UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No.: 1:15-cv-22009-UU

BAPTIST HOSPITAL OF MIAMI, INC., *et al.*,

Plaintiffs,

v.

HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC., *et al.*,

Defendants.
_____/

ORDER ON MOTION TO REMAND

THIS CAUSE is before the Court upon Plaintiffs' Motion for Remand, D.E. 30, filed on June 26, 2015. The Motion is now fully briefed and ripe for disposition.

THE COURT has reviewed the pertinent portions of the record and is otherwise fully advised in the premises.

BACKGROUND

Plaintiffs, collectively referred to as "Baptist," are a group of non-profit health care providers incorporated in Florida with their principal places of business in Florida. D.E. 1-1 at 11. Plaintiffs originally filed their Complaint in the Circuit Court of the 11th Judicial Circuit in and for Miami-Dade County, Florida on April 22, 2015. *Id.* at 23. Defendants, collectively referred to as "Humana," are for-profit health maintenance organizations. *Id.* at 11-12. Defendant Humana Health Insurance Company of Florida, Inc., is incorporated in Florida with its principal place of business in Florida. *Id.* The following allegations are taken from Plaintiffs' original Complaint filed in state court.

In November 2001, Baptist and Humana entered into a Hospital Participation Agreement ("HPA") whereby Baptist agreed to participate in Humana health plans in exchange for certain reimbursement terms. *Id.* at 13. A copy of the agreement was attached as Exhibit A to the

service copy of Plaintiffs' Complaint, and was filed separately with the Court. D.E. 29-1. Baptist alleges that Humana breached the HPA in three ways. First, that Humana failed to pay the proper rate of reimbursement as specified in the HPA. *Id.* at 14. Second, that Humana improperly excluded Baptist's facilities from the provider network established for healthcare insurance offered to the public through the health insurance marketplace for Florida (the "Florida Exchange"). *Id.* at 15. Third, that Humana improperly reduced payments to Baptist during the government's sequestration in 2013 based on the government reducing payments to Medicare Advantage Organizations. *Id.* at 16.

Humana terminated the HPA effective August 14, 2014. *Id.* Baptist alleges that after Humana terminated the HPA, Baptist would still provide services to Humana members under three different scenarios, and, depending on the circumstances, Humana was required to reimburse Baptist for the provided services at varying rates.

First, under Florida law, Baptist was required to provide emergency medical services to Humana members, and Humana was required to reimburse Baptist at a rate set by the Florida statute, Fla. Stat. § 641.513. *Id.* at 18. Baptist alleges that Humana filed to reimburse Baptist for emergency medical services at the rate mandated by Florida law. *Id.*

Second, where Baptist had provided emergency care and continued to provide care after the patient was stabilized, Baptist sought authorization from Defendants to continue treatment. *Id.* at 19. Baptist alleges that it made a continuing offer to Humana to provide authorized non-emergency services to Humana members subject to reimbursement equal to Baptist's billed charges. *Id.* Humana allegedly authorized such care. *Id.* Baptist alleges that this conduct created an implied-in-fact contract or an implied-in-law contract. *Id.* Plaintiffs allege that, under the implied-in-fact theory, they are owed the amount of billed charges submitted to Humana. *Id.* Under their implied-in-law theory, Plaintiffs are owed the reasonable value of the services

provided. *Id.* at 21

Third, Humana entered into a number of Letters of Agreement with Baptist whereby Baptist agreed to render medical services to specific patients in exchange for reimbursement at rates set forth in the letters. *Id.* at 21. Each letter pertained to a different Humana member. *Id.* These letters were attached to as Exhibit C to the service copy of Plaintiff's Complaint and separately filed with the Court. D.E. 29-3. Humana allegedly breached these Letters of Agreement for failing to pay Baptist at the agreed reimbursement rates. *Id.* at 17.

Based on these underlying allegations, Baptist alleges the following six counts in its initial Complaint: (I) Breach of Contract for breaching the HPA; (II) Violation of Fla. Stat. § 641.513, for failing to pay Baptist at the statutorily set rate for emergency services; (III) Breach of Implied-In-Fact Contract for failing to pay Baptist for the billed charges after the termination of the HPA; (IV) Breach of Implied-In-Law Contract for Humana's failure to pay for the reasonable value of Baptist's services provided after the termination of the HPA; (V) Breach of Express Contract - Letters of Agreement; and (VI) Promissory Estoppel for representing that Humana would reimburse Baptist for providing out-of-network healthcare services to Humana members.

