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NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION EIGHT

DOUGLAS HOPPER, Plaintiff and Respondent, v. ANTHEM BLUE CROSS OF CALIFORNIA et al., Defendants and Appellants.	B277039 (Los Angeles County Super. Ct. No. BC527570)

APPEAL from a judgment of the Superior Court of Los Angeles County, William F. Highberger, Judge. Affirmed.

Douglas Hopper, in pro. per.; Law Offices of Anne L. Holland and Anne L. Holland for Plaintiff and Appellant.

Foley & Lardner, Eileen R. Ridley and Alan R. Ouellette for Defendants and Respondents.

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Douglas Hopper appeals from a judgment denying his petition to vacate an arbitration award and confirming the award in favor of respondent Anthem Blue Cross of California (Anthem). The award involved fraudulent claims submitted to Anthem by Hopper's agent and Anthem's recoupment of payments made for those claims. Hopper argues the arbitration award should be vacated because the arbitration panel refused to allow him to pursue a claim under the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001 et seq.). Because the panel correctly concluded he did not have authority to bring an ERISA claim, we affirm.

BACKGROUND

In 1983, Hopper, a doctor and healthcare provider, entered a "Participating Provider Agreement" with Anthem (the Provider Agreement), a healthcare insurer, to provide medical services to Anthem members. He terminated that agreement in 2008. In 2013, he filed a state court complaint against Anthem. The complaint asserted individual and class claims based on Anthem's alleged practice of "clipping," or deducting prior overpayments from later claims submitted by Hopper to Anthem between 2010 and 2013. The overpayments were made for services Anthem claimed either were not provided or were misrepresented on claim forms.

Based upon the Provider Agreement, Anthem moved to compel arbitration of Hopper's individual claims pursuant to the Federal Arbitration Act (FAA) (9 U.S.C. § 1 et seq.) and to dismiss his class claims. The court found that the FAA applied and granted the motion: It dismissed the class claims and sent the parties to arbitration to resolve the individual claims.

On June 19, 2014, Hopper filed his demand for arbitration with the American Arbitration Association (AAA) pursuant to the terms of the Provider Agreement. Based on his "clipping" allegations, Hopper asserted claims for violation of Business and Professions Code section 17200, fraud, conversion, violation of fair procedure, intentional and negligent interference with prospective economic advantage, and declaratory and injunctive relief. His demand did not assert a claim under ERISA. Anthem filed counterclaims for intentional misrepresentation, concealment, violations of Business and Professions Code section 17200, and declaratory relief, based upon allegations Hopper or his agents submitted fraudulent claims to Anthem exceeding $200,000.

The arbitration hearing was originally scheduled for May 2015 but was continued to October 2015 due to Hopper's delay in producing documents. According to Anthem's counsel, during a June 25, 2015 conference with the panel, Hopper requested leave to submit an amended arbitration demand, which the panel granted. The panel also permitted Anthem to file objections to the proposed amended demand. The stated purpose of the amendment was to correct false allegations of fact in the original demand. Hopper did not inform the panel he intended to add a claim under ERISA.

On July 7, 2015, Hopper submitted his proposed amended arbitration demand, which added an ERISA claim, among other changes. He alleged essentially that Anthem's withholding of payments constituted an "adverse benefit determination" under ERISA, subjecting Anthem to ERISA's rules and regulations for notice and review. He alleged he had "standing" as a "beneficiary" under ERISA to assert this claim because Anthem

"paid the benefits directly to [him] pursuant to assignments" from his patients assigning their rights to him to receive benefits under their insurance plans.

Anthem objected to the proposed amendment. Anthem argued that (1) the ERISA claim was untimely because there was no good cause for Hopper's delay and (2) Hopper lacked "standing" to sue for ERISA violations because he was not an ERISA "beneficiary" with the right to enforce ERISA notice and review rules.

Hopper responded to Anthem's objections. He argued that he had standing under ERISA to enforce his patients' rights through the assignments they signed, and submitted a document reflecting one such assignment.

