Chapter 87

Health Care Institutions

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I. INTRODUCTION

§ 87:1 Scope note

This chapter discusses federal court litigation relating to health care institutions and providers of health care services, whether academic medical centers, health systems, physicians, physician groups or other facilities (collectively referred to in this chapter as "providers" unless otherwise indicated). Litigation involving providers generally falls into three distinct groupings: (i) federal

administrative litigation; (ii) federal business litigation; and (iii) government enforcement litigation. This chapter is organized accordingly.

Federal administrative litigation

Sections 87:2 to 87:26 of this chapter discuss federal administrative litigation involving providers and address three areas that frequently draw providers into the administrative litigation process and may result in judicial review by a federal court. While the authors acknowledge that the focus of this treatise is federal court litigation, the areas addressed in Sections 87:2 to 87:26 of this chapter each detail the administrative process preceding federal court review for two reasons. First, navigating the administrative process is a necessary prerequisite to seeking judicial review in federal court and one which a provider must pursue before commencing federal court litigation. Second, federal court review of administrative decisions is limited and, therefore, the administrative process is the means by which providers may create and shape the record and identify the issues which the federal court ultimately will review. Thus, the importance of understanding the administrative process, and how to navigate it, cannot be overstated.

In terms of substantive areas, Sections 87:2 to 87:10 of this chapter focus on administrative litigation before the U.S. Department of Health & Human Services Departmental Appeals Board (DAB) relating to provider certification or participation[1] in the Medicare program and provider enrollment and termination litigation[2] relating to the Medicare and Medicaid programs. Both areas can have far-reaching and significant financial implications for providers, given that those programs, together, are generally the largest payors of health care services for any provider.

In Sections 87:11 to 87:22 of this chapter, we explore Recovery Audit Contractor (RAC) administrative appeals and litigation, including: (i) the administrative process for appealing from an unfavorable RAC audit determination;[3] (ii) the current state of the backlog at the administrative law judge (ALJ) level of appeals;[4] (iii) the escalation process for avoiding delays at the Qualified Independent Contractor (QIC), ALJ or DAB levels;[5] and (iv)

[Section 87:1]

[1]See §§ 87:3 to 87:6.

[2]See §§ 87:7 to 87:10.

[3]See § 87:12.

[4]Sec. § 87:14.

[5]See § 87:20.

the law governing federal court review of such decisions.[6]

Finally, Sections 87:23 to 87:26 of this chapter address rate-setting and other reimbursement litigation at an administrative level, such as litigation arising from Medicaid State Plan Amendments or the assumptions or calculations included in regularly promulgated fee schedules or other rate-setting methodologies by the Centers of Medicare and Medicaid Services for Medicare reimbursement. Disputes in this area run a wide and diverse gamut and may include cost report appeals and decisions on allowable costs, Medicare and Medicaid coverage determinations, and claim denials for particular beneficiary services.

Federal business litigation

Sections 87:27 to 87:78 of this chapter address federal business litigation involving providers. In Sections 87:27 to 87:50, we address perhaps the most frequently litigated area of business litigation involving providers at present: payor-provider and managed care litigation. Section 87:28 begins with a brief discussion of the distinction between in-network and out-of-network providers and how that distinction can affect the types of claims such providers may assert as a plaintiff or face as a defendant. This portion of this chapter continues with a discussion of frequently litigated issues—namely, preemption,[7] provider standing,[8] and exhaustion of payor appeals processes.[9] Sections 87:38 to 87:49 then move to address specific causes of action available to providers as well as claims that may be asserted against providers. Finally, Section 87:50 discusses litigation arising from governmental sequestration as applied to Medicare payments, an issue which may be litigated in federal court depending on the terms of the relevant contract between the provider and payor.

Sections 87:51 to 87:58 discuss litigation relating to the Emergency Medical Treatment and Active Labor Act (EMTALA), a federal statute intended to prevent hospitals from "patient dumping" high-risk or indigent patients by refusing to provide them with emergency medical care or inappropriately transferring them to another facility in an unstable condition. To this end, Section 87:51 summarizes the requirements which EMTALA imposes on all Medicare-participating hospitals, Sections 87:52 to 87:58 address litigation alleging EMTALA violations, and offers practical guidance for handling such cases.

Sections 87:59 to 87:60 of this chapter focus on medical staff

[6]See § 87:22.

[7]See §§ 87:30 to 87:32.