On May 27, 2015, Defendants removed this action to federal court. In their Notice of Removal, Defendants contend that this action is removable under the Federal Officer Statute, 28 U.S.C. § 1442(a)(1), and that this action is removable because it raises substantial federal questions and thus arises under the laws of the United States. D.E. 1. On June 26, 2015, Plaintiffs moved to remand this action to state court.

LEGAL STANDARD

"In evaluating a motion to remand, the removing party bears the burden of demonstrating federal jurisdiction." *Triggs v. John Crump Toyota, Inc.*, 154 F.3d 1284, 1287 n.4 (11th Cir.

1998). The Court must determine whether it has subject matter jurisdiction based on the operative complaint at the time of removal. *See Poore v. American-Amicable Life Ins. Co. of Tx.*, 218 F.3d 1287, 1291 (11th Cir. 2000), *overruled in part on other grounds in Alvarez v. Uniroyal Tire Co.*, 508 F.3d 639, 640-41 (11th Cir. 2007); *Ehlen Floor Covering, Inc. v. Lamb*, 660 F.3d 1283, 1287 (11th Cir. 2011) ("The existence of federal jurisdiction is tested as of the time of removal.").

The Federal Officer Removal Statute, 28 U.S.C. § 1442(a)(1), allows removal of any civil action against "any officer (or any person acting under that officer) of the United States or of any agency thereof, in an official or individual capacity, for or relating to any act under color of such office." "The right of removal 'is made absolute whenever a suit in a state court is for any act 'under color' of federal office, regardless of whether the suit could originally have been brought in a federal court.'" *Magnin v. Teledyne Cont'l Motors*, 91 F.3d 1424, 1427 (11 th Cir. 1996) (quoting *Willingham v. Morgan*, 395 U.S. 402, 406 (1969)).

"A private party seeking to remove under the federal officer removal statute must satisfy four criteria: (i) it must be a person; (ii) it must be acting under a federal officer or agency; (iii) it must be sued for actions under color of such office; and (iv) it must have a colorable federal defense." *Assocs. Rehabilitation Recovery, Inc. v. Humana Med. Plan, Inc.*, – F. Supp. 3d –, No. 14-cv-21677, 2014 WL 7404547, at *2 (S.D. Fla. Dec. 10, 2014). The statute is not narrow or limited and "is broad enough to cover all cases where federal officers can raise a colorable defense arising out of their duty to enforce federal law." *Willingham*, 395 U.S. 406-07.

Under 28 U.S.C. § 1441(c)(1)(A), an action is removable if it includes "a claim arising under the Constitution, laws, or treaties of the United States." "As a general rule, a case arises under federal law only if it is federal law that creates the cause of action." *Diaz v. Sheppard*, 85 F.3d 1502, 1505 (11th Cir. 2996). However, an action alleging only state law claims may be

removable under this provision where a "state-law claim necessarily raise[s] a stated federal issue, actually disputed and substantial, which a federal forum may entertain without disturbing any congressionally approved balance of federal and state judicial responsibilities." *Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 545 U.S. 308, 314 (2005).

DISCUSSION

Defendants contend in their Notice of Removal that this Court has jurisdiction under the Federal Officer Removal Statute because (A) Defendant Humana Medical was acting on behalf of the federal government in administering the federal employee health benefits plan ("FEHBA"); and (B) Defendants were acting as Medicare Advantage Organizations. Defendants further contend that this action is removable because it raises substantial federal questions. The Court addresses each argument in turn.

I. Federal Officer Removal Statute

A. FEHBA plans

"Congress enacted the FEHBA, 5 U.S.C. §§ 8901-14, to create a comprehensive program of subsidized health care benefits for federal employees and retirees." *Muratore v. United States OPM*, 222 F.3d 918, 920 (11th Cir. 2000). "The FEHBA grants significant authority to OPM . . . to administer the program by contracting with qualified private carriers to offer a variety of health care plans, . . . by distributing information on the available plans to eligible employees, . . . , by promulgating necessary regulations, . . . , and by interpreting the plans to determine the carrier's liability in an individual case." *Id.* (quoting *Kobleur v. Grp. Hospitalization & Med. Servs.*, 954 F.2d 705, 709 (11th Cir. 1992)).