The panel issued a tentative ruling denying Hopper's request to add an ERISA claim and inviting him to respond to other issues. Hopper submitted additional argument on his ERISA claim. The panel then held oral argument on the request. After argument, Hopper submitted additional argument via e-mail.

While the panel granted Hopper's request to amend certain other claims, it denied his request to add an ERISA claim. It reasoned: "The Panel finds that Claimant does not have standing to bring these derivative claims. The request to amend is also untimely as the arbitration hearing will occur on October 12, 2015. The addition of an ERISA claim would change the scope of the hearing and require additional preparation on new issues which have not been raised in the year the case has been pending. The hearing has previously been continued because of a delay by Claimant in producing documents. In addition to the substantive finding on standing, the Panel finds that further

delay is not warranted and undermines the value of arbitration. Claimant has been provided time and opportunity to meet the objections raised."

After this ruling, Hopper submitted additional argument on his ERISA claim. In response, the panel wrote, "The Panel's ruling is based on the AAA Rules granting the arbitrators discretion on whether to allow the filing of an Amended Claim; the date on which the Amended claim was first asserted; the ERISA standing allegations in the First Amended Demand and the cases cited on ERIS[A] by both Parties in the briefs. The ruling is not based on one case cited. We look to the Supreme Court and the Ninth Circuit for controlling caselaw. Other decisions can be instructive if the court's discussion or analysis is of similar legal issues."

Anthem later filed a motion for summary adjudication of Hopper's claims and its own fraud-based counterclaims. The panel granted the motion, awarding Anthem $166,827.06 plus interest, which represented the outstanding amounts Anthem had not yet recouped from Hopper. Anthem declined to proceed on its remaining counterclaims. Hopper filed a motion for reconsideration. The panel denied the motion and entered the final award in favor of Anthem.

Hopper filed a petition in the trial court to vacate the award, arguing among other points that the panel exceeded its jurisdiction and failed to hear material evidence when it denied his request to add an ERISA claim. Anthem responded to the petition and requested the court confirm the award. The court denied the petition and confirmed the award, entering judgment in favor of Anthem. Hopper appealed.

DISCUSSION

Hopper's appeal focuses exclusively on the panel's denial of his request to add an ERISA claim. We review de novo the trial court's decision confirming the arbitration award. (*Lindenstadt v. Staff Builders, Inc.* (1997) 55 Cal.App.4th 882, 892, fn. 7.) The parties disagree whether state or federal law applies to our review of the arbitration award itself. It makes no difference because Hopper seeks review under two subdivisions that are substantially the same under both federal and state law: "The arbitrators exceeded their powers and the award cannot be corrected without affecting the merits of the decision upon the controversy submitted," and "[t]he rights of the party were substantially prejudiced by the refusal of the arbitrators to postpone the hearing upon sufficient cause being shown therefor . . . ." (Code Civ. Proc., § 1286.2, subd. (a)(4) & (5); see 9 U.S.C. § 10(a)(3) & (4) [award may be vacated "where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown" or "where the arbitrators exceeded their powers"].)

Generally we may not vacate an award based on errors of fact or law. (*Moncharsh v. Heily & Blase* (1992) 3 Cal.4th 1, 11 (*Moncharsh*); *Biller v. Toyota Motor Corp.* (9th Cir. 2012) 668 F.3d 655, 662-663 (*Biller*).) But Hopper invokes a narrow exception that "[a]rbitrators may exceed their powers by issuing an award that violates a party's unwaivable statutory rights or that contravenes an explicit legislative expression of public policy." (*Richey v. AutoNation, Inc.* (2015) 60 Cal.4th 909, 916.) He relies on *Pearson Dental Supplies, Inc. v. Superior Court* (2010) 48 Cal.4th 665 (*Pearson Dental*), which involved an arbitration award rejecting an employee's statutory employment

claims as time-barred. The court held the arbitrator clearly erred in concluding the employee's claims were time-barred, and that error was reviewable because the arbitration involved unwaivable statutory claims and the legal error deprived the employee of a hearing on the merits. (*Id.* at p. 675.)

