

UIC Law Review

Volume 45
Issue 3 *The 10th Annual Employee Benefits
Symposium*

Article 7

Spring 2012

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Recommended Citation

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MEDICAL PROVIDER CLAIMS: STANDING, ASSIGNMENTS, AND ERISA PREEMPTION

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I. INTRODUCTION

The Employee Retirement Income Security of 1974, as amended (“ERISA”) treats participants and beneficiaries drastically different from how it treats medical providers. Congress adopted ERISA for the express purpose of protecting the interests of participants and beneficiaries in their employee benefit plans.¹ As it has turned out, ERISA claimants are often required to pay for mistakes made by plan administrators when communicating a plan’s terms or conditions. Often, medical providers do not have this same problem.

ERISA increases participants’ risks with a combination of its preemptive force and its limited remedial scheme. ERISA preempts state law causes of action that could otherwise provide participants with relief. It goes on to limit considerably the remedies that are available under ERISA, sometimes to *nothing*: no remedy whatsoever. In contrast, medical providers are permitted to pursue state law causes of actions and seek whatever remedies may be available under state law. The following hypothetical illustrates the difference.

An executive employee wakes one morning to find her husband deathly ill. He is rushed to a hospital. There, the doctors developed an experimental surgical procedure that could save his life. They expect he will die unless they perform the operation in the next two hours. Stricken with grief, the executive calls her employer.

She asks if the employer’s health plan (the “Plan”), which is covered by ERISA, covers the experimental procedure. Not realizing the Plan excludes experimental procedures, the Director of Human Resources tells her the Plan will cover the operation. “Have your husband get the operation. The Plan covers it.” The executive hangs up and signs the hospital paperwork, which includes a valid assignment of her husband’s Plan benefits.

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1. 29 U.S.C. § 1001(a) (2006).

Thirty minutes later, as a result of the same illness, the executive collapses and becomes incapacitated. The hospital contacts her father, who holds a medical power of attorney for his daughter. He authorizes the executive's operation, but he cannot pay for it.

The hospital tracks down the executive's employer and reaches the Vice President ("VP") of Employee Benefits. The VP makes the same mistake the HR Director made, and tells the hospital the Plan covers the procedure. "Go ahead and perform the operation," the VP says. "The Plan covers it." The hospital never discusses the husband's operation with the VP or any other agent of the Plan or the employer. Other than the HR Director, who spoke only with the executive, no one at the employer knows the executive's husband is in the hospital.

The hospital performs both operations. The executive and her husband survive and recover from the illness.

The hospital submits both bills to the Plan. Both are denied on the grounds that the Plan does not cover experimental procedures. The husband and wife properly exhaust their administrative remedies under ERISA, but both claims are denied on final appeal and by the independent review organization.

The executive, her husband, and the hospital all sue the Plan and the employer. For each operation, the hospital files state law claims in its individual capacity for breach of contract and negligent misrepresentation. It also files the same state law claims as an assignee of the executive and her husband, as well as a claim for benefits under § 502(a)(1)(B) of ERISA. For their part, the executive and her husband file state law claims for breach of contract and negligent misrepresentation, and a claim under ERISA § 502(a)(1)(B).² Ultimately, the hospital recovers on its claim for the executive's surgery, but not for her husband's surgery. The husband fails to recover anything. The executive and her husband must pay for the husband's operation out-of-pocket.

Under ERISA case law, this hypothetical could be a reality. The courts have made it clear that rarely will an oral promise to a plan participant or beneficiary that purports to modify the terms of the written plan be enforceable. Any state law claim based on that promise will be preempted by ERISA. Any claim brought under ERISA will, absent extraordinary circumstances, generally fail. In contrast, that same oral promise to a medical provider can be enforced through a state law claim.

This Article analyzes how the courts distinguish between

2. 29 U.S.C. § 1132(a)(1)(B) (2006). Assume the parties do not pursue a claim under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), or any other state law claims.

promises made to a medical provider and promises made to participants or beneficiaries. The rule is that ERISA preempts a claim only when it affects the relationships among traditional ERISA entities—the employer, the plan and its fiduciaries, and the participants and beneficiaries. That is like saying ERISA promises can be broken because ERISA was enacted to protect participants.³ Unfortunately, the issues are not that simple.

As relevant here, ERISA regulates health care benefits provided by private employers. As a nation we have learned, since at least July 30, 1965,⁴ until President Obama adopted the Affordable Care Act,⁵ that the delivery and financing of health care is not easy. As with many things, one of the difficult aspects of administering the two is achieving a system of effective communications. When communications break down—when there is a misstatement or an unintentional misrepresentation about the existence or extent of plan coverage—disputes can arise. By distinguishing between participants and medical providers, the courts have construed ERISA as establishing a framework for determining, when disputes arise, (1) which party should bear the risk of misstatements and misrepresentations and (2) what standard of care a plan must breach before it bears responsibility for its errors.

There may be legitimate reasons for subjecting medical providers and participants to different levels of risk. Medical providers may not have the same access to plan information that Congress affords participants. For example, if a participant is unsure about whether a procedure is covered, he may request a copy of the plan document.⁶ Medical providers may not have this option. If the issue is important enough, a participant can ask a court to clarify her rights under the plan.⁷ Of course, a participant

3. See ERISA § 2(b), 29 U.S.C. § 1001(b) (stating that “[i]t is hereby declared to be the policy of [ERISA] to protect . . . the interest of participants in employee benefit plans and their beneficiaries. . .”). The author does not intend to accuse any court of improper motives. The author believes that, except for extremely rare cases where judges engage in intentional misconduct (such as accepting bribes), courts in all cases do what they believe is the right thing. It should also be noted that Congress expressly designed ERISA to protect the “interests” of participants in their benefits plans. Participants could be said to have an interest in their employer forming and maintaining employee benefit plans. *Infra* notes 193 and 196 and accompanying text.

4. President Johnson ushered in Medicare when, on July 30, 1965, he enacted the Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 42 U.S.C.).

5. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (to be codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

6. ERISA § 104(b)(4), 29 U.S.C.A. § 1024(b)(4) (2008).

7. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

should not have to file a federal lawsuit to be assured a plan will be held to its promises.

One alternative is to have the employer direct the promise to the medical provider. In such a case, the promise could be enforceable under state law. This seems like a trap for the unwary. It could also be perceived as “unfair,” as if the courts are quick to preempt an employee’s state law claim but gladly allow a commercial enterprise to pursue the same claim under almost identical circumstances. Regardless of the reasons, the case law is clear. Oral promises to participants that are contrary to the plan’s terms are generally not enforceable absent extraordinary circumstances, whereas promises to medical providers are not only enforceable, but could also lead to mandatory attorneys’ fees or extra-contractual damages, depending on which state law applies.

This Article also reviews relevant doctrines that could impact whether a medical provider’s claim would be viable. Part II of this Article reviews ERISA preemption. Part III examines the exclusive vehicles for civil enforcement of ERISA under § 502(a).⁸ Part IV reviews the limits to remedies that are available under ERISA. Part V evaluates whether medical providers have standing to bring a claim for relief under ERISA. The standing analysis extends to Article III standing, statutory standing under ERISA § 502(a), and derivative standing as an assignee of a claim. Part VI surveys cases finding that state law claims brought by medical providers are not completely preempted by ERISA. Part VII concludes.

II. A PRIMER ON ERISA PREEMPTION

A. *Brief Summary of Federal Preemption*

“The Supremacy Clause, U.S. Const., Art. VI, may entail preemption of state law . . . by express provision, by implication, or by a conflict between federal and state law.”⁹ Under express preemption, “Congress can define explicitly the extent to which its enactments pre-empt state law.”¹⁰ “[I]n the absence of explicit statutory language, state law is pre-empted where it regulates conduct in a field that Congress intended the Federal Government to occupy exclusively.”¹¹ “Finally, state law is pre-empted to the

8. 29 U.S.C. § 1132(a).

9. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995) (citing *Pacific Gas & Elec. Co. v. State Energy Res. Conservation and Dev. Comm’n*, 461 U.S. 190 (1983) and *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218 (1947)).

10. *English v. Gen. Elec. Co.*, 496 U.S. 72, 78-79 (1990) (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95-98 (1983)).

