WARD v. ALTERNATIVE HEALTH DELIVERY SYSTEMS

55 F. Supp.2d 694 (1999) | Cited 0 times | W.D. Kentucky | June 7, 1999

MEMORANDUM OPINION

This matter is before the Court on Defendant's Renewed Motionto Dismiss [dkt. # 60]. After reviewing the Motion and beingotherwise sufficiently advised, the Court finds that Plaintiff'sstate law claims are pre-empted by ERISA and that Plaintiff, ahealth-care provider does not have standing to bring this causeof action under ERISA. Accordingly, Plaintiff's claims aredismissed pursuant to Rule 12(b)(6) for the reasons set forth inthis opinion.

Background

Plaintiff provided chiropractic health-care services to membersof Defendants' health maintenance organization. Plaintiff allegesthat she is owed additional monies for these services becauseDefendants did not pay her the full 100% of the allowable chargefor treatment of plan participants. Plaintiff filed suit allegingcauses of action for: 1) breach of contract; 2) violation ofK.R.S. § 304.17A-171; 3) unjust enrichment; 4) breach of impliedcovenant of good faith and fair dealing; 5) a declaration ofrights under her managed care agreement; 6) violation of K.R.S. §367.175; and 7) claims under the Employee Retirement IncomeSecurity Act (ERISA).

The Defendants filed motions to dismiss pursuant to Rule12(b)(6). In an Order dated April 27th, 1998 the Court stated "AsDefendants' motions to dismiss incorporate matters outside thepleadings, Federal Rule of Civil Procedure 12(b) requires thatthey be construed as motions for summary judgment and disposed ofas provided in Rule 56." The Court allowed limited discoverypursuant to Rule 56(e). The Court then denied Defendants' motionsto dismiss [dkt. # 2 & 4] at that juncture to allow the partiesan opportunity to address the applicability of a recent ERISAopinion from Judge McKinley. See Community Health Partners,Inc., v. Commonwealth, of Ky., 14 F. Supp.2d 991 (W.D.Ky. 1998).The Defendants were permitted to renew their motions on or beforeOctober 16, 1998.

Having now conducted a more extensive review of the pleadings,the Court finds it unnecessary to go beyond the pleadings andwill adjudicate the motion to dismiss pursuant to Rule 12(b)since the legal issue at the heart of the motion, preemption, canbe decided on the pleadings.

Motion To Dismiss Standard

"When a party moves to dismiss an action under Rule 12(b)(6)for failure to state a claim upon which relief can be granted,both sides proceed with the expectation that the court willdecide the motion on

the basis of the pleadings alone unless thecourt notifies them otherwise." Song v. City of Elyria,985 F.2d 840, 842 (6th Cir. 1993). The complaint is construed in alight most favorable to the Plaintiff, and all factualallegations are accepted as true. Sistrunk v. CityStrongsville, 99 F.3d 194, 197 (6th Cir. 1996). A dismissal willonly be granted if "`it appears beyond doubt that the Plaintiffcan prove no set of facts in support of his claim that wouldentitle him to relief.'" Ang v. Procter & Gamble Co.,932 F.2d 540, 544 (6th Cir. 1991) (quoting Conley v. Gibson,355 U.S. 41, 45-46, 78 S.Ct. 99, 2 L.Ed.2d 80 (1957)).

Defendant argues that Plaintiff does not have standing to bringa cause of action under ERISA and that her state law claims arepreempted and therefore Plaintiff's claims should be dismissedpursuantto Rule 12(b)(6) for failure to state a claim. As Defendantalleges Plaintiff does not have standing to bring a cause ofaction under ERISA, the Court will begin by first addressingjurisdictional issues before it analyzes the merits of theclaims.