[8]See §§ 87:33 to 87:35.

[9]See § 87:36.

and peer review litigation. The Health Care Quality Improvement Act (HCQIA) mandates that providers with organized medical staffs afford certain due process and fair hearing rights for professional review actions that may relate to a practitioner's clinical competence or professional conduct. As a result, decisions to grant, curtail or revoke medical staff privileges or to take other types of corrective actions are subject to intense legal challenge and may give rise to constitutional, discrimination, antitrust, and contract claims, among others. Sections 87:59 to 87:60 provide a case law analysis of the most common litigation pitfalls and tactics to avoid them.

The focus of Sections 87:61 to 87:65 is private antitrust litigation involving providers. These Sections include a discussion of the range of contexts in which private antitrust litigation has arisen, including class action lawsuits against providers—namely, health systems—seeking damages for consummated mergers.[10] These Sections also cover conspiracy and monopolization claims alleged between providers and payors for a variety of price-fixing conspiracies and refusals to deal, both unilateral and multilateral.[11]

Sections 87:66 to 87:68 follow with a discussion of two unique health care issues in bankruptcy cases involving providers: (i) the treatment of Medicare and Medicaid provider agreements as executory contracts;[12] and (ii) the ability of the government, as a creditor of a provider which has filed for bankruptcy protection, to assert setoff or recoupment rights with respect to alleged Medicare and Medicaid overpayments made prior to the bankruptcy filing.[13]

Finally, Sections 87:69 to 87:78 of this chapter address issues affecting providers when information about their patients may be relevant to proceedings in commercial litigation. In particular, those Sections discuss the procedural prerequisites to any use or disclosure of patient information, up to and potentially including the health care provider's obligation to seek a protective order for sensitive patient information. Those Sections also explain how obligations may differ depending on whether the health care provider is a party to the underlying commercial litigation or merely a source of discovery.

Government Enforcement Litigation

Sections 87:79 to 87:98 of this chapter focus on government

[10]See § 87:65.

[11]See §§ 87:62 to 87:64.

[12]See § 87:67.

[13]See § 87:68.

enforcement litigation involving providers. In Section 87:79, we present an overview of heightened government enforcement efforts in recent years to address fraud, waste, and abuse in health care, including the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) and the substantial recoveries obtained under the federal government's three principal tools for health care fraud prevention and enforcement: (i) the False Claims Act (FCA);[14] (ii) the Stark Law;[15] and (iii) the Anti-Kickback Statute (AKS).[16]

In Sections 87:80 to 87:87, for example, we discuss FCA actions against providers, with reference to the treatment of FCA litigation generally, addressing the types of conduct on which FCA claims against health care institutions have traditionally been based, significant case law specific to the health care area, and practical considerations and litigation strategies unique to health care institutions.

Sections 87:88 to 87:93 turn to the Stark Law[17] and the AKS,[18] and provide an overview of the elements, penalties and exceptions under those statues, a summary of significant case law interpreting recent amendments to and accompanying regulations of both laws, and a discussion of the Self-Disclosure Protocols,[19] designed to allow entities to self-report under the Stark Law and the AKS, as well as the benefits and risks associated with self-disclosure in the context of developing a comprehensive litigation strategy.

Sections 87:94 to 87:98 conclude with a discussion of the various governmental antitrust challenges to health care providers and payors. Buoyed by a string of victories in federal court, the Federal Trade Commission (FTC) and State Attorneys General have grown increasingly aggressive in challenges under Section 7 of the Clayton Act to combinations between hospitals.[20] The Department of Justice has continued to press monopolization claims[21] against both hospitals and private payors for efforts to leverage local market power to secure more favorable reimbursement rates or most-favored-nations status, while FTC continues to closely scrutinize efforts by physician groups to combine. In a market increasingly driven by the Affordable Care Act's mandate

[14]See §§ 87:80 to 87:87.

[15]See §§ 87:88 to 87:90.

[16]See §§ 87:91 to 87:93.

[17]See §§ 87:88 to 87:90.

[18]See §§ 87:91 to 87:93.

[19]See §§ 87:90, 87:92.

[20]See § 87:95.

[21]See § 87:96.

to lower overall costs through capitation and other risk-sharing mechanisms, health care providers, payors and the antitrust authorities are seeking a balance between achieving cost savings and the mandates of the antitrust laws. In addition, the FTC continues to push back on what it views as expansions of the state action doctrine, which immunizes many actions undertaken by or overseen by state governments, and it has aggressively and successfully campaigned to halt the use of reverse-payment patent litigation settlements (so-called "pay for delay") between pharmaceutical brand owners and generics.