11. *Id.* at 79; *Fidelity Fed. Sav. & Loan Ass’n v. De la Cuesta*, 458 U.S.

extent that it actually conflicts with federal law. Thus, the Court has found pre-emption where it is impossible for a private party to comply with both state and federal requirements or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.”¹² Whether a federal law preempts state law turns on congressional intent.¹³

“[W]here federal law is said to bar state action in fields of traditional state regulation,” the Court assumes “that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.”¹⁴ “Thus, when the text of a pre-emption clause is susceptible of more than one plausible reading, courts ordinarily ‘accept the reading that disfavors pre-emption.’”¹⁵ “[A]n assumption of nonpre-emption is not triggered,” however, “when the State regulates in an area where there has been a history of significant federal presence.”¹⁶

B. ERISA’s Express Preemption

ERISA § 514(a) provides that “the provisions of [Titles I and IV of ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .”¹⁷ “The term ‘State law’ includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State” (including the District of Columbia).¹⁸ With § 514, Congress intended “to establish the regulation of employee welfare benefits plans ‘as exclusively a federal concern.’”¹⁹

ERISA § 514(b) carves out certain state laws from the reach of ERISA preemption. As relevant here, those include state laws regulating insurance, banking, or securities.²⁰ Under § 514(b)(2)(B)—known as the deemer clause—an employer’s self-insured plan cannot be considered an insurance company subject to a state’s insurance laws.²¹ Congress also carved out generally

141, 153 (1982).

12. *English*, 496 U.S. at 79 (internal citations and quotations omitted).

13. *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 516 (1992).

14. *Travelers*, 514 U.S. at 655 (quoting *Rice*, 331 U.S. at 230).

15. *Altria Grp., Inc. v. Good*, 555 U.S. 70, 77 (quoting *Bates v. Dow Agrosciences LLC*, 544 U.S. 431, 449 (2005)).

16. *U.S. v. Locke*, 529 U.S. 89, 108 (2000).

17. 29 U.S.C. § 1144(a) (2006).

18. ERISA § 514(c)(1), 29 U.S.C. § 1144(c)(1).

19. *Travelers*, 514 U.S. at 656 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

20. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

21. 29 U.S.C. § 1144(b)(2)(B); see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987) ([T]o summarize the pure mechanics of [ERISA § 514(a) and (b)(2)]: If a state law “relate[s] to . . . employee benefit plan[s],” it is preempted. § 514(a). The saving clause excepts from the pre-emption clause laws

applicable criminal laws of the states from the pre-emptive force of ERISA.²²

Early in its jurisprudence of ERISA preemption, the Court interpreted ERISA preemption very broadly, holding that “a law ‘relates to’ an employee benefit plan . . . if it has a connection with or reference to such a plan.”²³ Since then, the Court has struggled with the scope of ERISA’s “relate-to” preemption. In some cases, the Court “observed repeatedly that this broadly worded provision is ‘clearly expansive.’”²⁴ At the same time, the Court “recognized that the term ‘relate to’ cannot be taken ‘to extend to the furthest stretch of its indeterminacy,’ or else ‘for all practical purposes preemption would never run its course.’”²⁵ “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.”²⁶ Justice Scalia once remarked that the Court’s application of ERISA’s “relate to” provision “was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else.”²⁷

To overcome the difficulty of determining when a state law “relates to” an employee benefit plan, the Court decided to “go beyond the unhelpful text and frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.”²⁸ Using this analysis, the Court held that § 514 preempts at least three categories of state law: (1) laws that mandate employee benefit structures or their administration, (2) laws that bind employers or plan administrators to particular choices or preclude uniform administrative practices, and (3) laws that provide alternative enforcement mechanisms to ERISA’s civil enforcement provisions.²⁹

In one of the earlier cases involving preemption of a state law cause of action, the Court held that ERISA preempts state common law tort and contract actions asserting improper

that “regulat[e] insurance.” § 514(b)(2)(A). The deemer clause makes clear that a state law that “purport[s] to regulate insurance” cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B).)

22. ERISA § 514(b)(4), 29 U.S.C. § 1144(b)(4).

23. *Shaw*, 463 U.S. at 96-97 (1983).

24. *Egelhoff v. Egelhoff ex. rel. Breiner*, 532 U.S. 141 (2001) (quoting *Travelers*, 514 U.S. at 655).

25. *Id.*

26. *Shaw*, 463 U.S. at 100 n.21; *Travelers*, 514 U.S. at 659-62.

27. *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 335 (1997) (Scalia, J., concurring).

28. *Travelers*, 514 U.S. at 656.

29. *Id.* at 658-60; *Trs. of AFTRA Health Fund v. Biondi*, 303 F.3d 765, 775 (7th Cir. 2002).

processing of a claim for benefits.³⁰ Following *Pilot Life*, the courts have found a host of state law claims founded on an employer's misrepresentations or misstatements preempted by ERISA.³¹

In *Franklin v. QHG of Gadsden, Inc.*,³² the employee's husband was confined to a 24-hour nursing care home due to his illness. The expenses were covered by the plan sponsored by her employer, Goodyear Tire & Rubber Company. She received an offer to work at Baptist Memorial Hospital, but she wanted her husband's expenses for nursing care covered. Baptist Memorial provided her assurances that the expenses would be covered, and she accepted its offer. Afterward, Baptist Memorial reduced the benefits. She sued alleging, among other things, misrepresentation. The Eleventh Circuit had little trouble finding her state law claims related to an employee benefit plan and were therefore preempted.³³ The court dismissed Franklin's argument that she had an independent agreement: "the written terms of a medical welfare plan cannot be modified by oral [or 'separate and distinct'] agreements,' the 'alleged misrepresentation relates directly to [the] medical benefits plan,' and plaintiff's state law claims are preempted."³⁴

In a second case, *Tart v. IMV Energy Systems of America, Inc.*,³⁵ the plaintiff agreed to work for the defendant only after the defendant promised that its health plan would cover fertility treatments. General Electric purchased Tart's employer one year after Tart's date of hire and amended the plan to eliminate the promised benefits. Relying on *Franklin*, and rejecting the plaintiff's argument that he had an independent agreement, the district court held the plaintiff's state law claims for

30. *Dedeaux*, 481 U.S. at 41.

31. See, e.g., *Carlo v. Reed Rolled Thread Die Co.*, 49 F.3d 790 (1st Cir. 1995); *Degan v. Ford Motor Co.*, 869 F.2d 889 (5th Cir. 1989); *Lister v. Stark*, 890 F.2d 941 (7th Cir. 1989); *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6 (2d Cir. 1992); *Pohl v. Nat'l Benefits Consultants, Inc.*, 956 F.2d 126 (7th Cir. 1992); *Muse v. IBM*, 103 F.3d 490 (6th Cir. 1996); *Griggs v. E.I. DuPont De Nemours & Co.*, 237 F.3d 371 (4th Cir. 2001); *Reliable Home Health Care, Inc. v. Union Cent. Ins. Co.*, 295 F.3d 505 (5th Cir. 2002); *Bartholet v. Reishauer A.G.*, 953 F.2d 1073 (7th Cir. 1992); *Elmore v. Cone Mills Corp.*, 23 F.3d 855 (4th Cir. 1994); *Nester v. Allegiance Healthcare Corp.*, 162 F. Supp. 2d 901 (S.D. Ohio 2001); see generally Paul J. Ondrasik, Jr. and Leslie R. Hoffman, *The Inconsistent Oral Promise and Related Problems*, ERISA Litigation Conference – 15th Annual, ELC GLASS-CLE 296, Glasser Legalworks (2002) (discussing ERISA preemption of state law claims based on employers' misrepresentations or misstatements).

32. *Franklin v. QHG of Gadsden, Inc.*, 127 F.3d 1024 (11th Cir. 1997).

33. *Id.* at 1028-29.

34. *Tart v. IMV Energy Sys. of Am., Inc.*, 374 F. Supp. 2d 1172, 1180-81 (N.D. Ga. 2005) (quoting *Franklin*, 127 F.3d at 1029).

