

United States District Court
Northern District of California

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN JOSE DIVISION

CALIFORNIA SPINE AND
NEUROSURGERY INSTITUTE,

Plaintiff,

v.

BOSTON SCIENTIFIC CORPORATION,

Defendant.

Case No. 18-CV-07610-LHK

**ORDER GRANTING MOTION TO
REMAND AND DENYING REQUEST
FOR EXPENSES AND FEES**

Re: Dkt. No. 18

Plaintiff California Spine and Neurosurgery Institute (“Plaintiff”) brings suit against Defendant Boston Scientific Corp. (“Defendant”) alleging breach of oral contract and promissory estoppel. Plaintiff originally brought suit in the Superior Court of Santa Clara County but Defendant removed the suit to the United States District Court for the Northern District of California. Before the Court is Plaintiff’s motion to remand and for attorneys’ fees and costs. Having considered the submissions of the parties, the relevant law, and the record in this case, the Court GRANTS Defendant’s motion to remand and DENIES Defendant’s request for attorneys’ fees and costs.

I. BACKGROUND

A. Factual Background

1 Plaintiff is a provider of medical services. ECF No. 1-1 (“Compl.”) at ¶ 19. Defendant is a
2 health insurance company providing health coverage to subscribers or dependents of subscribers
3 under insurance policies underwritten by Defendant. *Id.* at ¶ 7. In the healthcare industry, medical
4 services providers sometimes enter into a contract with a health insurance company such that the
5 health services providers are “in network” with the health insurer, which allows subscribers to the
6 health insurer to “pay lower co-payments and deductibles to obtain care and treatment from a
7 contracted [healthcare] provider.” *Id.* at ¶¶ 10-11. Being “in network” with a health insurer also
8 allows the health insurer to set rates of pay for services rendered by the healthcare provider. *Id.* at
9 ¶ 9.

10 Plaintiff is an “out-of-network provider” or “non-participating provider,” meaning that
11 Plaintiff has not entered into contracts with health insurance companies. *Id.* In particular, Plaintiff
12 does not have a written contract with the Defendant setting rates of pay for services rendered by
13 the Plaintiff. *Id.* Being an out-of-network provider means that to “properly determine whether or
14 not to provide medical services to a patient, the common practice . . . is to obtain a separate oral
15 promise and assurance of payment from the [health insurer].” *Id.* at ¶ 15. It is common practice for
16 a health insurer to pay “a percentage of the market rate for the procedure, also described as [] an
17 average payment for the procedure performed or provided by similarly situated medical providers
18 within similarly situated areas or places of practice.” *Id.* at ¶ 16. Health insurers typically use the
19 phrase “usual, customary, [and] reasonable” (“UCR”) to describe how much a health insurer is
20 willing to pay for medical services provided by an out-of-network provider. *Id.*

21 On March 5, 2018, Plaintiff’s employee phoned Defendant to ascertain what kind of health
22 coverage Defendant would offer one of Plaintiff’s Patients. *Id.* at ¶ 19. The Patient in question was
23 one of Defendant’s insureds, *id.* at ¶ 6, meaning that the Patient was a participant in an employee
24 health benefit plan governed by the Employee Retirement Income and Security Act of 1974
25 (“ERISA”), ECF No. 2-1. Plaintiff alleges that Defendant offered “promises and information . . .
26 that DEFENDANT would pay for the services to be provided to Patient and under what terms that
27 payment would be made.” Compl. at ¶ 19. In particular, Defendant allegedly informed Plaintiff

1 that the Patient had a deductible and a maximum out of pocket limit for healthcare of \$6,000, of
 2 which \$0 had been paid. *Id.* at ¶ 21. Plaintiff was allegedly promised that Defendant would pay
 3 80% of the UCR rate once the Patient met his or her deductible. Moreover, after the Patient met
 4 the maximum out of pocket limit, Plaintiff was allegedly promised that Defendant would pay
 5 100% of the UCR rate. *Id.* at ¶ 22.