One final note regarding this chapter is worth mentioning. Specifically, this chapter is not intended to be, nor is it, a comprehensive treatise on health care litigation in federal courts. Rather, the authors wrote this chapter to give the practitioner an introduction to this area and to highlight salient issues and developments. In this regard, the chapter should be a starting point for guidance in this area, but should not be the only place one looks.

II FEDERAL ADMINISTRATIVE LITIGATION

A. LITIGATION BEFORE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES DEPARTMENTAL APPEALS BOARD

§ 87:2 Overview

Providers are frequently drawn into administrative litigation[1] before the Department of Health and Human Services (HHS) Departmental Appeals Board (DAB), an entity which provides "impartial, independent review of disputed decisions in a wide range of [HHS] programs under more than 60 statutory provisions."[2] The DAB's jurisdiction covers disputes involving Medicare, Medicaid and other large public assistance grant programs and discretionary federal grant programs, as well as enforcement cases brought by the Centers for Medicare and Medicaid Services (CMS).[3] Although the DAB's decisions are subject to federal court review, the federal district court applies a deferential review standard and generally does not allow the

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[Section 87:2]

[1]See generally Chapter 139 "Administrative Agencies" (§§ 139:1 et seq.) for discussion of administrative agency adjudication and federal court review of those determinations.

[2]U.S. Dep't of Health & Human Servs., About DAB, available at http://www.hhs.gov/dab/about/index.html.

[3]U.S. Dep't of Health & Human Servs., About DAB, available at http://www.hhs.gov/dab/about/index.html.

more than $1,000.[3]

Venue is proper in the district court for the judicial district "in which the party resides or where such individual, institution, or agency has its principal place of business" or the United States District Court of the District of Columbia if the party does not reside within any judicial district, or if the individual, institution or agency does not have its principal place of business within any such judicial district.[4]

The regulations also set forth rules relating to timing for the filing of a civil action and permit the appellant to request an extension of time to file such an action, provided that such request meets certain criteria.[5]

Under the regulations, a court may not review a regulation or instruction that relates to a method of payment under Medicare Part B if the regulation was published, or the instructions issued, before January 1, 1991.[6] The regulations set forth a standard of review to be applied by the district courts which does not permit review or reversal of findings of fact supported by substantial evidence, which are deemed to be conclusive.[7] Finally, when the Secretary's decision is adverse to a party due to a party's failure to submit proof in conformity with a regulation prescribed under Section 205(a) pertaining to the type of proof a party must offer to establish entitlement to payment, the court will review only whether the proof confirms with the regulation and the validity of the regulation.[8]

III. FEDERAL BUSINESS LITIGATION

A. MANAGED CARE AND PAYOR-PROVIDER LITIGATION

§ 87:27 Overview

Federal court litigation involving providers and commercial payors, namely, insurance companies, has become increasingly common in recent years. Litigation of this type frequently arises as a result of insurer reimbursement, or failure to reimburse (whether in whole or in part), for services that a provider has rendered to a group health insurance plan member, provider billing practices and Medicare payment reductions due to federal

[3]42 C.F.R. § 405.1006(c)(1).

[4]42 C.F.R. § 405.1136(b)(1) to (2).

[5]42 C.F.R. § 405.1136(c); see also 42 C.F.R. §§ 405.1130, 1132, 1134.

[6]42 C.F.R. § 405.1136(e).

[7]42 C.F.R. § 405.1136(f)(1).

[8]42 C.F.R. § 405.1136(f)(2).

sequestration.

Provider claims relating to insurer reimbursement can be grouped into three broad categories: (i) "rate of payment" claims, which generally relate to the computation of payments made pursuant to a contract between the provider and insurer or the correct execution of such payment; (ii) "right to payment" claims, which implicate coverage and benefits established by the terms of a plan without regard to a provider agreement; and (iii) "hybrid claims," which challenge both the rate of and the right to payment.[1]

§ 87:28 Distinction between in-network and out-of-network providers

A threshold consideration with respect to reimbursement claims, from a provider perspective, is whether the provider is "in-network"?that is, has contracted with the insurer to provide services to members (insured patients) at pre-negotiated rates as set by contract—or "out-of-network"—that is, has not contracted with the insurer and, therefore, is not contractually guaranteed payment for services provided to members.