35. *Tart*, 374 F. Supp. 2d at 1172.

misrepresentation were preempted by ERISA.³⁶

As the foregoing cases indicate, an employee's state law claim based on broken promises, misstatements, and misrepresentations are preempted by ERISA. It does not help an employee to claim that a separate agreement existed with the employer. Any such claim is preempted. This form of preemption is sometimes referred to as "defensive" preemption, because it is considered an affirmative defense that can be pled, or waived, in both state and federal courts.³⁷

C. ERISA Conflict Preemption

ERISA preempts a state law if it "conflicts with the provisions of ERISA or operates to frustrate its objectives."³⁸ When it does, there is no need to determine whether ERISA's "relate to" provision preempts the state law.³⁹ In *Boggs*, the Court held ERISA preempts a Louisiana law that would permit a non-participant spouse to transfer an interest in undistributed pension benefits through her will.⁴⁰ The United States District Court for the Northern District of West Virginia held a West Virginia statute that would extinguish the Pension Benefit Guaranty Corporation lien on a warehouse sold in a tax sale was preempted because it conflicts with ERISA § 4068, 29 U.S.C. § 1368.⁴¹

D. Field Preemption

The clearest example of ERISA field preemption is the doctrine of complete preemption.⁴² Complete preemption is a

36. *Id.*; see also *Ellenburg v. Parkway, Inc.*, 763 F.2d 1091 (9th Cir. 1985).

37. *Saks v. Franklin Covey Co.*, 316 F.3d 337, 349-50 (2d Cir. 2003); *Bertoni v. Stock Bldg. Supply*, 989 So. 2d 670, 674 (Fla. Dist. Ct. App. 2008).

38. *Boggs v. Boggs*, 520 U.S. 833, 841 (1997).

39. *Id.*

40. *Boggs*, 520 U.S. at 844-54; *Branco v. UFCW-N. Cal. Emp'rs Joint Pension Plan*, 279 F.3d 1154 (9th Cir. 2002).

41. *Pension Benefit Guar. Corp. v. Boury, Inc.*, No. 5:02-CV-161, 2009 WL 3334924 (N.D. W.Va. October 14, 2009) (unpublished), available at http://scholar.google.com/scholar_case?case=8159676710432161345&q=Pension+Benefit+Guaranty+Corp.+v.+Boury,+Inc&hl=en&as_sdt=2,14.

42. As the Court noted, the different categories of preemption are not "rigidly distinct." "Indeed, field preemption may be understood as a species of conflict preemption." *English*, 496 U.S. at 79 n.5. For example, in some instances courts have suggested that ERISA's express "relate to" preemption and conflict preemption may be the same. *Ellis v. Liberty Life Assur. Co. of Boston*, 394 F.3d 262, 275-76 (5th Cir. 2004). However, the court may have been alluding to § 514 as an "express conflict provision." *David P. Coldesina, D.D.S. v. Estate of Simper*, 407 F.3d 1126, 1136 (10th Cir. 2005); *Van Natta v. Sara Lee Corp.*, 439 F. Supp. 2d 911, 924 n.4 (N.D. Iowa 2006). In placing ERISA complete preemption under the rubric of field preemption, this Article follows the lead of the Court. *Rush Prudential HMO v. Moran*, 536 U.S. 355,

jurisdictional doctrine. In contrast to “defensive preemption,” which does not provide a basis for federal jurisdiction, complete preemption empowers a federal court with jurisdiction over what would otherwise be a state law claim. Complete preemption is often an issue when a defendant removes a state law claim for benefits to federal court.⁴³

A civil action filed in state court may be removed to federal court if the claim “arises under” federal law.⁴⁴ As a general rule, claims based on state law do not arise under federal law and thus are not removable. To determine whether an action arises under federal law, the courts rely on the well-pleaded complaint rule. Under that rule, courts “examine the ‘well pleaded’ allegations of the complaint and ignore potential defenses.”⁴⁵ “As a general rule, absent diversity jurisdiction, a case will not be removable if the complaint does not affirmatively allege a federal claim.”⁴⁶

One exception to the well-pleaded complaint rule arises when the preemptive force of a federal law “is so powerful as to displace entirely any state cause of action”⁴⁷ In such a case, a complaint may be removed even if the complaint alleges only state causes of actions. For example, in *Avco Corp. v. Machinists*,⁴⁸ the Court held that an employer’s state law claim to enjoin a strike as a violation of the “no-strike” clause under the collective bargaining agreement was removable under § 301 of the Labor Management Relations Act.⁴⁹ Similarly, in *Metropolitan Life*, the Court held that, due in part to ERISA’s civil enforcement scheme at § 502(a), 29 U.S.C. § 1132(a), ERISA completely preempts a state law cause of action asserting improper processing of benefit claims under a plan covered by ERISA.⁵⁰

At least two consequences stem from a court’s finding that a state law claim is completely preempted. First, complete

378 (2002) (citing *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 64 (1987)).

43. A claim for plan benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), may be brought in state court or federal court because state and federal courts have concurrent jurisdiction. ERISA § 502(e), 29 U.S.C. § 1132(e). Provided that the other requirements of removal are satisfied, a § 502(a)(1)(B) claim can be removed because the action arises under federal law. 28 U.S.C. § 1441 (2006).

44. 29 U.S.C. § 1441(b).

45. *Beneficial Nat’l Bank v. Anderson*, 539 U.S. 1, 6 (2003).

46. *Id.*

47. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 64 (1987) (quoting *Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 23-24 (1983)).

48. *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968).

49. 29 U.S.C. § 185 (2006).

50. *Metro. Life*, 481 U.S. at 64. See *infra* notes 65-70 for a more detailed discussion of ERISA’s civil enforcement scheme under ERISA § 502(a), 29 U.S.C. § 1132(a).

preemption serves as the basis for removal of a state law claim.⁵¹ Second, complete preemption “convert[s] an ordinary state common law complaint into one stating a federal claim.”⁵² Prior to *Aetna v. Davila*,⁵³ to be completely preempted, a claim was required both (1) to relate to an employee benefit plan and (2) fall within the scope of ERISA’s civil enforcement provisions set forth in ERISA § 502(a).⁵⁴

Davila clarified the analysis of complete preemption under ERISA. It rose in the context of managed care litigation and involved numerous claimants consolidated into one case. To illustrate one claim, the claimant’s treating physician recommended an extended hospital stay after her surgery. The managed care organization that administered her employer’s health plan, CIGNA, denied coverage for the stay. Later, she experienced postsurgery complications that she alleged were caused by CIGNA’s failure to authorize her extended hospital stay.⁵⁵

Seeking tort damages,⁵⁶ she sued CIGNA in Texas state court under the Texas Health Care Liability Act (“THCLA”)⁵⁷ alleging CIGNA violated its duty of care. CIGNA removed the case to federal court and the claimant filed a motion to remand. The District Court held the claim was completely preempted by ERISA and denied the motion.⁵⁸ All of the claimants involved in the case refused to amend their complaints to include an ERISA claim and appealed the denial of the motion to remand.⁵⁹ On appeal, the United States Court of Appeals for the Fifth Circuit held the claims were not completely preempted, and CIGNA appealed to the Supreme Court.

Relying on *Pilot Life*, the Court held that “any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-

51. See, e.g., *Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc.*, 958 F. Supp. 1137, 1144 (E.D. Va. 1997) (stating that “[i]t is important to recognize that the jurisdictional doctrine of complete preemption differs from the federal defense of ERISA preemption. Only the former, not the latter, is a basis for removal.”) (footnote omitted).

52. *Custer v. Sweeney*, 89 F.3d 1156, 1165 (4th Cir. 1996) (quoting *Metro. Life*, 481 U.S. at 64).

53. *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004).

54. *Marks v. Watters*, 322 F. 3d 316, 323 (4th Cir. 2003) (citing *Metro. Life*, 481 U.S. at 66-67).

55. *Davila*, 542 U.S. at 204-05.

56. *Id.* at 214.

57. TEX. REV. CIV. STAT. ANN. §§ 88-001-88.003 (West 2004 Supp. Pamphlet).

58. *Davila*, 542 U.S. at 205.

59. *Id.*

empted.”⁶⁰ The Court went on to hold that under the complete preemption doctrine, “causes of action within the scope of the civil enforcement provisions of § 502(a) [are] removable to federal court.”⁶¹

Next the Court held that the claimant’s THCLA cause of action was within the scope of ERISA § 502(a)(1)(B):

[I]f an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls “within the scope of” ERISA § 502(a)(1)(B). In other words, if an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant’s actions, then the individual’s cause of action is completely pre-empted by ERISA § 502(a)(1)(B).⁶²

The Court found that the THCLA did not establish an “independent legal duty” because the managed care organization’s duties would be triggered only if the plan’s terms covered the denied treatment. If the plan did not cover the treatment, then the managed care entity could not be held liable for the denial.⁶³

Courts have construed *Davila* to require that a claim must satisfy three elements to be completely preempted by ERISA. First, the claim must fall within the scope of the civil enforcement provisions of ERISA § 502(a).⁶⁴ Second, the plaintiff must have standing to bring a suit under ERISA.⁶⁵ Third, ERISA does not completely preempt a claim if the claim implicates a duty that is independent of ERISA.⁶⁶

The first element required for complete preemption is the claim must fall within the civil enforcement provisions in § 502(a) of ERISA.⁶⁷ Those enforcement provisions play a pivotal role in ERISA litigation.