6 After allegedly receiving these promises from Defendant, on August 2, 2018, the Patient
 7 underwent a surgical procedure performed by Plaintiff. *Id.* at ¶ 18. Following the procedure,
 8 Plaintiff submitted its claims to Defendant accompanied by the Patient's various medical records.
 9 *Id.* at ¶ 29. Defendant processed Plaintiff's bill but determined to pay Plaintiff \$0 out of a total
 10 billed amount of \$77,000. *Id.* at ¶ 30.

11 **B. Procedural History**

12 On October 19, 2018, Plaintiff filed a complaint in the California Superior Court of Santa
 13 Clara County. ECF No. 1-1 at summons. Plaintiff asserted two causes of action: (1) breach of oral
 14 contract, and (2) promissory estoppel. *Id.* at 6-7. On December 19, 2018, Defendant removed the
 15 case to the United States District Court of the Northern District of California. ECF No. 1 at 2.
 16 Defendant removed the case even though the complaint contained state law causes of action
 17 because Defendant believed that Plaintiff raised a cause of action under federal law. *Id.* at 3.
 18 Specifically, Defendant believed that ERISA, 29 U.S.C. § 1001, *et seq.* completely preempted
 19 Plaintiff's state law claims such that the Northern District of California would have original
 20 jurisdiction over Plaintiff's claims. *Id.*

21 On January 24, 2019, Plaintiff filed a motion to remand the case back to state court and to
 22 seek expenses and fees. ECF No. 18 ("Mot."). On February 7, 2019, Defendant filed an
 23 opposition. ECF No. 22 ("Opp."). On February 14, 2019, Plaintiff filed a reply. ECF No. 23
 24 ("Reply").

25 **II. LEGAL STANDARD**

26 **A. Motion to Remand**

27 A suit may be removed from state court to federal court only if the federal court would

1 have had subject matter jurisdiction over the case. 28 U.S.C. § 1441(a); *see Caterpillar Inc. v.*
 2 *Williams*, 482 U.S. 386, 392 (1987) (“Only state-court actions that originally could have been filed
 3 in federal court may be removed to federal court by the defendant.”). If it appears at any time
 4 before final judgment that the federal court lacks subject matter jurisdiction, the federal court must
 5 remand the action to state court. 28 U.S.C. § 1447(c).

6 The party seeking removal bears the burden of establishing federal jurisdiction. *Provincial*
 7 *Gov’t of Marinduque v. Placer Dome, Inc.*, 582 F.3d 1083, 1087 (9th Cir. 2009). “The removal
 8 statute is strictly construed, and any doubt about the right of removal requires resolution in favor
 9 of remand.” *Moore-Thomas v. Alaska Airlines, Inc.*, 553 F.3d 1241, 1244 (9th Cir. 2009) (citing
 10 *Gaus v. Miles, Inc.*, 980 F.2d 564, 566 (9th Cir. 1992)).

11 **B. Request for Attorneys’ Fees**

12 Following remand of a case upon unsuccessful removal, the district court may award “just
 13 costs and any actual expenses, including attorney fees, incurred as a result of the removal.” 28
 14 U.S.C. § 1447(c). The award of fees and costs is within the discretion of the district court. *Lussier*
 15 *v. Dollar Tree Stores, Inc.*, 518 F.3d 1062, 1065 (9th Cir. 2008). Nonetheless, “[a]bsent unusual
 16 circumstances, courts may award attorney’s fees under § 1447(c) only where the removing party
 17 lacked an objectively reasonable basis for seeking removal. Conversely, when an objectively
 18 reasonable basis exists, fees should be denied.” *Martin v. Franklin Capital Corp.*, 546 U.S. 132,
 19 141 (2005).

20 The objective reasonableness of removal depends on the clarity of the applicable law and
 21 whether such law “clearly foreclosed the defendant’s basis of removal.” *Lussier*, 518 F.3d at 1066-
 22 67. “If the law in the Ninth Circuit is not so clear as to make the removing party’s endeavor
 23 entirely frivolous, a court will deny the request for attorney’s fees.” *FSM Dev. Bank v. Arthur*,
 24 2012 WL 1438834, at *7 (N.D. Cal. Apr. 25, 2012) (brackets omitted).