Standing to Sue Under ERISA

Pursuant to 29 U.S.C. § 1132(a)(1), only a "participant orbeneficiary" may file suit for benefits under ERISA. Plaintiffclaims she is a beneficiary since under the healthcare plan,benefits may be paid to either the participant or the healthcareprovider. However, even though the Court must accept allwell-pleaded allegations as true for purposes of a motion todismiss, the Court cannot rely solely on Plaintiff's allegationsof status as a beneficiary when determining if she has standingunder ERISA. See Firestone Tire and Rubber Co. v. Bruch,489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989); Cromwell v.Equicor-Equitable HCA Corp., 944 F.2d 1272, 1281 (6th Cir.1991), cert. dismissed, 505 U.S. 1233, 113 S.Ct. 2, 120 L.Ed.2d931 (1992). Standing issues require independent inquiries becauseif Plaintiff does not qualify as a "beneficiary" under ERISA, hercause of action must be dismissed. See Teagardener v.Republic-Franklin Inc. Pension Plan, 909 F.2d 947, 952 (6th Cir.1990) (holding that assertions in the pleadings of ERISAbeneficiary status is insufficient to confer standing), cert.denied, 498 U.S. 1027, 111 S.Ct. 678, 112 L.Ed.2d 670 (1991).

Pursuant to the provisions found in the ERISA statute,"beneficiary" is defined as "a person designated by aparticipant, or by the terms of an employee benefit plan, who isor may become entitled to a benefit thereunder." See29 U.S.C. § 1002(8). Plaintiff alleges she is a beneficiary since thehealth plan states that benefits may be paid either to theparticipant or to the health care provider. Defendant argues thatthis provision in the health plan does not confer beneficiarystatus to the Plaintiff. Rather, Defendant argues the provisionis simply a direct payment provision "allowing AHDS to paybenefits to which a member is entitled directly to a provider.The provider is not entitled to benefits, but merely receivespayment for services rendered to those plan participants orbeneficiaries who are eligible for benefits." [See dkt. # 21].

Plaintiff, a health care provider participating in Defendant'shealth care plan does not qualify as a "beneficiary" conferringher with standing to bring this cause of action under ERISA. Bydefinition, a

beneficiary is someone entitled to benefits undera plan. Here, Plaintiff assumes that because the health planprovides that a health care provider may be paid benefitsdirectly that she is therefore entitled to benefits under theplan. A legal assumption such as this is not enough to conferbeneficiary status. Moreover, there is nothing in the pleadingsto indicate that Plaintiff has received an assignment from a planparticipant or beneficiary giving her derivative standing underERISA. Without an assignment of benefits, Plaintiff does not havestanding to bring a cause of action under ERISA. See City ofHope Nat. Med. Ctr. v. Healthplus, Inc., 156 F.3d 223, 227-28(1st Cir. 1998) (holding that when an ERISA beneficiary assignsreimbursement rights to a health care provider, that provideracquires derivative standing under ERISA and is able to sue as a"beneficiary"); see also Hermann Hosp. v. MEBA Med. & BenefitsPlan, 845 F.2d 1286, 1289-90 (5th Cir. 1988) (holding that ahospital which provided health care services to a beneficiary ofan ERISA plan did not have independent standing under ERISA tobring action for payment of services rendered but that it wouldhave had standing if it were an assignee of a beneficiary).Accordingly, Plaintiff's ERISA cause of action is dismissed forlack of standing.[1]

Even though Plaintiff does not have standing to bring a causeof action under ERISA, her state law claims may nevertheless besubject to ERISA preemption. Therefore, the Court must nowdetermine whether any of Plaintiff's state law claims arepreempted by ERISA.

Plaintiff's State Law Claims & ERISA Preemption

The Court begins by acknowledging the presumption against ERISApreemption. However, 29 U.S.C. § 1144(a) states that ERISA willpreempt all state laws that "relate to" an employee benefit plan.The Sixth Circuit has interpreted such preemption to include"virtually all state law claims relating to an employee benefitplan. . . ." Cromwell v. Equicor-Equitable HCA Corp.,944 F.2d 1272, 1276 (6th Cir. 1991), cert. dismissed, 505 U.S. 1233, 113S.Ct. 2, 120 L.Ed.2d 931 (1992). A state law "relates to" anemployee benefit plan if it "has a connection with or referenceto such a plan." Shaw v. Delta Air Lines, Inc., 463 U.S. 85,97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983). Therefore, ifPlaintiff's state law claims either have a "connection with" or"reference to" an employee benefit plan, they will be subjectedto ERISA preemption and dismissed.

"Connection With" Analysis

The Sixth Circuit has stated that in order to determine if astate law has a "connection with" an ERISA plan, the court should"`look both to the objectives of the ERISA statute as a guide tothe scope of the state law that Congress understood wouldsurvive, as well as to the nature of the effect of the state lawon ERISA plans.'" Davies v. Centennial Life Ins. Co.,128 F.3d 934, 939 (6th Cir. 1997) (quoting California Div. of LaborStandards Enforcement v. Dillingham Constr., N.A., Inc.,519 U.S. 316, 325, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997)).