III. ERISA’S CIVIL ENFORCEMENT PROVISIONS

In *Pilot Life*, the Court observed that the civil enforcement provisions of ERISA § 502(a) are the exclusive vehicle for actions by ERISA plan participants and beneficiaries asserting improper

60. *Id.* at 209.

61. *Id.* (quoting *Metro. Life*, 481 U.S. at 66).

62. *Id.* at 210 (internal citations omitted).

63. *Id.* at 212-13.

64. *Ehlen Floor Covering, Inc. v. Lamb*, 660 F.3d 1283, 1287-88 (11th Cir. 2011).

65. *Id.*

66. *Id.*

67. 29 U.S.C.A. § 1132(a) (West 2009).

processing of a claim for benefits.⁶⁸ In other words, any actions based on ERISA must be brought under one of the provisions in § 502(a). The provisions that are relevant here are ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and § 502(a)(3), 29 U.S.C. § 1132(a)(3).⁶⁹

Under § 502(a)(1)(B), a participant or beneficiary may only be awarded benefits that are due under the terms of the plan.⁷⁰ A participant or beneficiary may also bring an action under § 502(a)(1)(B) to enforce his rights under the terms of the plan or to clarify his rights to future benefits under the terms of the plan.

ERISA § 502(a)(3) permits a participant, beneficiary, or fiduciary to bring a civil action to enjoin any action that violates ERISA or the terms of the plan.⁷¹ In addition, an action may be brought to redress a violation of ERISA, or to enforce any provision of ERISA or the terms of the plan, but the relief under § 502(a)(3) is limited to “appropriate equitable relief.”⁷²

These two provisions of ERISA, §§ 502(a)(1)(B) and 502(a)(3), are generally the only cause of actions that would be available to a participant injured by a plan’s misstatement or misrepresentation. And, as the exclusive vehicle for ERISA actions, these sections limit the ERISA remedies that are available to a participant or beneficiary.

A. ERISA Remedies

There are a considerable number of cases and articles that discuss ERISA’s limited remedies.⁷³ Accordingly, this Article will

68. *Pilot Life*, 481 U.S. at 53.

69. The remedies that are available under ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2), are limited to the relief provided under ERISA § 409, 29 U.S.C. § 1109. Under that section, generally, a fiduciary can be held personally liable for losses to the plan resulting from, or a disgorgement of profits realized by a use of plan assets in, a breach of ERISA fiduciary duties. Relief under § 409 can only be imposed on ERISA fiduciaries, and the recovery must inure to the benefit of the plan. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140-48 (1985). *See also LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248 (2008). This Article will not address remedies that run in favor of the plan, and thus will not cover ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2).

70. *See, e.g., Clair v. Harris Trust & Sav. Bank*, 190 F.3d 495, 497 (7th Cir. 1999) (stating that “only benefits specified in the plan can be recovered in a suit under section 502(a)(1)(B)”).

71. ERISA § 502(a)(3)(A); 29 U.S.C.A. § 1132(a)(3)(A).

72. ERISA § 502(a)(3)(B); 29 U.S.C.A. § 1132(a)(3)(B).

73. *See, e.g., Dana Muir, ERISA Remedies: Chimera or Congressional Compromise?*, 81 IOWA L. REV. 1 (1995); Andrew Stumpff, *Darkness at Noon: Judicial Interpretation May Have Made Things Worse for Benefit Plan Participants Under ERISA Than Had the Statute Never Been Enacted*, 23 ST. THOMAS L. REV. 221, 233-36 (2011); Peter K. Stris, *ERISA Remedies, Welfare Benefits, and Bad Faith: Losing Sight of the Cathedral*, 26 Hofstra. LAB. &

provide only a brief review.

The available remedies under §§ 502(a)(1)(B) and 502(a)(3) are generally limited to benefits due under the terms of the plan, an injunction, or other appropriate equitable relief. Notably, ERISA does not authorize an award of extra-contractual compensatory, or punitive damages for the improper or untimely processing of benefit claims.⁷⁴ Moreover, § 502(a)(3) does not authorize monetary damages, but instead limits relief to “appropriate equitable relief.”⁷⁵

Appropriate equitable relief is relief that was “typically available in equity.”⁷⁶ This includes equitable remedies such as an “injunction, mandamus, and restitution, but not compensatory damages.”⁷⁷ Recently, the Court may have broadened the generally accepted concepts of what relief may be available under § 502(a)(3), but absent an amendment to ERISA, it is doubtful that extra-contractual or punitive damages will ever be available under ERISA § 502(a)(3).⁷⁸

Generally, no relief is available under § 502(a)(3) where Congress provided for adequate relief in another provision of ERISA.⁷⁹ Thus, where a participant is eligible for relief under § 502(a)(1)(B), he is not permitted to bring a simultaneous claim under ERISA § 502(a)(3) that in essence is a disguised benefit claim.⁸⁰ However, if the two claims allege different injuries, both may be pursued.⁸¹

Most circuits have allowed ERISA claimants to proceed under the doctrine of equitable estoppel.⁸² To succeed on an estoppel claim, plaintiffs must usually, depending on the court,

EMP. L.J. 387 (2009).

74. *Russell*, 473 U.S. at 148.

75. *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Todisco v. Verizon Commc'ns, Inc.*, 497 F.3d 95, 99 (1st Cir. 2007).

76. *Mertens*, 508 U.S. at 256.

77. *Id.*

78. *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011). Other forms of relief that might be available in connection with ERISA litigation include, but are not limited to, attorneys' fees (though attorneys' fees are discretionary), prejudgment interest, postjudgment interest, and “ill-gotten” plan assets or profits. ERISA § 502(g), 29 U.S.C. § 1132(g); *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1030 (4th Cir. 1993); *Harris Trust and Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 247-53 (2000).

79. *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996).

80. *Mondry v. Am. Family Mut. Ins. Co.*, 557 F.3d 781, 805 (7th Cir. 2009) (citing *Korotynska v. Metro. Life Ins. Co.*, 474 F.3d 101, 106 (4th Cir. 2006)).

81. See *Gore v. El Paso Energy Corp. Long Term Disability Plan*, 477 F.3d 833, 839-40 (6th Cir. 2007); *Hill v. Blue Cross and Blue Shield of Mich.*, 409 F.3d 710 (6th Cir. 2005).

82. See, e.g., *Mello v. Sara Lee Corp.*, 431 F.3d 440, 444-47 (5th Cir. 2005); *Robert E. Hoskins, Equitable Estoppel as a Remedy Under ERISA*, 56 S.D. L. REV. 456 (2011).

demonstrate similar (though not always identical) elements: (1) a material misrepresentation in writing, (2) reasonable and detrimental reliance, and (3) extraordinary circumstances.⁸³ “Principles of estoppel, however, cannot be applied to vary the terms of unambiguous plan documents; estoppel can only be invoked in the context of ambiguous plan provisions.”⁸⁴ Indeed, the “Supreme Court, followed by several courts of appeals, has indicated that a modification that purports to vest welfare benefits must be contained in the plan documents and must be stated in clear and express language.”⁸⁵

If an oral misrepresentation is made by a plan fiduciary and the statement arises to the level of a breach of fiduciary duties, then a participant might have a claim under ERISA § 502(a)(3).⁸⁶ For example, in *Varity*, the employer intentionally misled plan participants about their future benefits to induce them to agree to transfer to a newly established company that the employer reasonably knew would fail.⁸⁷ The Court found this to be a breach of fiduciary duty that was actionable under § 502(a)(3) and affirmed the remedy of reinstatement to the employer’s old plan.⁸⁸

The Seventh Circuit’s opinion in *Frahm* distinguishes between the course of conduct found in *Varity* and mere “bad advice delivered verbally.”⁸⁹ There, the retiree plaintiffs alleged their employer made oral representations about their retirement benefits, but later breached those representations when it raised the retiree’s cost of medical benefits.⁹⁰ The retirees argued that these representations were actionable pursuant to *Varity*. The Seventh Circuit found the employer in *Varity* engaged in a “campaign of disinformation that led employees to surrender their benefits.”⁹¹ The court rejected the notion that ERISA § 404(a),⁹²

83. *Mello*, 431 F.3d at 444-45; *Hoskins*, *supra* note 82, at 471-73.

