospital for services after the point it believes the patient was stable and could have been transferred to an in-network facility.

Kaiser challenged the MAC's interpretation and application of 42 C.F.R. § 422.113(b)(3) and asserted that the federal statute limits its application to transfer disputes and requires the MAO to defer only to the decision of the treating physician to physically transfer or discharge a patient – not whether the enrollee is stable for

purposes of Kaiser's financial responsibility. In response, the court stated that, "Kaiser's attempt to divorce the duty of assuming the provision of emergency care without prior authorization from the obligation to pay for that care runs counter to the regulatory scheme." The statutory language at issue makes the treating physician's determination of stability binding on the MAO applicable to the MAO's financial responsibility for emergency medical care. The MAO may not require the provider to call for approval of services prior to the point of stabilization. The court found the Secretary's interpretation of the regulations to be consistent with the regulation and "well within the bounds of reasonable interpretation."

Kaiser further argued that even if the MAC's reading of the regulation was permissible, the Secretary exceeded her authority in promulgating the regulation inconsistent with the Medicare statute 42 U.S.C. 1395w-22(d)(2), which Kaiser read to impose an affirmative obligation on the treating physician to apply the definition of "stability" provided under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). Under EMTALA, any hospital that accepts payment from Medicare must treat patients who seek emergency services without inquiry into the patient's insurance coverage or ability to pay until the patient's condition has stabilized. 42 U.S.C. 13955dd. The regulation prohibits transfer of emergency patients not yet stabilized. Kaiser contended that under EMTALA, the enrollee would have been deemed stable for transfer. The court found that even if the treating physician erred in applying the precise legal standard for stabilization, the regulations make clear that the treating physician's determination of stability is binding on the MAO. Further, EMTALA's definition of "stabilization" establishes an objective standard of reasonableness met by the treating physician.

In the alternative, Kaiser argued that the lack of meaningful administrative or judicial review of the treating physician stabilization determination violates Kaiser's due process rights under the Fifth Amendment. Regarding this theory of the case, the court stated that MAOs have no property interest in Medicaid or Medicare payments. Further, the wide discretion resting with the physician negates Kaiser's claim to a protectable property interest created by the State; even if Kaiser could establish a property interest, there is no compulsion to participate in the Medicare program and thus no taking the Fifth Amendment.

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Smilow and Katz v. Anthem Life & Disability Ins. Co.
No. 15-MD-02617 (N.D. Cal. Nov. 24, 2015)

The U.S. District Court for the Northern District of California denied plaintiffs' motion to remand, finding that the plaintiffs' breach of contract and unjust enrichment claims were completely preempted by ERISA and that the Court had subject matter jurisdiction over the action under 28 U.S.C. § 1331, and therefore removal was proper.

Plaintiffs Michael Smilow and Jessica Katz (plaintiffs) filed a putative class action in the Supreme Court of Kings County, New York against defendants Anthem Life & Disability Insurance Company, Empire Healthchoice Assurance, Inc., and Empire Healthchoice HMO, Inc. Plaintiffs asserted ten causes of action against defendants under New York law pertaining to an alleged data breach. Defendants removed the action to the Eastern District

of New York and provided two bases for federal subject matter jurisdiction: (1) federal question jurisdiction under the Employee Retirement Income Security Act of 1974 (ERISA); and (2) federal question jurisdiction under HIPAA. The Judicial Panel on Multidistrict Litigation transferred the case to the Northern District of California.

The Northern District of California began its analysis of whether removal was proper by noting that ERISA contains "expansive preemption provisions . . . which are intended to ensure that employee benefit plan regulation would be 'exclusively a federal concern.'" The court explained that in order to determine whether removal is proper on the basis of ERISA complete preemption, the Ninth Circuit follows the U.S. Supreme Court's decision in *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004), which provides a two-prong test. According to the so-called *Davila* test, an action is preempted and thus removable to federal court if: (1) an individual could have brought the claim under ERISA § 502(a), and (2) there is no other independent legal duty that is implicated by the defendant's actions.