A provider's in- or out-of-network status may impact the types of claims that the provider may bring, the court in which the provider may bring them, and the body of law which will apply to those claims. For example, an in-network provider may look to contract law as a basis for actions challenging an insurer's failure to reimburse the provider because the provider's relationship with the insurer and its rights and obligations are governed and defined by the provider agreement.[1] Depending on the citizenship of the parties and the amount in controversy, such a claim could be brought in state or federal court in the first instance, or, if brought in state court, removed by the defendant-insurer.[2]

For years, out-of-network providers have also looked to state law (both common law and statutes) to challenge insurer conduct with respect to services rendered to health insurance plan

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[Section 87:27]

[1]Montefiore Medical Center v. Teamsters Local 272, 642 F.3d 321, 325, 50 Employee Benefits Cas. (BNA) 2496 (2d Cir. 2011); Borrero v. United Healthcare of New York, Inc., 610 F.3d 1296, 1302, 49 Employee Benefits Cas. (BNA) 1642 (11th Cir. 2010); Merrick v. UnitedHealth Group Inc., 127 F. Supp. 3d 138, 148 (S.D. N.Y. 2015).

[Section 87:28]

[1]CardioNet, Inc. v. Cigna Health Corp., 751 F.3d 165, 177-78, 58 Employee Benefits Cas. (BNA) 1001 (3d Cir. 2014).

[2]See generally Chapter 1 "Subject Matter Jurisdiction" (§§ 1:1 et seq.) and Chapter 12 "Removal to Federal Court" (§§ 12:1 et seq.).

members. In recent years, however, courts increasingly have held that such suits are preempted by, and must be brought under, the Employee Retirement Income Security Act of 1974 (ERISA), a federal statute which was enacted primarily to address public concerns of mismanagement and abuse relating to private pension plans, but which also regulates other employee benefits plans, including employer-sponsored health plans.[3] As a result of this growing body of caselaw, providers should consider ERISA as a potential vehicle to seek reimbursement from or challenge reimbursement decisions by insurers. Likewise, insurers faced with a claim relating to provider reimbursement should consider whether such a claim is preempted by ERISA.

§ 87:29 Preliminary procedural considerations

Four procedural issues are commonly litigated in connection with provider reimbursement claims under the Employee Retirement Income Security Act of 1974 (ERISA):[1] (i) preemption;[2] (ii) provider standing;[3] (iii) exhaustion of plan remedies or appeals processes;[4] and (iv) pleading specificity.[5] These issues are frequently raised by defendant-insurers in the context of removal petitions and/or motions to remand and motions to dismiss and, therefore, can either short-circuit a plaintiff-provider's lawsuit early on or result in protracted and expensive motions practice, delaying adjudication on the merits. As a result and due to their importance, we have placed our discussion of these issues at the beginning of our discussion of provider reimbursement claims, as they should be considered by practitioners representing providers before suit is filed. At the same time, practitioners representing insurers should consider whether these issues can be raised as affirmative defenses to complaints filed by providers seeking reimbursement for services rendered.

§ 87:30 Preliminary procedural considerations—Preemption

Preemption affects the types of claims which a provider may assert against an insurer, as well as the claims or counterclaims which an insurer may assert against a provider. Therefore,

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[3]See generally Chapter 106 "ERISA" (§§ 106:1 et seq.).

[Section 87:29]

[1]See generally Chapter 106 "ERISA" (§§ 106:1 et seq.).

[2]See §§ 87:30 to 87:32.

[3]See §§ 87:33 to 87:35.

[4]See § 87:36.

[5]See § 87:37.

whether state common law and statutory claims are preempted by the Employee Retirement Income Security Act of 1974 (ERISA)[1] is a frequently litigated issue among providers and insurers in connection with reimbursement claims.[2]

There are two primary forms of ERISA preemption — "complete" preemption[3] and "express" preemption.[4] Complete preemption occurs when a claim ostensibly arising under state law is recast as a federal claim because it seeks to recover benefits or enforce rights under an ERISA-covered plan and, therefore, is deemed to fall within the scope of the civil enforcement provision of Section 502(a) of ERISA.[5] Express preemption, also known as "defensive preemption" or "conflict preemption," arises under Section 514(a) of ERISA, which generally preempts any state law that "relate[s] to any employee benefit plan."[6] Both preemption concepts should be considered because they have the potential to affect a provider's choice of forum and choice of remedies.