25 **III. DISCUSSION**

26 Plaintiff’s motion deals with two separate but interrelated issues. First, Plaintiff argues that
 27 the case ought to be remanded to state court because Plaintiff’s causes of action are not completely
 28

1 preempted by ERISA. Second, Plaintiff seeks fees and costs for improper removal. The Court
2 discusses each issue in turn.

3 **A. ERISA Preemption**

4 Plaintiff argues that this action was incorrectly removed because Plaintiff does not have
5 standing to bring a claim under the ERISA statute. Mot. at 5. Defendant responds by contending
6 that Plaintiff's two state law claims "are merely a disguised claim for benefits under ERISA."
7 Opp. at 7. The Court finds Plaintiff's argument more compelling.

8 "[R]emoval on ERISA grounds is only appropriate if ERISA completely preempts a state
9 law claim." *Holloway v. Gilead Scis., Inc.*, 2016 WL 3526060, at *1 (N.D. Cal. June 23, 2016)
10 (citing *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 944-45 (9th Cir.
11 2009)). If removal was improper, "the district court lack[s] subject matter jurisdiction, and the
12 action should [be] remanded to the state court." *Doctors Med. Center of Modesto, Inc. v. Principal*
13 *Mut. Life Ins. Co.*, 2008 WL 4790534, at *2 (E.D. Cal. Aug. 28, 2008) (quoting *Matheson v.*
14 *Progressive Specialty Ins. Co.*, 319 F.3d 1089, 1090 (9th Cir. 2003)).

15 The United States Supreme Court's decision in *Aetna Health Inc. v. Davila* "sets forth a
16 two-prong test for determining whether a state law claim is completely preempted by ERISA's
17 civil enforcement provision. Under that test, a state law cause of action is completely preempted if
18 (1) the plaintiff, 'at some point in time, could have brought [the] claim under ERISA §
19 502(a)(1)(B),' and (2) 'there is no other independent legal duty that is implicated by [the]
20 defendant's actions.'" *Hansen v. Grp. Health Coop.*, 902 F.3d 1051, 1059 (9th Cir. 2018) (quoting
21 *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004)). "[T]his test from *Davila* is conjunctive,
22 and both elements need to be met to show complete preemption." *Id.*

23 In the instant case, the Court finds that Plaintiff could not have brought its claims under
24 ERISA § 502(a)(1)(B), so the first prong of the *Davila* test is not met. ERISA § 502(a)(1)(B)
25 provides:

26 A civil action may be brought—(1) by a participant or beneficiary—
27 . . . (B) to recover benefits due to him under the terms of his plan, to

1 enforce his rights under the terms of the plan, or to clarify his rights
to future benefits under the terms of the plan.”

2 In other words, an ERISA *participant* or *beneficiary* may bring a civil action to “recover benefits
3 due to him under the terms of his plan.” *Id.* “Participant” is defined as “any employee or former
4 employee of an employer, or any member or former member of an employee organization, who is
5 or may become eligible to receive a benefit of any type from an employee benefit plan which
6 covers employees of such employer or members of such organization, or whose beneficiaries may
7 be eligible to receive any such benefit.” 29 U.S.C. § 1002(7). “Beneficiary” is defined as “a person
8 designated by a participant, or by the terms of an employee benefit plan, who is or may become
9 entitled to a benefit thereunder.” *Id.* § 1002(8).

10 Under Ninth Circuit law, “ERISA does not preempt ‘claims by a third party [medical
11 provider] who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an
12 independent entity claiming damages.’” *Catholic Healthcare West-Bay Area v. Seafarers Health
13 & Benefits Plan*, 321 Fed. App’x 563, 564 (9th Cir. 2008) (emphasis in original) (quoting *The
14 Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1008 (9th Cir. 1995)). Specifically, “ERISA
15 only permits suits brought by an ERISA plan’s participants, beneficiaries, fiduciaries, or assignees
16 of those individuals—not other third parties” such as a hospital. *Cnty. Hosp. of the Monterey
17 Peninsula v. Wm. Michael Stemler, Inc.*, 2013 WL 5312865, at *2 (N.D. Cal. Sept. 23, 2013); *see
18 also Quaresma v. BC Life & Health Ins. Co.*, 623 F. Supp. 2d 1110, 1116 (E.D. Cal. 2007) (“A
19 healthcare provider’s suit against an ERISA plan for payment is generally not subject to removal
20 because the provider is neither an ERISA ‘beneficiary’ nor a ‘participant’” (emphasis in
21 original)).