We will assume for the sake of analysis that Hopper's ERISA claim involves unwaivable statutory rights subject to *Pearson Dental*. To determine if the panel's decision is reviewable, *Pearson Dental* instructs us to address two issues: (1) whether the panel made an error of law in denying Hopper's request to add an ERISA claim and (2) if there was such an error, whether there are sufficient grounds to vacate the award. (*Pearson Dental, supra,* 48 Cal.4th at pp. 672-673.) Because we find the panel made no error of law in finding Hopper lacked statutory authority to bring his proposed ERISA claim, we need not address the second question. Nor do we need to address the panel's alternate finding that Hopper's request to add the ERISA claim was untimely.[1]

ERISA specifies that "a participant or beneficiary" may 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." (29 U.S.C. § 1132(a)(1)(B); see *Blue Cross v. Anesthesia Care Associates Medical Group, Inc.* (9th Cir. 1999) 187 F.3d 1045, 1050-1051 (*Anesthesia Care*).) Many courts have held a healthcare provider like Hopper is neither a plan "participant" nor a "beneficiary" under the statute. (See *DB Healthcare, LLC*

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[1] The parties argue extensively about ERISA preemption, but we need not address that issue either. Hopper only raises that point in arguing his request to amend was timely.

v. Blue Cross Blue Shield of Ariz., Inc. (9th Cir. 2017) 852 F.3d 868, 874-875 (*DB Healthcare*); *Brown v. Bluecross Blueshield of Tenn., Inc.* (6th Cir. 2016) 827 F.3d 543, 545-546 (*Brown*); *Pa. Chiropractic Ass'n v. Independence Hospital Indem. Plan, Inc.* (7th Cir. 2015) 802 F.3d 926, 929; *Rojas v. Cigna Health & Life Ins. Co.* (2d Cir. 2015) 793 F.3d 253, 257; *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.* (9th Cir. 2014) 770 F.3d 1282, 1289 (*Spinedex*).)

The only way Hopper can bring a civil action to enforce ERISA is "derivatively, relying on [his] patients' assignments of their benefits claims." (*Spinedex, supra,* 770 F.3d at p. 1289; see *DB Healthcare, supra,* 852 F.3d at p. 874.) He asserts he obtained assignments from patients that stated in pertinent part: "I hereby assign all rights and benefits under my contract with my insurance company to Douglas Hopper, MD for the purposes of determining the details of the benefits of my policy and obtaining payment for services given. [¶] The assignment further permits Dr. Hopper to obtain from my insurance all information necessary, for a determination of benefits allowed under the contract and permits the direct disclosure to Dr. Hopper of all information including the benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered. [¶] The assignment shall allow Dr. Hopper to take actions necessary to obtain the benefits I have, in good faith, been promised by my insurance. All benefits are to be paid directly to Dr. Hopper."

Hopper argues these assignments gave him the authority to sue to enforce ERISA claims procedures contrary to Anthem's recoupments. He is incorrect. Anthem had authority to recoup overpayments by virtue of the parties' Provider Agreement,

which had nothing to do with his patients' "rights and benefits" under any ERISA-covered benefit plan. The Provider Agreement was purely between Hopper and Anthem, and as the arbitration panel found, it gave Anthem "the right to offset any overpayments to Dr. Hopper against any amounts payable to 'the physician'."[2] Hence, "[t]he dispute here is not over the *right* to payment, which might be said to depend on the patients' assignments to the Providers, but the *amount*, or level, of payment, which depends on the terms of the provider agreements." (*Anesthesia Care, supra*, 187 F.3d at p. 1051 [dispute over fee schedule set by provider agreements did not fall within patient assignment of right to benefits].) Because Hopper's patients could not have brought an ERISA claim to challenge Anthem's recoupments, neither could Hopper. (*Brown, supra*, 827 F.3d at p. 548 ["A healthcare provider-assignee 'stands in the shoes of the beneficiary,' and can only assert claims that could have been brought by patients themselves."].)