§ 87:31 Preliminary procedural considerations—Preemption—Complete preemption

The complete preemption analysis as applied to provider reimbursement claims bears mention. Specifically, under the U.S. Supreme Court's decision in *Metropolitan Life Insurance Co. v. Taylor*, a state law claim is completely preempted if it falls within the scope of Section 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (ERISA),[1] which authorizes a participant or beneficiary to 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."[2] Where a state law complaint brought in state court is subject to complete preemp-

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[Section 87:30]

[1]See generally Chapter 106 "ERISA" (§§ 106:1 et seq.).

[2]See Chapter 106 "ERISA" (§§ 106:1 et seq.) for discussion of ERISA preemption. See Chapter 1 "Subject Matter Jurisdiction" (§§ 1:1 et seq.) for discussion of preemption generally.

[3]See § 87:31.

[4]See § 87:32.

[5]29 U.S.C.A. § 1132(a).

[6]29 U.S.C.A. § 1144(a).

[Section 87:31]

[1]See generally Chapter 106 "ERISA" (§§ 106:1 et seq.).

[2]Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 60 n.1, 107 S. Ct. 1542, 95 L. Ed. 2d 55, 8 Employee Benefits Cas. (BNA) 1417 (1987); see also Borrero, 610 F.3d at 1301 (Section 502(a) "definitively converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-

tion, it provides a basis for federal question jurisdiction and may be removed to federal court.[3]

The two-part *Davila* test determines whether a claim falls within the scope of Section 502(a) and, therefore, is completely preempted by ERISA. The *Davila* test requires two inquiries: (i) whether the plaintiff could have brought its claim under § 502(a); and (ii) whether no other legal duty supports the plaintiff's claim.[4] Both prongs must be satisfied for complete preemption to exist.[5]

With respect to the first *Davila* prong, courts have held that two requirements must be met: (i) the plaintiff's claim must fall within the scope of ERISA; and (ii) the plaintiff must have standing to sue under ERISA.[6] Courts have generally held that a "rate of payment" claim does not necessarily implicate an ERISA plan

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pleaded complaint rule"). Additionally, "ERISA creates a comprehensive civil enforcement scheme that completely preempts any state-law cause of action that duplicates, supplements, or supplants an ERISA remedy." Montefiore Med. Ctr., 642 F.3d at 327 (internal quotation omitted).

[3]See Chapter 1 "Subject Matter Jurisdiction" (§§ 1:1 et seq.) for discussion of federal question jurisdiction. See also Aetna Health Inc. v. Davila, 542 U.S. 200, 204, 124 S. Ct. 2488, 159 L. Ed. 2d 312, 32 Employee Benefits Cas. (BNA) 2569 (2004).

[4]Davila, 542 U.S. at 210; Connecticut State Dental Ass'n v. Anthem Health Plans, Inc., 591 F.3d 1337, 1345, 48 Employee Benefits Cas. (BNA) 1674 (11th Cir. 2009). See also Gardner v. Heartland Indus. Partners, LP, 715 F.3d 609, 613, 55 Employee Benefits Cas. (BNA) 2018 (6th Cir. 2013); Treasurer, Trustees of Drury Industries, Inc. Health Care Plan and Trust v. Goding, 692 F.3d 888, 897, 54 Employee Benefits Cas. (BNA) 1064, 83 Fed. R. Serv. 3d 743 (8th Cir. 2012); Montefiore Med. Ctr., 642 F.3d at 328; Hansen v. Harper Excavating, Inc., 641 F.3d 1216, 1221-23, 51 Employee Benefits Cas. (BNA) 1449 (10th Cir. 2011); Borrero, 610 F.3d at 1301; Lone Star OB/GYN Associates v. Aetna Health Inc., 579 F.3d 525, 530, 47 Employee Benefits Cas. (BNA) 2090 (5th Cir. 2009); Marin General Hosp. v. Modesto & Empire Traction Co., 581 F.3d 941, 946, 47 Employee Benefits Cas. (BNA) 2310 (9th Cir. 2009); Negron-Fuentes v. UPS Supply Chain Solutions, 532 F.3d 1, 7, 44 Employee Benefits Cas. (BNA) 1848 (1st Cir. 2008) (analyzing whether the plaintiff's claims are "in substance duplicated or supplanted by the ERISA cause of action . . . or instead whether all are directed at violation of a legal duty . . . independent of ERISA or the plan terms"); Franciscan Skemp Healthcare, Inc. v. Central States Joint Bd. Health and Welfare Trust Fund, 538 F.3d 594, 597, 44 Employee Benefits Cas. (BNA) 1609 (7th Cir. 2008); Pascack Valley Hosp. v. Local 464A UFCW Welfare Reimbursement Plan, 388 F.3d 393, 400, 33 Employee Benefits Cas. (BNA) 2575, 65 Fed. R. Evid. Serv. 859 (3d Cir. 2004), as amended, (Dec. 23, 2004).