The court concluded that under the first *Davila* prong, the plaintiffs could have brought their claims under § 502(a). The court noted that defendants had submitted documents showing that both Smilow and Katz received health benefits during the relevant time period as dependent beneficiaries of employer-sponsored ERISA plans. The court found that plaintiffs could have brought their unjust enrichment and breach of contract claims under § 502(a) because they were seeking to enforce their rights under the terms of the plan through these claims and their request for relief was a partial refund of the insurance premiums that plaintiffs paid to defendants. The court rejected the plaintiffs' argument that their complaint alleged breach of an implied contract, not breach of the express terms of their ERISA plan. The court explained that ERISA preemption applies if an individual *could* have, at some time, brought his or her claim under ERISA § 502(a).

Under the second *Davila* prong, the district court determined that defendants did not have an independent legal duty to protect plaintiffs' privacy pursuant to state law. The court thus rejected plaintiffs' argument that the ERISA plan coverage and benefits did not include and had not been shown to include privacy rights, pointing to the fact that the benefits handbooks plaintiffs received from defendants included a section requiring defendants to follow state laws and also included a section explaining plaintiffs' rights and defendants' legal duties under state law. The court explained that state law duties are not independent of ERISA when interpretation of the terms of the plaintiffs' plans forms an essential part of their claim. Additionally, state law legal duties are not independent from ERISA if they are based on an obligation under an ERISA plan and would not exist if the ERISA plan did not exist.

The court held that because the plaintiffs' breach of contract and unjust enrichment claims were completely preempted by ERISA § 502(a), the court had subject matter jurisdiction and removal was proper.

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Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr.o.
No. 13-03101, 2015 WL 5439223, (E.D. Pa. Sept. 15, 2015)

In 2013, Aetna Life Insurance Company (Aetna) sued Huntingdon Valley Surgery Center (Huntingdon), an ambulatory surgery center that is 80 percent owned by 22 physicians. Although Huntingdon is outside of Aetna's network, each physician-owner holds a separate provider agreement with Aetna. Aetna also sued Foundation Surgery Affiliates, LLC (FSA) and its wholly owned company, Foundation Surgery Management, LLC (FSM) because FSM manages Huntingdon's daily operations. Aetna alleged that Huntingdon, FSA, and FSM conspired together and violated Pennsylvania's anti-kickback statute, committed insurance fraud, and tortiously interfered with Aetna's provider contracts with Huntingdon's physician-owners.

Aetna contended that the surgery center, together with its owners and operators, paid the 22 physicians kickbacks (including ownership interests) so that these physicians would refer patients to Huntingdon rather than to less expensive in-network facilities in the same region. Further, Aetna said that defendants waived co-payments that Aetna's members were required to pay for services provided at an out-of-network facility (including Huntingdon), without informing Aetna of the waiver, and at the same time, billed Aetna for the full costs of the provided services. According to Aetna, the aforementioned conduct unlawfully inflated healthcare costs payable by Aetna.

In August 2014, the U.S. District Court for the Eastern District of Pennsylvania denied defendants' motion to dismiss on all claims except for unjust enrichment. Thereafter, Huntingdon counterclaimed alleging breach of contract, unjust enrichment, and improper payment of ERISA benefits. In April 2015, the district court denied Aetna's motion to dismiss on seven counterclaims but granted Aetna's motion on Huntingdon's ERISA benefits counterclaim. Next, in June 2015, defendants moved for summary judgment, and Aetna sought summary judgment on its insurance fraud claim and also moved for summary judgment on Huntingdon's seven remaining counterclaims. But, soon after, Huntingdon settled with Aetna.

In September 2015, the Eastern District of Pennsylvania granted summary judgment to FSM and FSA on several counts including violation of Pennsylvania's anti-kickback law (AKS), aiding and abetting insurance fraud, and equitable accounting but denied summary judgment to FSM on FSA on Aetna's claims for civil conspiracy and tortious interference with contract.