Defendant argues that Plaintiff's state law claims have a"connection with" an employee benefit plan

because they "rely onthe interpretation of employee benefit plans[.][I]f the servicethe plaintiff provides is not covered, or is partially coveredunder the plan, that in turn has an effect on the amount ofrecovery the plaintiff is seeking here." For support of thisproposition, Defendant cites Zuniga v. Blue Cross & Blue Shieldof Mich., 52 F.3d 1395, 1402 (6th Cir. 1995) (finding preemptionsince the plaintiff was seeking "payment of benefits under theplan for his treatment of covered patients" which "necessarilyreli[ed] on the existence and interpretation of . . . employeebenefit plans").

An examination of Plaintiff's state law claims reveals that allthese causes of action stem from a common core: the fact thatPlaintiff was not paid the full 100% allowable charge for herservices and treatment of covered plan participants. Apparently,Defendant's HMO contracts with various employers to providehealth care services as part of their employee benefits. Bystatute, "any willing provider" is allowed to participate in theHMO network. As such, Plaintiff became a participatinghealth care provider in Defendant's HMO and provided chiropracticservices to covered plan participants. Plaintiff now seeksreimbursement for services previously rendered to these coveredparticipants. Accordingly, Plaintiff's state law claimsnecessarily relate to an employee benefit plan since any recoverywould depend on whether the rendered services were initiallycovered under the employees' health plans, and whether Plaintiffhas already been paid some amount for treating these coveredparticipants. See e.g., Cromwell v. Equicor-Equitable HCACorp., 944 F.2d at 1276 (stating "[i]t is not the label placedon a state law claim that determines whether it is preempted, butwhether in essence such a claim is for the recovery of an ERISAplan benefit").

In addition, Plaintiff's statutory cause of action pursuant toKentucky Revised Statutes § 304.17A-171 provides another groundto trigger ERISA preemption as it too is sufficiently "connectedwith" an employee benefit plan. By specifically prohibitinghealth organizations from offering networks with limitedchiropractic providers, the statute mandates the plan'sstructure. Moreover, the statute also dictates that all coveredparticipants shall have access to the chiropractor of theirchoice. This too dictates a certain structure to which anemployer's health care plan must succumb. As such, this claimalso falls within the realm of ERISA preemption.[2] See e.g.,Texas Pharmacy Ass'n v. Prudential Ins. Co. of America,105 F.3d 1035 (5th Cir.) (determining that Texas statute which prohibitednetworks from excluding providers relates to ERISA plans becauseit "eliminates the choice of one method of structuring benefits"by prohibiting plans from contracting with restricted networks),cert. denied, ___ U.S. ___, 118 S.Ct. 75, 139 L.Ed.2d 34(1997); CIGNA Healthplan of Louisiana v. State of La.,82 F.3d 642 (5th Cir.) (holding that Louisiana's any-willing providerstatute relates to ERISA plans because it "requires ERISA plansto purchase benefits of a particular structure when they contractwith PPO's"), cert. denied, 519 U.S. 964, 117 S.Ct. 387, 136L.Ed.2d 304 (1996).

ERISA Preemption Savings Clause

Although state laws that "relate to" ERISA plans triggerpreemption, they may nonetheless be saved from preemption if theyfall within the ERISA "savings clause" as a law that regulatesinsurance. To determine if a state law "regulates insurance," theSupreme Court devised a two-prong analysis: 1) is

the law"specifically directed at the insurance industry" and 2) does thelaw apply to the "business of insurance" within theMcCarran-Ferguson Act? See Metropolitan Life Ins. Co. v. Mass.,471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985). The firstprong of the analysis is referred to as the "common sense"approach. The Supreme Court has stated that "[a] common-senseview of the word `regulates' would lead to the conclusion that inorder to regulate insurance, a law must not just have an impacton the insurance industry, but must be specifically directedtoward that industry." Pilot Life Ins. Co. v. Dedeaux,481 U.S. 41, 50, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). Under the secondprong of the analysis, a law will apply to the "business ofinsurance" if it 1) transfers or spreads the policyholder's risk;2) if it is an integral part of the policy relationship betweenthe insured and the insurer; and 3) if it is limited to entitieswithin the insurance industry. See Metropolitan Life, 471 U.S.at 743, 105 S.Ct. 2380. The Sixth Circuit has held that it is notnecessary to satisfy all three McCarran-Ferguson factors in orderto satisfy the second-prong of the "regulates insurance"analysis. See Davies v. Centennial Life Ins. Co., 128 F.3d 934,940 (6th Cir. 1997).