[5]Gonzalez v. Wells Fargo Bank, N.A., 28 A.D. Cas. (BNA) 1602, 57 Employee Benefits Cas. (BNA) 1085, 21 Wage & Hour Cas. 2d (BNA) 535, 2013 WL 5435789, at *10 (S.D. Fla. 2013).

[6]Conn. State Dental, 591 F.3d at 1350; see related discussion regarding standing to bring suit under ERISA in §§ 87:31 to 87:33 and Chapter 106 "ERISA" (§§ 106:1 et seq.).

and, therefore, would not fall within the scope of ERISA.[7] On the other hand, courts have held that a "right to payment" claim does implicate an ERISA plan and, as such, would fall within ERISA's scope.[8] Finally, courts have held that hybrid claims that challenge both the right to payment and rate of payment fall within the scope of ERISA.[9] As an example, if the payor only paid the provider half of the amount due for a surgical procedure, that would be a "rate of payment claim"; by contrast, if the payor denied that the provider has any right to reimbursement at all, that would be a "right to payment" claim.

With respect to the second *Davila* prong, a court must determine whether the provider is suing the insurer based on an independent legal duty that is separate from the ERISA plan.[10] "If a party is suing under obligations created by the plan itself, instead of under obligations independent of the plan and the plan member, the alleged obligations implicate legal duties which are not entirely independent of ERISA, and thus are subject to complete preemption."[11] Thus, determination of benefits under the plan, including what is "medically necessary" or a "Covered Service," and whether there is coverage for the full amount of a provider's submitted charges, has been held to fall within ERISA.[12]

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[7]Borrero, 610 F.3d at 1302; Conn. State Dental, 591 F.3d at 1350; Omnibus Order, Jacobs v. Highmark Health, 1:14-cv-24725-UU at *5 (S.D. Fla. Mar. 12, 2015); Innova Hosp. San Antonio, L.P. v. Humana Ins. Co., 25 F. Supp. 3d 951, 963-64 (W.D. Tex. 2014). See § 87:27 for discussion of rate of payment claims.

[8]Borrero, 610 F.3d at 1302; Conn. State Dental, 591 F.3d at 1350; Omnibus Order, Jacobs v. Highmark Health, 1:14-cv-24725-UU at *5 (S.D. Fla. Mar. 12, 2015); Innova Hosp. San Antonio, L.P. v. Humana Ins. Co., 25 F. Supp. 3d 951, 963-64 (W.D. Tex. 2014). See § 87:27 for discussion of right of payment claims.

[9]Conn. State Dental, 591 F.3d at 1351. See § 87:27 for discussion of hybrid claims.

[10]Omnibus Order, 1:14-cv-24725-UU, at *5.

[11]Gables Ins. Recovery v. United Healthcare Ins. Co., 39 F. Supp. 3d 1377, 1388 (S.D. Fla. 2013) (internal quotations and citations omitted) ("If the right to payment derives from the ERISA benefit plan as opposed to another independent obligation, the resolution of a right to payment dispute requires an interpretation of the plan . . .. Thus, any determination of benefits under the terms of an ERISA plan, even regarding a seeming independent breach of oral or implied contract based on verification of those benefits, falls under ERISA and is a legal duty dependent on, not independent of, the ERISA plan."); see also Montefiore Med. Ctr., 642 F.3d at 332; South Broward Hosp. Dist. v. Coventry Health and Life Ins. Co., 2014 WL 6387264, at *7 (S.D. Fla. 2014).

[12]Lone Star OB/GYN Assocs., 579 F.3d at 531; Omnibus Order, 1:14-cv-24725-UU, at *5; Innova Hosp., 25 F. Supp. 3d at 963-64.