For most of its claims, Aetna had sued under Pennsylvania anti-fraud statute section 4117(b)(2) (AKS), which forbids providers from compensating a person for recommending or securing the providers' services. The court, however, determined that FSM and FSA were not "health care provider[s]" covered under the Pennsylvania AKS statute. In a lengthy opinion invoking canons of statutory instruction, the court reasoned that FSM and FSA are not licensed under the state's regulatory scheme to provide health care in Pennsylvania. On the other hand, Aetna's claims for civil conspiracy and tortious interference with contract survived due to genuine issues of material fact. The court also noted that it will hold an evidentiary hearing prior to trial to determine whether personal jurisdiction exists over FSA.

On September 29, 2015, Aetna filed a motion for reconsideration, or in the alternative, for certification for interlocutory appeal. In its request, Aetna argued that in dismissing Aetna's AKS claims, the judge relied on FSM and FSA's statements that they billed Aetna differently from Medicare, which was later shown to be false. But the court denied Aetna's motion finding that the September opinion adequately addressed that issue. The court

also denied Aetna's motion for sanctions against FSA and its attorneys on the basis of the same allegedly misleading statement about Medicare billing. However, the court certified the following issues for interlocutory appeal to the Third Circuit Court of Appeals: Counts I (violation of Pennsylvania anti-kickback statute), Count III (insurance fraud), and Count IV (aiding and abetting insurance fraud). In its January 28, 2016 opinion, the court explained that the underlying opinion involved controlling issues of law that implicated issues of first impression, and allowed for "substantial ground for difference of opinion." Thus, the court said, an immediate appeal may material advance the ultimate termination of litigation.

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Baptist Hosp. of Miami, Inc. v. Humana Health Ins. Co. of Florida, Inc.
No. 13-03101, 2015 WL 5439223, (E.D. Pa. Sept. 15, 2015)

The U.S. District Court for the Southern District of Florida granted a motion by plaintiffs Baptist Hospital of Miami and a group of other health care providers (Baptist), and remanded Baptist's contract and sequestration-based reimbursement dispute to state court. In doing so, the court rejected arguments by defendant insurers Humana Health Insurance Company of Florida and affiliates (Humana) that federal court jurisdiction was proper under the Federal Officer Statute and on federal question grounds.

Baptist claimed that Humana breached the Hospital Participation Agreement (HPA) between the parties by: (1) failing to properly reimburse Baptist under the terms of the HPA, (2) improperly excluding Baptist's facilities from state of Florida's health care exchange, and (3) improperly reducing its payments to Baptist when the government reduced its payments to Medicare Advantage Organizations (MAOs) as part of the government-wide sequestration implemented by the Budget Control Act of 2011. Baptist also claimed that after Humana terminated the HPA and entered into individual Letters of Agreement to reimburse Baptist for medical services rendered to three particular Humana members, Humana failed to pay Baptist at the agreed reimbursement rates.

The court rejected Humana's argument that the Federal Officer Statute warranted removal. The court found that Humana was not acting on behalf of the federal government—and specifically, the Office of Personnel Management (OPM)—when it entered into the three separate Letters of Agreement to reimburse Baptist for medical services provided to the specific Humana members. First, the court found Humana's removal evidence insufficient, highlighting that the Letters of Agreement themselves were unclear about whether the particular Humana members were actually participants in the Federal Employees Health Benefit Plan (FEHBA). Second, and most critical, the court found that Humana's alleged duty arose from Letters of Agreement created outside of any FEHBA plan, and that Humana was not acting on behalf of OPM when it entered into the Letters of Agreement in the first place. As a result, Baptist was not suing Humana for breach of contract based on actions taken on behalf of a federal office or agency; instead, Baptist's claims arose out of Humana's independent actions to contract with Baptist, and thus removal under the Federal Officer Statute was improper.

