The Viability of State Law Claims Brought by Providers Against ERISA Qualified Plans

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I. Introduction

Each day nationwide hospitals admit thousands of patients for treatment. The process often requires the hasty verification of benefits by telephone so that the patient can immediately begin to receive the necessary medical care. Occasionally, the information transmitted to the hospital by the health insurance company, ERISA qualified plan, or third party administrator is incorrect.

If the information provided to the hospital is incorrect and the patient in fact has no healthcare coverage, financial damages quickly accrue as the hospital provides care in reliance on the inaccurate verification. The foregoing scenario, played out with varied but similar facts, has given rise to numerous complaints based on state law. Legal theories available to providers who fall victim to a misverification of coverage include breach of contract, promissory estoppel, and negligent misrepresentation. These state law actions collide with the preemptive scope of the Employment Retirement Income Security Act (ERISA).[1] As will be described more fully below, state and federal courts have grappled with these issues for nearly two decades and reached conflicting conclusions.

The Sixth Circuit has held that a provider's state law claims arising out of the incorrect verification of benefits by a third party administrator or plan are preempted by ERISA.[2] The Fifth, Ninth, Tenth, and Eleventh Circuits have found that state law claims for breach of contract, promissory estoppel, and negligent misrepresentation are generally not preempted by ERISA, so long as the claims derive from the provider's independent contractual or equitable rights, as opposed to the plan beneficiary's rights pursuant to the plan.[3] Most state and federal courts have followed the reasoning outlined by the majority of federal appellate courts and determined that claims arising out of the provider's right to receive compensation for medical care delivered to a plan beneficiary are not preempted.[4]

The Eighth Circuit carved out a more nuanced position in 1996 with its decision of *In Home Health v. Prudential*.[5] The Eighth Circuit found that a provider suing for negligent misrepresentation seeking damages from a third party administrator should be allowed to avoid ERISA preemption. The court noted that damages would ultimately be paid by the third party administrator (Prudential) rather than the ERISA qualified plan. This opinion leaves open the question within the Eighth Circuit of whether the plan itself could be held responsible financially for misrepresentations related to healthcare coverage.

Thus far, the U.S. Supreme Court has not accepted a case that would add clarity to the divergent opinions at the circuit court level. However, analysis of Supreme Court jurisprudence regarding ERISA preemption indicates that the highest court in the land would sustain the viability of state law claims brought on behalf of providers against the third party administrators and ERISA qualified plans.

II. General Scope of ERISA Preemption as Defined by the U.S. Supreme Court

Section 514(a) states that ERISA preempts "any and all state laws insofar as they now or hereafter relate to any employee benefit plans."[6] The U.S. Supreme Court has applied ERISA's preemption provision such that, "a law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."[7] In that case, the Court went on to qualify the foregoing statement by adding that, "some state actions may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan."[8] In *Mackey v. Lanier Collection Agency*,[9] the Court did not find that ERISA preempted Georgia's garnishment statement even though the enforcement of garnishment proceedings might have the collateral effect of causing administrative burdens on plans and even preventing the delivery of benefits to plan beneficiaries.[10]

III. The Weight of Authority Supports the Viability of State Law Claims

The Fifth Circuit addressed the survival of state law claims in light of ERISA preemption in *Memorial Hospital System v. Northbrook Life Insurance Company*.[11] The defendants in the *Memorial* case were Noffs, Inc. (Noffs), which provided healthcare benefits to its employees and dependents through a group insurance policy administered by the other defendant to the action, Northbrook Life Insurance Company (Northbrook). The policy stated that employees and dependents were not covered until after thirty days of continuous employment, at which time coverage would begin on the first day of the following month.[12]

Noffs hired Joseph Echols on September 10, 1986, and Echols' wife (Patient) sought treatment at Memorial sixteen days later. Personnel from Memorial verified coverage via telephone with Noffs at the time of admission. After hospital bills totaling $110,829.40 were delivered to Northbrook and Noffs, Northbrook advised Memorial for the first time that the Patient was not eligible for medical benefits due to the terms of the policy.[13]