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[2] The agreement stated: " 'Any amount paid by BLUE CROSS to PHYSICIAN under this Agreement determined subsequently by BLUE CROSS to have been an overpayment, or any amount owed by PHYSICIAN TO BLUE CROSS for any reason, will be considered indebtedness of PHYSICIAN to BLUE CROSS. BLUE CROSS shall have a first lien in the amount of such indebtedness and may, at its sole option, recover such indebtedness by: (i) requesting a refund from PHYSICIAN; and/or (ii) deducting from and setting off any amount or amounts due and payable from BLUE CROSS to PHYSICIAN [at] any time under this Agreement or any other agreement between BLUE CROSS and PHYSICIAN, or for any reason, an amount or amounts equal to such indebtedness of PHYSICIAN.' "

DB Healthcare is on point. In that case, insurers sought to recover payments from providers made in error. For one provider, the insurer withheld reimbursements from unrelated claims as a means of recouping the disputed past payments, the same procedure Anthem followed here. (*DB Healthcare, supra,* 852 F.3d at p. 871.) That provider sued to stop the offsetting and claimed the recoupment violated the same ERISA claims procedure regulations Hopper seeks to enforce. (*DB Healthcare*, at p. 873.) To establish authority to sue under ERISA, the provider relied on patient assignments that stated, " 'I Hereby Authorize My Insurance Benefits to Be Paid Directly to the Physician.' " (*DB Healthcare*, at p. 876.) The court interpreted the language to assign the provider only the right to payment of benefits, and not the right to prevent the insurer from offsetting overpayments by deducting from other payments due to the provider. (*Id*. at pp. 876-877.)

While the patient assignment in *DB Healthcare* was narrower than Hopper's patient assignment here, the court also reasoned that the provider's challenge to the recoupment was "not a suit to recover benefits under the ERISA plans. Rather, the claim relates to [the insurer's] process of post-payment claims review and practice of recouping erroneous payments. These are claims that the [provider's] 'patient-assignors could not assert,' [citation] as any recoupment would come from Providers not from the patients. [Citation.] The claims therefore do not fall within the scope of the assignment. [Citation.] Although a 'dispute . . . over the *right* to payment . . . might be said to depend on the patients' assignments to the Providers,' the dispute over recoupment 'depends on the terms of the provider agreements,'

not on the assignment." (*DB Healthcare, supra,* 852 F.3d at pp. 877-878.)

Similarly, in *Brown*, a healthcare provider sued an insurer under ERISA to recover recoupment payments and prevent further recoupment payments after the insurer found certain payments to the provider were improper. (*Brown, supra,* 827 F.3d at p. 545.) As authority to bring ERISA claims, the provider relied on patient assignments stating, " 'I request that payment of authorized insurance benefits . . . be made on my behalf' " to the provider. (*Brown*, at p. 544, fn. 1.) Again, although that assignment was narrower than Hopper's, the court held the providers' claims fell outside the assignment because the claims involved the recoupment process under the agreement between the provider and the insurer, which could not have been brought by the patients and did not implicate any rights held by patients or assigned to the providers. (*Id.* at p. 549.)[3]

As in *DB Healthcare* and *Brown*, Hopper lacked authority to assert an ERISA claim to challenge Anthem's recoupments arising under the Provider Agreement. Thus, the arbitration panel made no error of law when it rejected Hopper's proposed

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[3] Hopper argues that, unlike these cases, he had a derivative ERISA claim because he had no way to determine the basis for Anthem's recoupment, which contravened his *current* patients' ERISA procedural rights. Yet, the arbitration panel found Anthem "advised Dr. Hopper that they would recoup the monies fraudulently paid for the claims and, according to his testimony, Dr. Hopper understood that the recoupment would be against him." Hopper may not challenge this factual finding. (*Moncharsh, supra*, 3 Cal.4th at p. 11; *Biller, supra*, 668 F.3d at p. 662.)

amended demand and our review ends. (*Pearson Dental, supra,* 48 Cal.4th at pp. 672-673.)

DISPOSITION

The judgment is affirmed. Respondent is awarded costs on appeal.

SORTINO, J.*

WE CONCUR:

BIGELOW, P. J.

GRIMES, J.

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* Judge of the Los Angeles Superior Court, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.