84. *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 404 (6th Cir. 1998).

85. *Vallone v. CNA Fin. Corp.*, 375 F.3d 623, 632 (7th Cir. 2004) (citing *Inter-Modal Rail Emps. Ass’n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515 (1997)); see also *Frahm v. Equitable Life Assurance Society*, 137 F.3d 955, 958 (7th Cir. 1998), in which the court stated:

Although . . . a written plan may be combined with an oral promise, . . . the utility of reducing retirement promises to writing and avoiding arguments about who said what to whom are so fundamental to both ERISA and contract law that an extension of the writing requirement to all long-term commitments is an inescapable ingredient of the federal common law slowly accumulating in ERISA’s shadow.

86. *Varity Corp. v. Howe*, 516 U.S. 489 (1996); *Adams v. Freedom Forge Corp.*, 204 F.3d 475 (3d Cir. 2000).

87. *Varity*, 516 U.S. at 506-15.

88. *Id.*

89. *Frahm*, 137 F.3d at 961.

90. *Frahm*, 137 F.3d at 956-57.

91. *Id.* at 959.

the statute that establishes ERISA's fiduciary standards, "is a guarantor of accurate information at all times."⁹³ The court of appeals said "[t]reating [ERISA § 404(a)] as establishing a duty to give plan participants whatever benefits someone on the staff led them to believe were available would undermine an essential principle established by ERISA: there are no oral variances from written plans."⁹⁴

The limited remedies that are available under ERISA appear to be a strong motivating factor in disputes over whether a claim is preempted by ERISA. The potential to be awarded extra-contractual damages, punitive damages, or even mandatory attorneys' fees in state court, combined with the absence of such remedies under ERISA, gives plaintiffs an incentive to pursue state law claims. Another factor could be the deferential standard of review afforded to plan fiduciaries that have discretion to interpret a plan.⁹⁵ A third factor is that medical service providers may not have standing to pursue a claim under ERISA.

B. Standing

When state law remedies are not available because of ERISA preemption, standing can be critical. If the state law claims are preempted, then the only remedies a plaintiff may seek are those that are available under ERISA. But, as noted above, the only avenues available for ERISA are the exclusive civil enforcement vehicles set forth in ERISA § 502(a). Thus, if a plaintiff's state law claims are preempted, and the plaintiff has no standing to pursue a claim under § 502(a), the plaintiff will be left with no relief to pursue.⁹⁶

There are at least three ways a medical provider could lack standing to bring an ERISA claim. First, the provider may not have standing under Article III of the Constitution. Second, a provider may not have direct, statutory standing under § 502(a) of ERISA. Third, the provider may not have standing to bring a claim as an assignee—known as derivative standing—if the assignment is not valid.⁹⁷ Each is discussed below.

92. 29 U.S.C.A. § 1104(a) (West 2008).

93. *Frahm*, 137 F.3d at 958-59.

94. *Id.* at 960.

95. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

96. *See Felix v. Lucent Techs., Inc.*, 387 F.3d 1146, 1162 (10th Cir. 2004) (explaining that "our opinion leaves open the uncomfortable possibility that Plaintiffs may lack standing to sue under ERISA, but will then be preempted in state court under § 514 from asserting a state claim, leaving them with no remedy.").

97. In some cases, a medical service provider might not be a real party in interest under Rule 17 of the Federal Rules of Civil Procedure.

1. Article III Standing to Pursue Assigned Claims; in General

At common law, not all claims were assignable. For example, “[u]nder the common law and the law of most states, personal injuries claims are not assignable absent a statute to the contrary.”⁹⁸ In contrast, the Court today recognizes that “an assignee of a legal claim for money owed has standing to pursue that claim in federal court.”⁹⁹

In *Sprint*, payphone operators (“operators”) assigned their claims for payment from long distance communications carriers (such as Sprint or AT&T) (“carrier”) to aggregators (“aggregators”).¹⁰⁰ The aggregators would sue the carrier on behalf of the operators, remit any recovery to the operators, and receive a fee for this service. The carriers asserted the aggregators had no standing, and this argument reached the Supreme Court.¹⁰¹

To have standing under Article III:¹⁰²

[A] plaintiff must adequately establish: (1) an injury in fact (*i.e.*, a “concrete and particularized” invasion of a “legally protected interest”); (2) causation (*i.e.*, a “fairly . . . trace[able]” connection between the alleged injury in fact and the alleged conduct of the defendant); and (3) redressability (*i.e.*, it is “likely” and not “merely speculative” that the plaintiff’s injury will be remedied by the relief plaintiff seeks in bringing suit).¹⁰³

The Court found the aggregators satisfied all of these requirements.

The operators’ injury sufficiently established an injury in fact because “an assignee can sue based on his assignor’s injuries.”¹⁰⁴ As for redressability, the inquiry focuses on whether the injury “is likely to be redressed through the litigation.”¹⁰⁵ The majority opinion defines the “injury” as the carrier’s failure to pay¹⁰⁶ and the failure, by somebody—or anybody—“to receive” payment.¹⁰⁷ The requisite injury, the majority appears to imply, had nothing to do with whether the operators received payment. Because

98. *Lexington Ins. Co. v. S.H.R.M. Catering Serv., Inc.*, 567 F.3d 182, 185 (5th Cir. 2009) (internal quotations omitted).

99. *Sprint Commc’ns Co., L.P. v. APCC Servs., Inc.*, 554 U.S. 269, 271 (2008).

100. *Id.* at 271-72.

101. *Id.* at 272-73.

102. U.S. CONST. art. III, § 2.

103. *Sprint Commc’ns*, 554 U.S. at 273-74 (quoting *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992)) (punctuation omitted).

104. *Id.* at 286 (citing *Vt. Agency of Natural Res. v. United States ex rel. Stevens*, 529 U.S. 765 (2000)).

105. *Id.* at 287.

106. *Id.* at 273.

107. *Id.* at 287. The Court had no problem assuming the carriers caused that injury. *See id.* at 274 (stating that “[t]he ‘carriers’ caused that injury”).

successful litigation by the aggregators would result in the carriers writing somebody a check—even if to the aggregators and not to the operators—the injury, as defined by the majority opinion, could be redressed through the litigation.¹⁰⁸

2. Article III Standing as Assignee of an ERISA § 502(a)(1)(B) Claim

No court has addressed how *Sprint* might impact the assignment of a claim under ERISA § 502(a)(1)(B) to a medical service provider,¹⁰⁹ but *Sprint* should not have much impact. It seems a medical provider would easily satisfy *Sprint*'s three requirements for Article III standing: injury, causation, and redressability. A medical provider's claim would satisfy the requirements for redressability even under the standard articulated by Chief Justice Roberts in his dissent in *Sprint*. There, Chief Justice Roberts argues, *inter alia*, that redressability concerns whether the *complaining* party's injury—that the operators did not receive payment—can be redressed by the litigation.¹¹⁰ “We have never approved federal-court jurisdiction over a claim where the entire relief requested will run to a party not before the court.”¹¹¹ Because a medical provider seeks to redress its own injury before the court, even under the dissent's standard a medical provider would have Article III standing to pursue an assigned § 502(a)(1)(B) claim. There could, however, be some circumstances where an assignee of a § 502(a)(3) claim may not have Article III standing because the claim would not satisfy *Sprint*'s requirement for redressability.

3. Article III Standing as Assignee of an ERISA § 502(a)(3) Claim

Although no court has held that claims under § 502(a)(3) are assignable for standing purposes, some courts may have implied they are.¹¹² In *Neuma*, the plaintiff corporation (“Neuma”) entered

108. *Id.*

109. In an unpublished opinion, a magistrate judge relied on *Sprint* to recommend that a health benefit claim assigned to the plaintiff in a divorce decree should not be dismissed under Rule 12(b)(1) of the Federal Rules of Civil Procedure. *Harwood v. Unicare Life & Health Ins. Co.*, Civ. Act. No. SA-09-CV-0845 OG (NN), 2010 WL 1641273 (W.D. Tex. Apr. 19, 2010).

110. *Sprint Commc'ns*, 554 U.S. at 302 (Roberts, C.J., dissenting).

111. *Id.* (Roberts, C.J., dissenting).