After thorough analysis, the Fifth Circuit in *Memorial* concluded that the hospital's claim against the defendants for a violation of the Texas Insurance Code was not preempted by the terms of ERISA. In doing so, the court noted that barring such state law claims might actually be counterproductive to ERISA's goal of allowing the fair and efficient delivery of medical care and other welfare benefits to plan beneficiaries. The court's opinion yielded the following oft-quoted passage:

> If providers have no recourse under either ERISA or state law in situations such as the one *sub judice* (where there is no coverage under the express terms of the plan, but a provider has relied on assurances that there is such coverage), providers will be understandably reluctant to accept the risk of non-payment, and may require up-

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> front payment by beneficiaries—or impose other inconveniences—before treatment will be offered. This does not serve, but rather directly defeats, the purpose of Congress in enacting ERISA.[14]

About fifteen months after the Fifth Circuit decided *Memorial*, the Sixth Circuit confronted similar facts in *Cromwell v. Equicor* and reached the opposite result.[15] The plaintiffs in *Cromwell* provided home healthcare to a patient for six months in 1987. Prior to doing so, the plaintiffs alleged that they verified the patient's coverage via telephone with defendant Equicor, the administrator for a plan sponsored by co-defendant Beckman Industries. The defendants honored a certain portion of the plaintiffs' claims for reimbursement, but denied coverage for approximately two months of care. The plaintiffs filed suit in state court for breach of contract, promissory estoppel, negligence, and breach of good faith based on Equicor's verbal verification of coverage. The action was removed to federal court, and the district court dismissed the state law claims as preempted by ERISA.[16] The Sixth Circuit panel of judges issued a divided 2-1 opinion and determined that the plaintiffs' state law claims were properly dismissed with prejudice by the district court. Senior District Judge Feikens authored the majority opinion. Circuit Judge Suhrheinrich wrote a concurrence and cited three negative impacts related to the allowance of contractual and equitable claims brought by providers against ERISA qualified plans.

> First, a judgment in this type of case, obviously not limited to contractual damages since plaintiff was never a participant or beneficiary, will nonetheless have to be paid by the plan, leaving fewer funds available to pay the claims of beneficiaries. Second, the payment of the award will require actuarial adjustments, since such a judgment will not have been a factor in the plan's projections. Thus, the assessment of such judgments against a plan may reduce the amount available to the plan's beneficiaries and increase administrative costs. Third, the plan will also be subject to the laws of the individual states concerning the types of damages recoverable in tort, including consequential and punitive damages. The danger of inconsistent state laws, with its attendant effect of increasing the administration costs of a plan, is the key concern behind ERISA preemption.[17]

Circuit Judge Jones issued a lengthy dissent that included a detailed review of U.S. Supreme Court jurisprudence on the issue of ERISA preemption. After acknowledging the complexity of the issues, Circuit Judge Jones wrote as follows:

> It seems to me that the courts have become consumed in a fervor of preemption, sometimes avoiding admittedly difficult and complex analysis, by simply presuming preemption to apply. The problematic nature of such a practice is exemplified in the case at bar. The plaintiffs in this case, good-faith healthcare providers who provided care in reliance upon a plan's verification of benefits, cannot seek a remedy in either state or federal court.[18]

One day before the Sixth Circuit decided *Cromwell*, the Tenth Circuit filed its opinion in *Hospice of Metro Denver v. Group Health Insurance of Oklahoma* on September 10, 1991. Plaintiff/Appellant Hospice of Metro Denver, Inc. (Hospice) alleged that personnel verified coverage for long term care provided to an infant with Blue Cross on repeated occasions. After the patient was released from the Hospice, Blue Cross denied coverage on behalf of an ERISA qualified plan and cited the policy's pre-existing condition provisions. Hospice sued Blue Cross for promissory estoppel, quantum meruit, and separate claims as a third party beneficiary of the policy at issue.