The court likewise rejected Humana's argument that it was acting on behalf of the Centers for Medicare & Medicaid Services (CMS) when it reduced Medicare payments to Baptist under the government-wide sequestration. Citing specific guidance from CMS that an "MAO's payments to its contracted providers are governed by the terms of the contract between the MAO and the provider," the court found that whether Humana properly reduced payments to Baptist was governed by the terms of the parties' contracts—not any determination that Humana made in administering the Medicare plans. The court even went as far as to construe CMS's guidance as a "statement that the sequestration d[oes] not affect how health insurers pa[y] MAO contracted providers."

Finally, the court rejected Humana's contention that resolving Baptist's breach of contract claims would require the court to address various federal questions, including the proper application of the sequestration reductions to Medicare Advantage contracts and the proper construction and effect of the sequestration adjustment. Instead, the court found that CMS and the Department of Health and Human Services made clear that CMS was "prohibited from interfering in the payment arrangements between MAOs and contracted providers." As a result, only the terms of the HPA contract between Humana and Baptist governed the application and effect of sequestration—which required "no reference to federal law" or warranted removal on federal question grounds.

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Rose v. Healthcomp, Inc.
No. 1:15-cv-00619-SAB, 2015 WL 4730173 (E.D. Cal. Aug. 10, 2015)

On August 10, 2015, the U.S. District Court of the Eastern District of California granted plaintiff Debra Rose's motion to remand the matter to California Superior Court.

Ms. Rose was employed by Harris Ranch Beef Company and received health benefits as part of her compensation. Defendant HealthComp was the third party administrator for Ms. Rose's health benefits. Ms. Rose received medical treatment for liver failure and was placed on a transplant waiting list. HealthComp's Administrative Services Agreement with Harris Ranch Beef included a notice provision by which HealthComp notifies the plan sponsor (the employer) when an employee's health costs are rising. A HealthComp nurse case manager also had Ms. Rose sign a form authorizing HealthComp to access her medical records, but did not tell Ms. Rose that her medical records could be shared with her employer.

In December 2012, Ms. Rose's employer received a report from HealthComp that plaintiff would need an expensive liver transplant. Soon thereafter, Ms. Rose was fired. Ms. Rose alleged HealthComp improperly notified her employer of her medical condition and her need for a liver transplant. Ms. Rose brought an action for invasion of privacy and unfair business practices in violation of California law. She filed suit in California Superior Court, but defendant HealthComp removed the case to federal district court in the Eastern District of California.

Ms. Rose moved to remand the action to state court, arguing her state law privacy and unfair business practices claims are not preempted by ERISA. HealthComp countered that Mr. Rose's allegations are related to the ERISA plan because she alleges that medical information was disclosed in the performance of HealthComp's third-party administrator duties.

To decide the issue of preemption, the Court applied two prong tests. First, the court asked whether Ms. Rose could have brought her cause of action under ERISA. The court found that Ms. Rose was essentially alleging that by providing personal medical information to her employer, HealthComp acted in competing against the interest of the insured (on behalf of the employer) rather than in the interest of the employees and other beneficiaries. The court determined that the first prong was thus satisfied because Ms. Rose's breach of privacy and unfair business practices cause of action could have been brought as a fiduciary duty claim under ERISA § 502(a).

Second, the court asked whether the state law invasion of privacy and unfair business practices cause of action arise independently of ERISA or the ERISA plan terms. The court applied a "but for" standard to assess the relationship between the harm alleged and the ERISA-governed plan, and found that HealthComp did not meet the "but for" test. The state law right to privacy allegation would exist regardless of the disposition of any claim for benefits processed by HealthComp. In other words, the claim for disclosure of medical information would exist regardless of the case management undertaken in administering the health plan.

Therefore, the court granted plaintiff's motion to remand the matter to California Superior Court. The court did, however, deny plaintiff's motion for attorney's fees.

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