"A health plan insurer contracting with a government agency under a federal benefits program is considered a 'person acting under' a federal officer." *Anesthesiology Assocs. of Tallahassee, FL, P.A. v. Blue Cross Blue Shield of Fla., Inc.*, 133 F App'x 738, 2005 WL

6717869, *2 (11th Cir. 2005); *see Jacks v. Meridian Res. Co., LLC*, 701 F.3d 1224, 1231 (8th Cir. 2012). "A defendant meets the first requirement of 'acting under the direction of a federal agency or officer' by showing that the acts that form the basis for the state civil or criminal suit were performed pursuant to an officer's direct orders or to comprehensive and detailed regulations." *McMahon v. Presidential Airways, Inc.*, 410 F. Supp. 2d 1189, 1196 (M.D. Fla. 2006) (internal quotations and citations omitted).

A key inquiry to determine whether an action is based on an insurer's role in administering a FEHBA plan, and therefore whether it acts under the direction of OPM, is whether the plaintiff's claim is based on the plan participant's right to reimbursement and whether the plaintiff healthcare provider is seeking payment based on an assignment from the plan participant. *See Anesthesiology Assocs*., 2005 WL 6717869, at *3 ("Both sets of AAOT's claims are based on the plan participants' right to reimbursement from BCBS for medical service expenses performed by AAOT, which rights AAOT had acquired."); *Jacks*, 701 F.3d at 1230 n.3 (finding that claim was based on defendant's role as FEHBA administrator where claim challenged provision in the FEHBA plan that required an enrollee who received benefits in connection with any injury to compensate insurer); *The Ala. Dental Ass'n v. Blue Cross & Blue Shield of Ala., Inc.*, No. 205-cv-1230-MEF, 2007 WL 25488, at *7-8 (M.D. Ala. Jan. 3, 2007) (finding claims arose out of BCBS's role as a FEHBA administrator where Plaintiff submitted claims to defendant pursuant to assignments received from his patients). If a claim is based on a plan participant's right to reimbursement, then the claim is based on a contract negotiated and interpreted by OPM, and is subject to the "specific administrative regime" OPM has delineated "to assess the claims of enrollees who seek review of the benefit determinations under these plans." *The Ala. Dental Ass'n*, 2007 WL 25488, at *8; *see Anesthesiology Assocs.*, 2005 WL 6717869, at *2.

There are three separate Letters of Agreement that were attached to the service copy of Plaintiff's initial Complaint and separately filed with the Court. *See* D.E. 29-3. It is unclear, and Defendants do not explain, which Letter of Agreement authorizes coverage for a FEHBA plan participant. Each Letter of Agreement states, "For purposes of this Agreement, 'Covered Services' are those services covered under and defined in accordance with the applicable Member health benefits contract." D.E. 29-3 at 2, 4, 6. These Letters of Agreement each have a "Reimbursement" or "Services" section that lists the specific services the particular Humana member requires, and the reimbursement rate for those services. *Id.* Only one of these contains the following language, albeit in the "Payments" section: "To comply with state and/or federal statutes, Humana will process claims based on policy and plan provision[.]" *Id.* at 7. However, as stated above, the Letter of Agreement on which Defendants rely to establish federal jurisdiction fails to disclose whether the Humana member was a participant in a FEHBA plan.

Based on this record, Defendants are not entitled to removal for acting as federal officers pursuant to their contracts with OPM because they are not being sued for actions taken under such color of office. Rather, Plaintiffs assert a contract claim based on separate Letters of Agreement, which set forth the specific reimbursement rates for the medical services provided. D.E. 29-3. There is no reference to a specific FEHBA plan, the plan provisions, or any review process mandated by OPM. That covered services are defined based on the relevant member health benefits plan does not mean that a right to payment is based on the administration of the FEHBA plan. Instead, the right to payment arises out of a Letter of Agreement that does not expressly make a claim subject to the FEHBA plan's provisions and processes.