The Tenth Circuit relied on *Memorial* while deciding that an action brought by a healthcare provider to recover for promised payment is separate and distinct from an action that arises out of the rights of a plan participant seeking recovery pursuant to the terms of the plan.[19] The Tenth Circuit also relied on a Second Circuit case styled as *Rebaldo v. Cuomo*.[20] *Rebaldo* stands for the proposition that a state law should not be preempted so long as it does not impact "the structure, the administration, or the type of benefits provided by an ERISA plan" even though the state law might have some economic impact on the plan.[21]

The Eleventh Circuit joined the majority position and found that state law claims arising out of a misverification of benefits are not preempted in 1994 (*Lordman Enterprises, Inc. v. Equicor*).[22] The Ninth Circuit also adopted the majority position in 1995 (*Meadows v. Employer's Health Insurance*).[23] Indeed, most state and federal courts across the country have sustained the viability of state law claims brought by healthcare providers so long as the claims arise out of the contractual or equitable rights of the provider, as opposed to the rights derived from the terms of the ERISA qualified plan.[24]

In 1996, the Eighth Circuit stopped just short of wholly adopting the majority position with its decision *In Home Health, Inc. v. Prudential Insurance Company*.[25] Defendant Prudential allegedly provided false information to Home Health by stating the patient had not reached his $1 million lifetime maximum pursuant to the terms of an ERISA qualified plan. Based on those statements, Home Health admitted the patient and periodically contacted Prudential to insure that the patient had not yet reached the maximum coverage limit. Allegedly, Prudential consistently provided incorrect information and advised that the patient's policy had not yet been exhausted.[26] Home Health eventually incurred compensatory damages of approximately $40,000 because the patient had actually exhausted his lifetime maximum pursuant to the plan at issue.

Home Health filed an action in Missouri state court based on the tort of negligent misrepresentation, and the case was ultimately removed to federal district court wherein the trial judge required the plaintiff to file an amended complaint against Prudential and the plan defendants. After the district court granted Prudential's motion to dismiss based on ERISA preemption, Home Health abandoned its appeal of

the dismissal of the amended complaint and appealed the district court's refusal to remand the original complaint to Missouri state court. After determining that it still had jurisdiction to consider the propriety of the district court's refusal to remand Home Health's complaint, the Eighth Circuit turned its attention to the issue of ERISA preemption.

The court listed seven factors that should be considered to determine whether a state law "relates to" an ERISA qualified plan and, therefore, should be preempted.

> The factors include whether the state law: (1) negates the ERISA plan provision; (2) affects relations between primary ERISA entities; (3) impacts the structure of ERISA plans; (4) impacts the administration of ERISA plans; (5) has an economic impact on ERISA plans; (6) may be preempted consistent with other ERISA provisions; and (7) is an exercise of traditional state power. (citations omitted). We must evaluate these factors in light of the "totality of the state [law]'s impact on the plan," considering both how many factors favor preemption and how heavily they favor preemption.[27]

The court determined that Home Health's negligent misrepresentation claim against Prudential would not negate a plan provision, affect the primary ERISA entities, impact on plan structure, or impact on plan administration. The court further found that because Prudential was the sole defendant named in the original state court complaint, and Prudential had not alleged that the plan would be obligated to indemnify Prudential subsequent to an unfavorable verdict, Home Health's state law claim would have no economic impact on the Plan. It is unknown whether the Eighth Circuit would have reached the same result if it had to decide whether a state law claim against both the insurer and the plan should be preempted, because such a claim certainly could have an economic impact on the plan.