22 Here, there is no dispute that Plaintiff—a medical care provider—is neither a “beneficiary”
23 nor a “participant” to Defendant’s ERISA plan according to the statutory definitions of
24 “beneficiary” and “participant.” Moreover, there is no evidence in the record that the Patient ever
25 assigned his or her rights to Plaintiff, the medical provider. Thus, Plaintiff is also not the Patient’s
26 assignee. Per *Community Hospital*, “ERISA only permits suits brought by an ERISA plan’s
27 participants, beneficiaries, fiduciaries, or assignees.” Plaintiff is none of the aforementioned, so
28

1 Plaintiff could not have brought suit under ERISA § 502(a)(1)(B). Therefore, the first prong of the
2 *Davila* test—whether Plaintiff could have brought suit under ERISA § 502(a)(1)(B)—is not
3 satisfied.

4 The Ninth Circuit’s decision in *Marin Gen. Hosp.*, 581 F.3d 941, supports this Court’s
5 conclusion that Plaintiff could not have brought its claims under ERISA. In *Marin*, the hospital
6 telephoned a patient’s insurance company, which allegedly “verified the patient’s coverage,
7 authorized treatment, and agreed to cover 90% of the patient’s medical expenses at the Hospital.”
8 *Id.* at 943. After the *Marin* patient underwent the procedure, the patient’s insurance policy paid the
9 hospital part of what the hospital believed was owed. *Id.* However, the patient’s insurance
10 company refused to make any further payment. *Id.* Thus, the hospital filed suit in California state
11 court alleging, *inter alia*, breach of an oral contract and estoppel. *Id.* at 944. The insurance
12 company defendant removed to federal district court “on the ground that ERISA completely
13 preempted the Hospital’s claims.” *Id.* The hospital subsequently moved for remand, arguing that
14 ERISA did not preempt the hospital’s state law claims.

15 The Ninth Circuit held that the hospital’s state law claims were not preempted by ERISA
16 because the “Hospital does not contend that it is owed this additional amount because it is owed
17 under the patient’s ERISA plan. Quite the opposite. The Hospital is claiming this amount precisely
18 because it is not owed under the patient’s ERISA plan. The Hospital is contending that this
19 additional amount is owed based on its alleged oral contract with [the patient’s insurer].” *Id.* at
20 947.

21 *Marin* is highly analogous to the instant case. Here, Plaintiff brings two state law claims,
22 breach of oral contract and promissory estoppel, claims also brought by the *Marin* hospital.
23 Moreover, like *Marin*, Plaintiff does not contend it is owed more money under the Patient’s
24 ERISA plan. Rather, Plaintiff contends that it is owed more money based on the alleged oral
25 contract with Defendant, as evidenced by Plaintiff’s breach of oral contract cause of action. *Marin*
26 is clear that a claim that a medical provider is owed additional money based on an oral contract is
27 a different obligation than a payment to a medical provider required under a patient’s ERISA plan.

1 *Id.* at 498. Thus, Plaintiff “is suing in its own right pursuant to an independent obligation.” *Id.*

2 Defendant attempts to distinguish *Marin* to no avail. Defendant argues that the instant case
3 is different because unlike in *Marin*, here, Plaintiff’s call with Defendant exclusively “concerned
4 the Plan and the [Patient’s] rights under it” and because the insurance company did not “request or
5 authorize the Surgery or promise, guarantee, or otherwise agree to pay for it.” Opp. at 8. However,
6 in *Marin*, the phone call about the patient’s coverage also focused on the “patient’s coverage,
7 [and] authorized treatment” under the patient’s insurance plan. Likewise, in *Marin*, it is disputed
8 whether the *Marin* insurance company telephonically “agreed to cover 90% of the patient’s
9 medical expenses.” 581 F.3d at 943-44.