Plaintiffs' claim is thus similar to those made in *Orthopedic Specialists* and *Transitional Hospitals*. In *Orthopedic Specialists of New Jersey PA v. Horizon Blue Cross/Blue Shield of New Jersey*, 518 F. Supp. 2d 128, 131 (D.N.J. 2007), the plaintiff brought a claim for medical

services it provided based on pre-certification from the patient's insurer where the insurer agreed to reimburse Plaintiff for the procedure. The patient was a member of Defendant's FEHBA benefits plan, but the court found that Plaintiff's claim was based on the promise that Defendant gave to pay for the medical services provided and was "unrelated to the provision of benefits under the terms of the plan." *Id.* at 137. The Court found that Defendant's promise to pay was an "act . . . taken by Defendant and Defendant alone" and not completed pursuant to any control or direction from OPM. *Id.*

In *Transitional Hospitals Corporation of Louisiana v. Louisiana Health Services*, No. Civ. A. 02-354, 2002 WL 1303121, at *1 (E.D. La. June 12, 2002), the plaintiff brought claims against a defendant health insurer based on the defendant's representations that it would reimburse plaintiff for treatment rendered to a patient pursuant to his health insurance plan, which was a FEHBA benefits plan. The court found that the plaintiff's claims were not based on defendant's role as a federal officer because "Transitional's claims arise out of a contract that it alleges was created as a result of representations made by Blue Cross employees when Transitional attempted to verify coverage. The claims do not arise out of any of the procedures dictated by the OPM." *Id.* at *3.

Here, Plaintiffs' claims arise out of individual contracts, the Letter Agreements, wherein Defendants promised to reimburse Plaintiffs at a set rate for specific medical services that they provided. Consequently, the duty to pay Plaintiffs arises out of those Letters of Agreement and the representations Defendants made in the Letters, not out of Defendants' administration of a FEHBA plan or the benefits owed to patients under the FEHBA plan. And because Defendants were not acting under a federal agency by entering into Letters of Agreement with Plaintiffs, the federal officer removal statute does not provide a basis for removal jurisdiction over Plaintiffs' initial Complaint.

B. Acting as Medicare Advantage Organizations ("MAO")

Defendants also argue that this action is removable under 28 U.S.C. § 1442(a)(1) because Defendants were acting under the direction of the Centers for Medicare & Medicaid Services ("CMS") as an MAO by reducing payments to Plaintiffs during the sequestration.

Similar to health insurers administering FEHBA plans, courts have found that insurers can remove claims under the federal officer removal statute where the claims are based on the insurer's contract with CMS to administer Medicare benefits through Medicare Advantage plans. *See Einhorn v. CarePlus Health Plans, Inc.*, 43 F. Supp. 3d 1268, 1269-70 (S.D. Fla. 2014); *Assocs. Rehabilitation Recovery, Inc.*, 2014 WL 7404547, at *2. Determining whether the claim is based on a health insurer's actions under its contract with CMS requires determining whether the insurer made coverage determinations under Medicare Advantage plans, or made payments to patients or providers in accordance with the schedules of benefits conferred by the Medicare plans. *See Einhorn*, 43 F. Supp. 3d at 1270 (finding federal officer removal jurisdiction where insurer had acted as an MAO in seeking reimbursement for benefits paid on behalf of beneficiary); *Assocs. Rehabilitation Recovery*, 2014 WL 7404547, at *2 (claim was based on insurer's denial of Medicare benefits, finding "Plaintiff's claims concern Defendant's denial of payments, payments which it denied pursuant to its authority and obligations under federal law"); *Neurological Assoc. – H. Hooshmand, M.D., P.A. v. Blue Cross/Blue Shield of Fla., Inc.*, 632 F. Supp. 1078, 1080 (S.D. Fla. 1986) (claim based on insurer's compliance with the Department of Health and Human Services' instruction to immediately suspend payments on all assigned claims submitted by Plaintiffs).

Here, Plaintiffs' breach of the HPA claim is not brought based on Defendants' administration of Medicare plans. Instead, Plaintiffs allege that Defendants arbitrarily and unilaterally reduced payments for services by 2% based on CMS's reduced payments made to

MAOs, despite having negotiated rates based on Medicare specific facility rates. D.E. 1-1 at 16. However, as alleged in Plaintiff's initial Complaint, CMS issued multiple advisory letters explaining that "MAO's payments to its contracted providers are governed by the terms of the contract between the MAO and the provider." D.E. 30-1 at 4; D.E. 1-1 at 16; D.E. 30-2. In the HPA, the parties set forth the rates that Plaintiffs would be owed for providing medical services for Medicare HMO products. D.E. 25-2 at 38-40, 43-44, 55-57, 60-61. Thus, whether or not Defendants properly reduced payment to Plaintiffs is governed by the terms of the HPA, and not any determination that Defendants made in administering Medicare plans. Plaintiffs are not contesting Defendants' determination of Medicare plan benefits or any specific claim for payment based on medical services provided to a Medicare plan participant. Instead, Plaintiffs are contesting Defendants' conduct under the HPA based on CMS's statement that the sequestration did not affect how health insurers paid MAO contracted providers.