Therefore, in order for K.R.S. § 304.17A-171 to fall within theERISA savings clause as a statute that "regulates insurance" itmust satisfy both prongs of the Metropolitan Life "regulatesinsurance" analysis: 1) that it is a law "specifically directedat the insurance industry;" and 2) that it applies to the"business of insurance" because it satisfies one or more of theMcCarran-Ferguson factors.

Is Kentucky Revised Statutes § 304.17A-171 specifically directedat the insurance industry?

Plaintiff alleges K.R.S. § 304.17A-171, a statute whichprohibits discrimination between classes of health care providersis saved from ERISA preemption because it is a statute which"regulates insurance." Plaintiff states that the statutesatisfies the "common sense" prong of the two-part MetropolitanLife "regulates insurance" analysis since it is found in theinsurance code, it affects insurance by forbidding discriminationin reimbursement of network providers and because it "affects anintegral part of the relationship between the insurer and theinsured." [See dkt. # 59, p. 3]. For support of this proposition,Plaintiff cites Community Health Partners, Inc. v. Kentucky,14 F. Supp.2d 991 (W.D.Ky. 1998). In Community Health, the courtheld that although Kentucky's "any-willing provider" statute was"related to" an employee benefit plan, it was not subject toERISA preemption because it was saved from preemption as a lawspecifically directed towards the insurance industry. Id. at1001. The court reasoned that since Kentucky's "any-willingprovider" statute "affects specific terms of the insurancepolicies" and is found in the insurance code, this was"sufficient to establish that the AWP regulates insurance." Id.at 1002.

Plaintiff argues that K.R.S. § 304.17A-171 is saved frompreemption because like the "any-willing provider statute" atissue in Community Health, it too is "located within theKentucky insurance code, . . . appl[ies] to the same healthbenefit plans, and . . . forbid[s] forms of discrimination byplans toward providers." [See dkt. # 59, p. 2]. In response,Defendant argues the statute is not specifically aimed at theinsurance industry because by definition, it includesorganizations outside the industry. For support, Defendant citesPrudential Insurance Company v. National Park Medical Center,Inc., 154

F.3d 812 (8th Cir. 1998).

In Prudential, the Eighth Circuit held that Arkansas'any-willing provider statute was not saved from ERISA preemptionbecause: 1) it was not a state law which "regulate[d] insurance;"and 2) it did not satisfy any of the McCarran-Ferguson factors asa law which applied to "the business of insurance." See id.Specifically, in determining that the statute was not a law which"regulated insurance," the Eighth Circuit reasoned:

it was the intent of the General Assembly in enacting the Arkansas PPA `to provide the opportunity of providers to participate in health benefit plans.' Furthermore, the statutory term `health benefit plans' includes far more than just insurance or the insurance industry, because the Arkansas PPA defines that term to include `any entity or program that provides reimbursement, including capitation, for health care services.' An act that purports to regulate `health benefit plans' so broadly as to include employers and administrators of self-insured plans, as well as traditional insurance, simply does not fit within a common-sense view of a law directed specifically toward the insurance industry. Even if we were to accept appellants' argument that the Arkansas PPA regulates `health care insurers,' as defined, rather than `health benefit plans,' it is clear that the statutory term `health care insurers' also goes well beyond the scope of the insurance industry, because it is defined by the statute to include, but not be limited to, insurance companies, hospital and medical services corporations, health maintenance organizations, preferred provider organizations, physician hospital organizations, third-party administrators, and prescription benefit management companies authorized to administer, offer, or provide health benefit plans.

Appellants' argument that the Arkansas PPA has been codified as part of the Arkansas insurance code is unpersuasive, because the law reaches so far beyond the insurance industry. . . . [I]t is not a law directed at the insurance industry at all, but a law directed at regulation of broadly defined health benefit plans, only some of which fall within the insurance industry.