112. *Biomed Pharms., Inc. v. Oxford Health Plans, Inc.*, 775 F. Supp. 2d 730 (S.D.N.Y. 2011); *Neuma, Inc. v. Wells Fargo & Co.*, 515 F. Supp. 2d 825, 848-49 (N.D. Ill. 2006); *Suntrust Bank v. Aetna Life Ins. Co.*, 251 F. Supp. 2d 1282, 1290-91 (E.D. Va. 2003). In some opinions the implication is at best tenuous, arising only because the court failed to dismiss for lack of standing even though a court has a duty to determine its jurisdiction. See *Lance v. Coffman*, 549 U.S. 437, 439 (2007) (explaining how “federal courts must determine that they have jurisdiction before proceeding to the merits.”).

into an agreement—commonly referred to as a viatical settlement agreement—under which a plan participant assigned his rights under a life insurance plan sponsored by Wells Fargo in exchange for a lump sum payment.¹¹³ Under the agreement, Neuma would pay the premiums and receive the death benefits as a plan beneficiary when the participant died.¹¹⁴ The participant's coverage under the plan ended upon his termination of employment,¹¹⁵ but he had the right to convert to an individual policy within thirty-one days after termination.¹¹⁶

Before Neuma tendered payment to the participant, it contacted Wells Fargo to inquire about the participant's employment status.¹¹⁷ Wells Fargo confirmed the employment status, but failed to mention the participant was scheduled to be terminated in thirty days.¹¹⁸ When the participant terminated, nobody informed Neuma and the coverage lapsed without any possibility of a conversion.¹¹⁹ After it learned of the employee's termination, Neuma requested copies of plan documents.¹²⁰ Wells Fargo furnished Neuma with some disclosures, but Neuma asserted Wells Fargo did not furnish all the disclosures required by ERISA.¹²¹ Neuma filed a suit against Wells Fargo seeking benefits pursuant to ERISA § 502(a)(1)(B), relief under § 502(a)(3), and statutory penalties under §§ 502(a)(1)(A) and 502(c).¹²²

The court first considered whether Neuma might have adequate relief under § 502(a)(1)(B), which would render it ineligible to bring a § 502(a)(3) claim.¹²³ The court found that Neuma was not a participant or beneficiary of the plan, and dismissed the § 502(a)(1)(B) for lack of standing.¹²⁴ Accordingly, the § 502(a)(3) claim survived. The court dismissed the § 502(c) claim, however, because Neuma was not a participant or beneficiary and thus lacked standing for that claim.¹²⁵ Curiously, though, the court did not dismiss the § 502(a)(3) claim for lack of standing. The court did not address this issue, but presumably the

113. *Neuma*, 515 F. Supp. 2d at 829.

114. *Id.* at 830.

115. *Id.* at 831.

116. *Id.*

117. *Id.* at 834.

118. *Id.*

119. *Id.* at 836-37.

120. *Id.* at 837-38.

121. *Id.*

122. *Id.* at 841-45; 29 U.S.C. §§ 1132(a)(1)(A), 1132(c).

123. *Id.* at 845-46.

124. *Neuma*, 515 F. Supp. 2d at 848.

125. *See id.* at 858 (ruling that Neuma was not a beneficiary, but providing an example of how a third-party provider could potentially have standing as a beneficiary, e.g., as a beneficiary of a life insurance plan); *see also infra* note 129.

court knew Neuma did not have standing under § 502(a)(3) as a participant or beneficiary. One possible explanation is the court assumed Neuma had derivative standing as an assignee of the § 502(a)(3) claim. In this way, the court implied that an assignee has standing to bring a claim under § 502(a)(3) of ERISA.

Varity provides an example of the type of claim that a medical provider may not have Article III standing to pursue.¹²⁶ The question is whether, if one of the employees in *Varity* had been treated at a hospital and assigned her claim, the hospital would have standing to seek the reinstatement of the employee into the employer's old plan. It would seem that, even under *Sprint*'s generous theory of standing as an assignee, the court would not be able to redress the injury in the litigation.¹²⁷ Unlike in *Sprint*, where a win by the operators would result in the carriers cutting a check to the aggregators, in this hypothetical the hospital could not receive payment in the litigation because § 502(a)(3) does not authorize monetary relief. Instead, the employee would have to receive a court order of reinstatement. Even then, the employee would have to exhaust her administrative remedies under ERISA. Only after those two steps were completed could the medical provider be awarded cash payment in the litigation. It appears, then, that the injury—either the failure of the hospital to receive payment or the failure of the plan to pay—could not be redressed in the litigation. Accordingly, an assignee of a *Varity*-type claim may not have Article III standing to pursue the § 502(a)(3) claim.

An example of an assigned § 502(a)(3) claim that would likely survive an Article III challenge would be a subrogation claim. It is common for ERISA health plans—particularly those that are fully insured—to assign to a third party the right to pursue a subrogation claim on behalf of the plan. And like the operators in *Sprint*, such assignees typically turn over the proceeds from the litigation to the plan and receive a fee for their services (which typically is bundled within a larger fee arrangement). This fact pattern is almost identical to the fact pattern in *Sprint*, and thus a § 502(a)(3) subrogation claim is likely assignable for purposes of the assignee's standing under Article III.

4. *Statutory Standing to Pursue ERISA Claims*

The concept of statutory standing is distinct from Article III standing.¹²⁸ In *Sprint*, the Court addressed whether an

126. See *supra* text accompanying notes 85-87.

127. It is also possible the provider would not be a real party in interest under Rule 17 of the Federal Rules of Civil Procedure.

128. *CGM, LLC v. BellSouth Telecomms., Inc.*, 664 F.3d 46, 52 (4th Cir. 2011). An example of one distinction is that, procedurally, a motion to dismiss for lack of Article III standing is filed under Rule 12(b)(1) of the Federal Rules of Civil Procedure. *Id.* Dismissal for lack of standing under § 502(a) should be

assignment confers Article III standing on the assignee; *Sprint* did not, of course, consider standing under ERISA § 502(a).

The courts clearly hold that statutory standing under ERISA § 502(a)(1)-(3) is limited to participants, beneficiaries, fiduciaries, and the Secretary of Labor.¹²⁹ Only a participant or beneficiary has standing to bring a claim for benefits under ERISA § 502(a)(1)(B).¹³⁰ ERISA § 502(a)(3) by its terms only authorizes lawsuits by participants, beneficiaries, and fiduciaries.¹³¹ Nowhere does the text of ERISA authorize medical providers to bring a claim under ERISA. Moreover, medical providers will rarely, if ever, be considered a participant, beneficiary, or fiduciary of a plan.¹³² Accordingly, to seek relief under ERISA, their only recourse is to bring a claim as an assignee of a participant or beneficiary.

5. Derivative Statutory Standing as an Assignee

Several courts of appeals have held that a medical service provider may have derivative standing under § 502(a). Under the doctrine of derivative standing, the assignee of an ERISA benefit claim “stands in the shoes of his assignor, and, if the assignment is

pursued under Rule 12(b)(6) of the Federal Rules of Civil Procedure. *Id.*

129. See, e.g., *Cripps v. Life Ins. Co. of N. Am.*, 980 F.2d 1261, 1264-65 (9th Cir. 1992) (noting that statutory standing is limited to participants, beneficiaries, fiduciaries, and the Secretary of Labor).

130. ERISA § 502(a)(1)(B); 29 U.S.C. § 1132(a)(1)(B); *Pascack Valley Hosp. Inc. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 400 (3d Cir. 2004) (citing *Franchise Tax Bd.*, 463 U.S. at 27).

131. 29 U.S.C. § 1132(a)(3); see also *Sonoco Prods. Co. v. Physicians Health Plan, Inc.*, 338 F.3d 366, 372 (4th Cir. 2003) (stating “only parties entitled to pursue an ERISA claim under § 502(a)(3) are ‘participants,’ ‘beneficiaries,’ and ‘fiduciaries’”).