II. Federal Question Jurisdiction

Defendants also allege that this Court has subject matter jurisdiction over this action because Plaintiffs' Complaint necessarily raises a stated federal issue. Specifically, Defendants contend that Plaintiffs' Complaint satisfies the *Grable & Sons Metal Products, Inc. v. Darue Engineering & Manufacturing*, 545 U.S. 308, 312-14 (2005), test for determining whether a complaint stating a state law claim arises under federal law.

Under *Grable*, a state law claim may arise under federal law where it "necessarily raise[s] a stated federal issue, actually disputed and substantial, which a federal forum may entertain without disturbing any congressionally approved balance of federal and state judicial responsibilities." *Id.* at 314. This is a "special and small" category of cases. *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 699 (2006). As noted in *Empire Healthchoice*, the claim in *Grable* was based on the action of a federal agency and the

compatibility of that action with federal law, it involved the resolution of an issue of law, and its resolution would be controlling in numerous other cases. *Id.*

Here, Defendants contend that resolution of Plaintiffs' Complaint requires the Court to determine the proper application of sequestration reductions as implemented by the Budget Control Act of 2011, and to determine the proper construction and effect of the federal sequestration adjustment. D.E. 1 ¶ 46. That is simply not true. As CMS and the Department for Health and Human Services made clear in multiple letters, CMS was "prohibited from interfering in the payment arrangements between MAOs and contracted providers by section 1854(a)(6)(B)(iii) of the Social Security Act." D.E. 30-2 at 2. "Thus, whether and how reductions to plan payments due to sequestration might affect an MAO's payments to its contracted providers are governed by the terms of the contract between the MAO and the provider." *Id.* at 3.

The case upon which Defendants rely illustrates why Plaintiffs' claim does not satisfy the *Grable* test. In *New York City Health and Hospitals Corporation v. WellCare of New York, Inc.*, 769 F. Supp. 2d 250, 256 (S.D.N.Y. 2011), plaintiff's breach of contract claim alleged that defendant entered into a contract with CMS to pay health care providers in accordance with Medicare law and regulations, but that defendant did not pay plaintiff the amount for the services provided to defendant's Medicare enrollees. "Therefore, in order to prevail on its breach of contract claim, HHC will have to prove that WellCare's failure to pay the DRG amount violated Medicare law and regulations." *Id.* The court distinguished the claim before it from that presented in *Rencare, Ltd. v. Humana Health Plan of Texas, Inc.*, 395 F.3d 555 (5th Cir. 2004), because *RenCare* "involved a payment dispute between an MA Organization and a Contracted Provider, wherein the Contracted Provider sued in Texas state court for breach of contract, detrimental reliance, fraud, and violations of state law." *Id.* at 258. "The *RenCare* court

emphasized that contracts between MA Organizations and Contracted Providers are subject to very few restrictions, and that the contracting parties can generally negotiate their own terms." *Id.* This action is like that in *RenCare*, where an MAO and a contracted provider have entered into a contract and resolution of Plaintiffs' breach of contract claim requires no reference to federal law. *See id.* ("By contrast, the parties here had no contractual relationship and reimbursement is governed by a complex federal regulatory scheme."). Accordingly, it is

ORDERED AND ADJUDGED that the Motion, D.E. 30, is GRANTED. This cause is REMANDED to the 11th Judicial Circuit in and for Miami-Dade County, Florida pursuant to 28 U.S.C. § 1447(c) for LACK OF SUBJECT MATTER JURISDICTION. It is further

ORDERED AND ADJUDGED that the Clerk of Court shall administratively close this case.

DONE AND ORDERED in Chambers at Miami, Florida, this _18th_ day of August, 2015.

URSULA UNGARO
UNITED STATES DISTRICT JUDGE

copies provided to: Counsel of Record