IV. Possible Resolutions by the U.S. Supreme Court

The precise scope of ERISA preemption has challenged the U.S. Supreme Court since the enactment of the statute. In 1997, Justice Stevens remarked in a footnote that the U.S. Supreme Court had already addressed and decided no fewer than sixteen cases regarding ERISA preemption.[28] The court also cited to "an avalanche of litigation" in the lower courts regarding ERISA preemption. The steady pace of ERISA decisions issued by the U.S. Supreme Court has continued unabated since 1997. Most recently, the court found that ERISA preempted claims brought by beneficiaries against health maintenance organizations (HMOs) for a violation of the Texas Healthcare Liability Act in *Aetna Health v. Davila*.[29]

None of the opinions that comprise U.S. Supreme Court jurisprudence on ERISA preemption directly addresses whether contractual and equitable claims brought by medical providers against insurance companies, third party administrators, and possibly even ERISA qualified plans for misverification of benefits can survive ERISA preemption. However, an examination of the Supreme Court doctrine indicates that the Supreme Court would not find such misverification claims brought on behalf of providers to be preempted by the terms of ERISA. For example, the *Davila* opinion, which dismissed alleged violations of state law based on ERISA preemption, distinguishes between claims derived from the terms of the ERISA qualified plan and claims arising from an "independent legal duty that is implicated by the defendant's actions . . . ."[30]

The Supreme Court sustained the viability of a New York statute that levied surcharges on HMOs that would have the net effect of increasing costs to ERISA qualified plans. (*Blue Cross v. Travelers*).[31] In doing so, the Court found that indirect economic impact on ERISA qualified plans does not necessarily trigger ERISA preemption.[32] The Court also reinforced in *Blue Cross* that preemption must turn on the congressional intent that motivated the enactment of ERISA.[33] In a similar decision, the Court found that ERISA did not preempt California's prevailing wage statute even though the law in some instances impacted employee benefit programs regulated by ERISA (*California Division of Labor v. Dillingham Construction*).[34] Justice Scalia filed a concurring opinion in the *California Division of Labor* case and stated that "applying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else."[35] Justice Scalia went on to suggest that the Court should change its approach to ERISA preemption analysis as follows:

> I think it would greatly assist our function of clarifying the law if we simply acknowledged that our first take on this statute was wrong; that the "relate to" clause of the pre-emption provision is meant, not to set forth a *test* for pre-emption, but rather to identify the field in which ordinary *field pre-emption* applies—namely, the field of laws regulating 'employee benefit plan[s] described in § 1003(a) of this title and not exempt under § 1003(b) of this title'. [Citation omitted].[36]

The case that most strongly suggests that the U.S. Supreme Court would not find that ERISA preempts misverification claims brought on behalf of healthcare providers remains *Mackey v. Lanier Collection Agency*.[37] In *Mackey*, the U.S. Supreme Court decided that ERISA preempted a Georgia statute designed to insulate welfare benefit plans from garnishment proceedings because the Georgia statute conflicted with the federal scheme. In contrast, the Court sustained enforcement of Georgia's general garnishment law and determined that ERISA does not "forbid the use of state law mechanisms for executing judgments against ERISA welfare benefit plans, even when those mechanisms prevent plan participants from receiving their benefits."[38] While discussing the scope of ERISA preemption, the Court explained that ERISA qualified plans are not immune from "run of the mill state law claims such as unpaid rent, failure to pay creditors or even torts committed by an ERISA plan . . . ."[39]

The U.S. Supreme Court may not accept a case arising out of

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an inaccurate verification of healthcare coverage because the Sixth Circuit stands alone in the view that such claims are pre-empted by ERISA. As described by the majority of U.S. Appellate Courts, the most persuasive arguments favor the viability of such claims. Hospitals and other healthcare providers should be allowed to rely on the healthcare coverage information transmitted by insurers, third-party administrators, and ERISA qualified plans. The equities certainly favor hospitals that fill the immediate need for medical care based on the specific promise of coverage and payment. Moreover, from a strictly legal perspective, these claims arise directly from the contractual and equitable rights of the medical provider, as opposed to the actual terms of an ERISA qualified plan.

Endnotes

1 Section 1144(a) of the Employee Retirement Income and Security Act of 1974, 29 USCS § 1144(a) states that except as provided in (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan.

2 *Cromwell v. Equicor*, 944 F.2d 1272 (6th Cir. 1991).