132. Depending on the language of the plan and the surrounding circumstances, it may be possible to argue that a medical provider is a beneficiary of the plan. See ERISA § 3(8); 29 U.S.C.A. § 1002(8) (West 2008) (defining the term “beneficiary”). For example, in *OSF Healthcare System v. Marcone Appliance Parts Co. Employee Benefit Plan*, No. 1:11-cv-01202-JBM-JAG, 2012 WL 264197 (C.D. Ill. Jan. 27, 2012), the court found that a medical provider could have standing as an “appointed representative” of the participant. In that case, the plan used the term “claimant,” but did not define that term. The plan did define the term “employee” and “dependent,” and the medical provider argued that the term “claimant” must mean something other than the covered employee or his dependents.” *Id.* The plan document provided further that the plan would consider a claim for benefits from a “properly designated representative.” The medical provider argued that, as the appointed representative, it was a “claimant,” and that a “claimant” was a beneficiary under the plan and thus a beneficiary with standing under ERISA. See *id.* Using these arguments, the medical provider survived a Rule 12(b)(1) motion to dismiss, but the court left open the possibility that the designation of the medical provider as an “appointed representative” was an invalid assignment that would deprive the medical provider of standing. *Id.*

valid, has standing to assert whatever rights the assignor possessed.”¹³³ This raises two issues for purposes of ERISA claims.

The first issue is whether ERISA allows the assignment of health care benefits.¹³⁴ “Almost every circuit to have considered the question has held that a health care provider can assert a claim under § 502(a) where a beneficiary or participant has assigned to the provider that individual’s right to benefits under the plan.”¹³⁵ *Misic* was one of the earliest cases to recognize standing as an assignee.

Dr. Misic performed dental services for the plan’s beneficiaries who would assign their benefits to him. The plan provided that it would pay for eighty percent of the cost of the beneficiaries’ dental care. When Dr. Misic submitted his bills, the plan paid less than eighty percent.

Dr. Misic sued the plan asserting both an ERISA claim as an assignee and various state law tort claims. Both the Defendant and the Department of Labor argued that only those parties identified in ERISA § 502(a) have standing to bring an ERISA claim. The court responded that this argument “mistakenly treat[s] Dr. Misic as a suitor in his own right. Dr. Misic sues derivatively, as [an] assignee of beneficiaries.”¹³⁶ Relying on numerous non-ERISA cases holding that a valid assignment confers standing on assignees, the court held that Dr. Misic had standing to sue as an assignee.

The validity of an assignment is the second issue to be considered in determining whether a medical provider has derivative standing. One potential objection to derivative standing to bring a § 502(a)(1)(B) claim is the claim is equitable and, therefore, the assignment would not be valid. A § 502(a)(1)(B) claim has been held to be equitable in the context of plaintiffs’ request for jury trials in ERISA cases. The Seventh Amendment¹³⁷ guarantees a jury trial for statutory actions that are “analogous to common-law law causes of action ordinarily decided in English law courts in the late 18th century, as opposed to those customarily heard by courts of equity”¹³⁸ In determining whether a statutory action would have been tried in law or in equity, the

133. *Misic v. Bldg. Serv. Emps. Health*, 789 F.2d 1374, 1378 n.4 (9th Cir. 1986).

134. *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1289 (5th Cir. 1988).

135. *See Montefiore Med. Ctr. v. Teamsters Local 272*, 642 F.3d 321, 329 (2d Cir. 2011) (quoting *Pascack Valley*, 388 F.3d at 400 n.7).

136. *Misic*, 789 F.2d at 1378.

137. U.S. CONST. amend. VII.

138. *Graham v. Hartford Life & Acc. Ins. Co.*, 589 F.3d 1345, 1355 (10th Cir. 2009); *but cf. Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 221 (2002) (Congress authorized an (a)(1)(B) claim “without reference to whether the relief sought is legal or equitable”).

court looks to “both the nature of the statutory action and the remedy sought. The more important factor is whether the remedy sought is legal or equitable in nature.”¹³⁹ Because a claim under ERISA “is an action to enforce a trust,” the courts have found them to be equitable in nature.¹⁴⁰ This rationale applies to § 502(a)(1)(B) claims as well as to § 502(a)(3) claims.¹⁴¹ And because a § 502(a)(1)(B) claim is equitable, it could be argued that the claim could not be validly assigned.

Even if a court were to address the issue, it could easily find that a § 502(a)(1)(B) claim is assignable. Courts routinely refer to ERISA plans as contracts under which parties are free to bargain over assignability.¹⁴² Under traditional principals of equity, the right to receive compensation under a contract was assignable.¹⁴³ And given that almost every circuit has held that a medical provider has standing to bring an assigned § 502(a)(1)(B) claim,¹⁴⁴ it seems unlikely any court would reverse its position based on a finding that a § 502(a)(1)(B) claim is equitable.

It may be, however, that a § 502(a)(3) claim is not assignable. Historically, there was no absolute prohibition against assigning equitable claims.¹⁴⁵ The test of assignability turned on whether the action would survive the death of the injured party and pass to the injured party’s heirs or estate.¹⁴⁶ In other words, generally, an equitable claim that is personal, or specific to the person, would not survive the injured party’s hypothetical death and was thus not assignable.¹⁴⁷ In contrast, equitable “claims for breach of

139. *Graham*, 589 F.3d at 1355.

140. *Id.* at 1356 (quoting *Adams v. Cyprus Amax Minerals Co.*, 149 F.3d 1156, 1162 (10th Cir.1998)); see also *Firestone*, 489 U.S. at 110 (stating that “ERISA abounds with the language and terminology of trust law.”).

141. *De Pace v. Matsushita Elec. Corp. of Am.*, 257 F. Supp. 2d 543, 573-74 (E.D.N.Y. 2003).

142. *Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1296 (11th Cir. 2004).

143. JOHN NORTON POMEROY, A TREATISE ON EQUITY AS ADMINISTERED IN THE UNITED STATES OF AMERICA - FOR ALL THE STATES AND TO THE UNION OF LEGAL AND REMEDIES UNDER THE REFORMED PROCEDURE 4 (Spencer W. ed. 5th ed. § 1275a 1941) (hereinafter *Pomeroy*).

144. See *supra* text accompanying note 132.

145. See *POMEROY*, *supra* note 143, at § 1277 (“Where the thing in action assigned is an equitable demand . . . the assignee must sue in his own name”); but see *Monticello Bldg. Corp. v. Monticello Inv. Co.*, 330 Mo. 1128, 1142, 52 S.W.2d 545, 553 (Mo. 1932) (citing, *inter alia*, 3 *POMEROY’S EQUITY* § 1276 (2d Ed.)) (“One may purchase a cause of action at law and enforce all legal rights which go with it, but the right to appeal to the conscience of a court of equity cannot be bought or sold”).

146. *POMEROY*, *supra* note 143, at § 1275. Any heir who is a beneficiary of a plan may have standing under ERISA in his or her individual capacity, whether or not the decedent’s claims survive.

147. *Street Search Partners, L.P. v. Ricon Intern., L.L.C.*, C.A. No. 04C-09-

fiduciary obligations and resultant unjust enrichment have been held to survive.”¹⁴⁸ Thus, some § 502(a)(3) claims may not be assignable, but others may. If the claim is not assignable, an argument could be made the assignment is not valid and the purported assignee does not have derivative standing to pursue the claim.

The issue of the validity of an assignment is determined under federal law.¹⁴⁹ Because ERISA does not address the matter, courts may “look to state law for inspiration,” provided the state law is not inconsistent with ERISA.¹⁵⁰ Looking to the law of New York, the United States District Court for the Southern District of New York ruled an assignment is valid if there is “a perfected transaction between the assignor and assignee, intended by those parties to vest in the assignee a present right in the things assigned.”¹⁵¹ “An assignment of rights is distinguished from a promise to perform in the future to the extent that it manifests the assignor’s intention to extinguish her claim to performance by the obligor and consequently create a legal relationship between the assignee and the obligor.”¹⁵² In this regard, the United States Court of Appeals for the Fifth Circuit distinguished an assignment that required the assignor to concur with how the claim would be settled from an assignment of an ERISA claim that reserved to the assignor the right to sue should the claim be denied.¹⁵³ The former was an invalid assignment, in part because the assignor retained control over the settlement process.¹⁵⁴ The retention of the right to sue in the latter, the Fifth Circuit held, did not prevent a valid assignment.¹⁵⁵

Most courts considering the issue have held that an ERISA claim is not assignable if the plan contains an anti-assignment clause that unambiguously prohibits the assignment.¹⁵⁶ Courts have found anti-assignment provisions that are “typical ‘spendthrift’” clauses to be ambiguous and therefore ineffective to prevent a valid assignment.¹⁵⁷ The Fifth Circuit’s opinion in

191-PLA, 2006 WL 1313859, *3 (Del. Super. May 12, 2006).