10 In addition, Defendant argues that the phone call that took place between Plaintiff and
11 Defendant to discuss the Patient’s out-of-network coverage indicated that Plaintiff was the
12 Patient’s assignee. Opp. at 11. Not so. In the context of an ERISA action, “an assignee’s standing
13 is limited to the scope of the assignment.” *Metcalf v. Blue Cross Blue Shield of Michigan*, 57 F.
14 Supp. 3d 1281, 1293 (D. Or. 2014). Simply because the Patient may have assigned his or her right
15 to communicate with Defendant about the Patient’s coverage under an out-of-plan provider fails to
16 prove that the Patient assigned to Plaintiff rights to pursue an ERISA action against Defendant.

17 Moreover, Defendant cites *Lodi Mem’l Hosp Ass’n v. Tiger Lines, LLC*, 2015 WL
18 5009093, at *6 (E.D. Cal. Aug. 20, 2015), for the notion that a court can *assume* an assignment of
19 rights to sue under ERISA existed based on the medical provider’s conduct. However, *Lodi* is
20 distinguishable because the *Lodi* defendants submitted a declaration attesting to the fact that “for
21 each claim form submitted by Plaintiff for payment, Lodi Memorial indicated that it had received
22 an assignment of benefits from the patient.” *Id.* at *5. No such declaration exists in the instant
23 case. Moreover, in *Lodi*, “the Complaint itself alleges that Plaintiff billed the [insurance] Plan
24 directly and received payment directly from the Plan.” *Id.* at *6. The Court in *Lodi* noted that such
25 billing is “only possible with an assignment of benefits.” *Id.* The instant complaint does not allege
26 that Plaintiff directly billed the Patient’s insurance plan.

27 In sum, Defendant has demonstrated that the first prong of the *Davila* test is not satisfied.

1 Because the “two-prong test of *Davila* is in the conjunctive,” *Marin*, 581 F.3d at 947, the Court
 2 need not discuss the second prong of the *Davila* test. The Court finds that Plaintiff’s claims are not
 3 completely preempted by ERISA, and thus, remand is warranted.

4 **B. Fees and Costs for Improper Removal**

5 “An order remanding a removed case to state court may require payment of just costs and
 6 any actual expenses, including attorney fees, incurred as a result of the removal.” *Martin v.*
 7 *Franklin Capital Corp.*, 546 U.S. 132, 134 (2005). “Absent unusual circumstances, courts may
 8 award attorney’s fees . . . only when the removing party lacked an objectively reasonable basis for
 9 seeking removal.” *Id.* at 141. “[W]hether a removal is improper is not dispositive in determining
 10 whether fees should be awarded” *Gardner v. UICI*, 508 F.3d 559, 562 (9th Cir. 2007). Fees
 11 are awarded at the discretion of the district court. *Toxic Injuries Corp. v. Safety-Kleen Corp.*, 57 F.
 12 Supp. 2d 947, 957 (C.D. Cal. 1999).

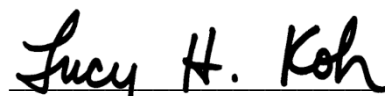
13 Though Plaintiff prevailed, the Court, in its discretion, declines to award any fees and
 14 costs. Although Defendant’s arguments were ultimately unpersuasive, there is no evidence that
 15 Defendant’s arguments were “frivolous or an improper basis for removal.” *Id.* at 958. Indeed,
 16 Defendant relied on evidence that suggested that the Patient assigned some of his or her rights to
 17 Plaintiff. Opp. at 11. Had there been an assignment of the right to pursue relief under the ERISA
 18 statute, removal would have been proper. Thus, like the *Toxic Injuries* court, this Court does not
 19 award fees and costs because the removal was not “so obviously barred as to warrant an award.”
 20 *Id.*

21 **IV. CONCLUSION**

22 For the foregoing reasons, the Court REMANDS the instant action to the Superior Court of
 23 Santa Clara County. Moreover, the Court DENIES Defendant’s request for fees and costs.

24 **IT IS SO ORDERED.**

25 Dated: May 3, 2019

26 

27 LUCY H. KOH
 28 United States District Judge