Id. at 829 (internal citations omitted).

Since it is this Court's belief that this circuit will followthe Eight's Circuit's analysis due to the almost identical natureof the statutes involved, the Court will apply the EighthCircuit's analytical framework to the facts in this case. Inpromulgating K.R.S. § 304.17A-171, it was the General Assembly'sintent to allow any licensed chiropractor to participate as aprovider and prohibit organizations from discriminating againstproviders when reimbursing them for their services. The term"health benefit plan" also "includes far more than just insuranceor the insurance industry" as did the Arkansas statute. Bydefinition, the term means

any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent

permitted by ERISA; health maintenance organization contract; or any health benefit plan which affects the rights of a Kentucky insured. . . .

See K.R.S. §§ 304.17A-170(1) and 304.17A-005(17). In addition,the term "health care insurer" is defined as

any entity, including but not limited to insurance companies, hospital and medical services corporations, health maintenance organizations, preferred provider organizations, and physician hospital organizations, that is authorized by the state of Kentucky to offer or provide health benefit plans, policies, subscriber contracts, or any other contracts of similar nature which indemnify or compensate health care providers for the provision of health care services.

See K.R.S. § 304-17A-170(7). Thus, "it is [likewise] clear that[Kentucky's] statutory term `health care insurers' [also] goeswell beyond the scope of the insurance industry, because it [too]is defined by the statute to include, but not be limited to,insurance companies." Prudential, 154 F.3d at 828-29 (emphasisadded). As this Court now has the benefit of the Prudentialanalysis, it must follow the Eighth Circuit's binding dictatethat "[a]n act that purports to regulate `health benefit plans'so broadly as to include employers and administrators ofself-insured plans, as well as traditional insurance, simply doesnot fit within a common-sense view of a law directed specificallytoward the insurance industry." Prudential, 154 F.3d at 828-29.Accordingly, as K.R.S. § 304.17A-171 is not a law that is"specifically directed towards the insurance industry," it doesnot fall within the ERISA savings clause as a law that"regulates" insurance and is not saved from ERISA preemption.See also Texas Pharmacy Ass'n v. Prudential Ins. Co. ofAmerica, 105 F.3d 1035 (5th Cir.) (holding that Texas'any-willing provider statute that prohibited networks fromexcluding providers was not limited to entities within insuranceindustry and therefore was preempted by ERISA), cert. denied,___ U.S. ___, 118 S.Ct. 75, 139 L.Ed.2d 34 (1997).

In finding that K.R.S. § 304.17A-171 does not satisfy the firstprong of the Metropolitan Life analysis as a law specificallydirected towards the insurance industry, it is not necessary toproceed furtherand analyze the statute according to the second prong'sMcCarran-Ferguson factors. Both prongs of the "regulatesinsurance" analysis must be satisfied in order for the statute tofall within the savings clause. Thus, having found all ofPlaintiff's state law claims preempted by ERISA and not subjectto the savings clause, these causes of action are dismissed.

1. Although Plaintiff does not have standing to bring suitunder ERISA, the Court nevertheless has jurisdiction over theremaining state law claims because: 1) it had proper removaljurisdiction over Plaintiff's ERISA claim; and 2) becauseDefendants properly raised ERISA preemption as a defense. SeeGiles v. NYL-Care Health Plans, 172 F.3d 332, 337 (5th Cir.1999) (stating that when ". . . a claim presents a federalquestion, it provides grounds for a district court's exercise ofjurisdiction upon removal. If the plaintiff moves to remand, allthe defendant has to do is demonstrate a substantial federalclaim, e.g., one completely preempted by ERISA, and the court maynot remand. Once the court has proper removal jurisdiction over afederal claim, it may exercise supplemental jurisdiction overstate law claims, even if it dismisses or

otherwise disposes ofthe federal claim. . . .") (internal citations omitted); seealso Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272,1278 (6th Cir. 1991) (stating that a "district court'sdetermination that appellants lacked standing does not void itsearlier determination that appellants' state law claims arepreempted"), cert. dismissed, 505 U.S. 1233, 113 S.Ct. 2, 120L.Ed.2d 931 (1992).

2. As the Court has determined the state law claims have a"connection with" an employee benefit plan, there is no need toconduct the "reference to" analysis to determine preemption sinceeither prong is determinative.