3 *Memorial Hospital System v. Northbrook Life*, 904 F.2d 236 (5th Cir. 1990); *The Meadows v. Employer's Health*, 47 F.3d 1006 (1995); *Hospice of Metro Denver v. Group Health*, 944 F.2d 752 (10th Cir. 1991); *Lordmann Enterprises v. Equicor*, 32 F.3d 1529 (11th Cir. 1994).

4 *Rehabilitation Institute v. Group Administrators*, 844 F.Supp. 1275 (N.D. Ill. 1994); *Parkside Lutheran v. R.J. Zeltner & Associates*, 788 F.Supp. 1002 (N.D. Ill. 1992); *Weiser v. United Food*, 273 Ill.App. 3d 905; 653 N.E. 2d 51 (1st Dist. Ill. App. 1995).

5 *In Home Health v. Prudential*, 101 F.3d 600 (8th Cir. 1996).

6 29 U.S.C. § 1144(a).

7 *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97, 103 Sup.Ct. 2890, 2899 (1983).

8 *Id.* at 100, footnote 21, 103 Sup.Ct. at 2901, footnote 21.

9 *Mackey v. Lanier Collection Agency*, 486 U.S. 825, 831-832, 108 Sup.Ct. 2182, 2186 (1988).

10 *Id.*

11 *Memorial Hospital System v. Northbrook Life Insurance Company*, 904 F.2d 236 (5th Cir. 1990).

12 *Memorial*, 904 F.2d at 238.

13 *Id.*

14 *Memorial*, 904 F.2d at 247-248.

15 *Cromwell v. Equicor*, 944 F.2d 1272 (6th Cir. 1991).

16 *Cromwell*, 944 F.2d at 1275.

17 *Cromwell*, 944 F.2d at 1279.

18 *Cromwell*, 944 F.2d at 1286.

19 *Hospice of Metro Denver*, 944 F.2d at 756.

20 *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2nd Cir. 1984), cert denied, 472 U.S. 1008, 105 S.Ct. 2702 (1985).

21 *Id.*

22 *Lordman Enterprises, Inc. v. Equicor, Inc.*, 32 F.3d 1529 (11th Cir. 1994).

23 *Meadows v. Employer's Health Insurance*, 47 F.3d 1006 (9th Cir. 1995).

24 *Rehabilitation Institute v. Group Administrators*, 844 F.Supp. 1275 (N.D. Ill. 1994); *Parkside Lutheran v. R.J. Zeltner & Associates*, 788 F.Supp. 1002 (N.D. Ill. 1992); *Weiser v. United Food*, 273 Ill.App. 3d 905; 653 N.E. 2d 51 (1st Dist. Ill. App. 1995); *Totton v. New York Life Insurance Co.*, 685 F.Supp. 27,31 (D.Conn. 1987).

25 *In Home Health v. Prudential*, 101 F.3d 600 (8th Cir. 1996).

26 *Id.* at 602.

27 *Id.* at 605.

28 *De Buono v. NYSA-ILA Medical and Clinical Services Fund, et al.*, 520 U.S. 806, 809, footnote 1, 117 S.Ct. 1747, 1749 (1997).

29 *Aetna Health v. Davila*, 542 U.S. 200, 204, 124 S.Ct. 2488, 2493 (2004).

30 *Davila*, 542 U.S. at 210, 124 S.Ct. at 2496.

31 *Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 115 S.Ct. 1671 (1995).

32 *Blue Cross*, 514 U.S. at 659-660, 115 S.Ct. at 1679.

33 *Blue Cross*, 514 U.S. at 655, 115 S.Ct. at 1677.

34 *California Division of Labor v. Dillingham Construction*, 519 U.S. 316, 319, 117 S.Ct. 832, 835 (1997).

35 *California Division of Labor*, 519 U.S. at 335, 117 S.Ct. at 843.

36 *California Division of Labor*, 519 U.S. at 336, 117 S.Ct. at 843.

37 *Mackey v. Lanier Collection Agency*, 486 U.S. 825, 831-832, 108 Sup.Ct. 2182, 2186 (1988).

38 *Mackey*, 46 U.S. 831-832, 108 S.Ct. at 2186.

39 *Id.*