148. *Id.*

149. *Weisenthal v. United Health Care Ins. Co. of N.Y.*, Nos. 07 Civ. 1175 (LAP) and 07 Civ. 0945 (LAP), 2007 WL 4292039, *4 (S.D.N.Y. Nov. 29, 2007).

150. *Id.*

151. *Id.* at *5.

152. *Id.* (citation omitted).

153. *Hermann Hosp. v. MEBA Med. and Benefits Plan*, 959 F.2d 569, 572-74 (5th Cir. 1992) (“Hermann II”).

154. *Id.*

155. *Id.*

156. *See generally Physicians Multispecialty Grp.*, 371 F.3d at 1295-96 (collecting cases); *La. Health Serv. and Indem. Co. v. Rapides Healthcare Sys.*, 461 F.3d 529, 537 (5th Cir. 2006) (“absent a statute to the contrary, an anti-assignment provision in a plan is permissible under ERISA”).

157. *Hermann II*, 959 F.2d at 569. According to the Fifth Circuit, a typical

Hermann II could, moreover, be construed to hold that an anti-alienation clause is *per se* impermissible under ERISA.¹⁵⁸ The United States District for the Southern District of New York has also suggested that a plan's complete bar to assignments would "violate the purpose and spirit of an ERISA medical plan."¹⁵⁹

An assignee generally cannot assign more than he owns.¹⁶⁰ Because of this rule, the remedies available to a medical provider who sues as an assignee of an ERISA claim are the same ERISA remedies that are available to participants. Because those remedies are limited, medical providers often choose to pursue their state law claims. A common issue with those claims is whether they are preempted by ERISA.

IV. ERISA DOES NOT PREEMPT MEDICAL PROVIDER STATE LAW CLAIMS

Medical provider claims can be divided into three categories: (1) ERISA § 502(a)(1)(B) claims brought by the provider as an assignee of a participant or beneficiary, (2) state law claims brought by providers in their individual capacity, and (3) state law claims brought pursuant to a service contract under which the provider agrees to provide services to the plan's participants for agreed-upon fees ("Provider Agreement Claims"). The courts have also recognized hybrid claims when the complaint alleges a violation of ERISA and a violation of a duty independent of ERISA.

"spendthrift" clause prevents an assignment "only to unrelated, third-party assignees—other than the health care provider of assigned benefits—such as creditors who might attempt to obtain voluntary assignments to cover debts having no nexus with the Plan or its benefits, or even involuntary alienations such as attempting to garnish payments for plan benefits." *See also* Univ. of Tenn. William F. Bowld Hosp. v. Wal-Mart Stores, Inc., 951 F. Supp. 724, 729-31 (W.D. Tenn. 1996).

158. *Herman II*, 959 F.2d at 575. There, the court stated:

The anti-assignment clause should not be applicable, however, to an assignee who, as here, is the provider of the very services which the plan is maintained to furnish. Were we to conclude otherwise, health care providers . . . would be unable to recover . . . unless [the participant] were to sue [the plan] . . . and [the medical service provider] in turn sue [the participant]. Such a result would be inequitable as [the participant] . . . would have no incentive to pursue payment and might be reluctant to sue the plan maintained by his own employer. . . .

159. *Protocare of Metro. N.Y., Inc. v. Mutual Ass'n Adm'rs, Inc.*, 866 F. Supp. 757, 762 (S.D.N.Y. 1994); *Ne. Dep't ILGWU Health & Welfare Fund v. Teamsters Local No. 229 Welfare Fund*, 764 F.2d 147, 154 n. 6 (3d Cir. 1985).

160. *See* *Scott v. Durham*, 772 F. Supp. 2d 978, 980 (N.D. Ind. 2011) (explaining that "a valid assignment gives the assignee neither greater nor lesser rights than those held by the assignor"); *but cf.* *Beckley Capital Ltd. P'ship v. DiGeromino*, 184 F.3d 52 (1st Cir. 1999) ("sometimes an assignee," such as a good faith purchaser for value, "may get more than the assignor").

A. *Courts Distinguish Actions Brought as Assignee from Those Brought Individually*

In *The Meadows v. Employees Health Insurance*,¹⁶¹ the Meadows, a substance abuse treatment facility, treated a participant covered by an ERISA health plan in 1990. For two different treatments, the Meadows received oral verification of coverage in a telephone call with the insurer. For one of those treatments the insurer furnished the Meadows a written verification. Later, the insurer denied the claim because the participant's plan coverage had terminated in 1989.¹⁶²

The Meadows sued the insurer in Arizona state court for negligent misrepresentations, estoppel, and breach of contract; the insurer removed the case to federal court.¹⁶³ The district court found that because the Meadows sued as an assignee, its state law claims were preempted and dismissed the case without prejudice.¹⁶⁴

The following year, the Meadows filed a second complaint in Arizona state court realleging the same three counts. "This time, however, the Meadows did not assert any claims as the assignee" of the plan participant.¹⁶⁵ Instead, the Meadows sued only as a third-party health care provider for claims that were non-derivative and independent of those which the [participant] might have had."¹⁶⁶ The issue before the Court of Appeals was "whether ERISA preempts claims by a third party who sues an ERISA plan not as an assignee of a purported beneficiary, but as an independent entity claiming damages."¹⁶⁷

The Ninth Circuit held the claims were not preempted. It reasoned that in 1990, at the time of the treatment and the misrepresentations by the insurer, neither the participant nor the Meadows had "any existing ties" to any ERISA plan.¹⁶⁸ As a result, the state law claims did not relate to any plan, and were therefore not preempted by ERISA.

In *Franciscan Skemp Healthcare, Inc. v. Central States Joint Board Health and Welfare*,¹⁶⁹ the Central States Joint Board Health and Welfare Trust Fund ("Central States") neglected to inform a health care provider—who telephoned to verify coverage—that the participant could lose her coverage

161. *The Meadows v. Emp'rs Health Ins.*, 47 F.3d 1006 (9th Cir. 1995).

162. *Id.* at 1007-09.

163. *Id.*

164. *Id.*

165. *Id.* at 1008.

166. *Id.*

167. *Id.* (emphasis in original).

168. *Id.* at 1009.

169. *Franciscan Skemp Healthcare Inc. v. Cent. States Joint Bd. Health*, 538 F.3d 594 (7th Cir. 2008).

retroactively if she failed to pay her COBRA premiums.¹⁷⁰ When Central States denied the claim because the participant was not covered, the provider brought an action in state court alleging state law claims of negligent misrepresentation and estoppel. Central States removed to federal court and argued the state law claims were completely preempted by ERISA.¹⁷¹

The Seventh Circuit relied on *Davila* to analyze whether the claims were completely preempted.¹⁷² Central States first argued that Franciscan-Skemp, the health care provider, had received an assignment from the participant and could therefore have derivative standing to bring a § 502(a)(1)(B) claim. The Court of Appeals found, however, that Franciscan-Skemp brought the claims not as an assignee, but entirely in its own right, because the claims arose not from the plan's terms, but from the oral misrepresentations of Central States.¹⁷³

The court also found that the oral representations that supported the state law claims gave rise to an independent legal duty.¹⁷⁴ In doing so, the court looked to the elements of negligent misrepresentation under Wisconsin law and concluded that the legal duties implicated by Wisconsin law were entirely independent from ERISA and any plan terms.¹⁷⁵ *Franciscan-Skemp* is in line with several cases from other circuits.¹⁷⁶

One of the more recent cases to emerge on this issue is *Access Mediquip v. UnitedHealthcare Insurance Co.*¹⁷⁷ *Access Mediquip* involved a medical device supplier, Access, which procured medical devices for medical service providers. The service providers used the medical devices in procedures performed on individuals covered by an ERISA health plan. Before procuring the device,

170. *Id.* at 595-96. COBRA is an acronym that stands for the "Consolidated Omnibus Budget Reconciliation Act of 1985." Under COBRA, a participant who loses coverage under a health plan upon a termination of employment may elect to continue that coverage for a certain period. The participant can be required to pay the premiums due, which are commonly referred to as "COBRA premiums." COBRA coverage can, under certain circumstances, be cancelled retroactively for a failure to pay the COBRA premiums. See generally I.R.C. § 4980B(f) and Treas. Reg. § 54.4980B-1 *et. seq.*

171. *Franciscan Skemp*, 538 F.3d at 596.

172. *Id.* at 596.

173. *Id.* at 597.

174. *Id.* at 599.

175. *Id.* at 598-99.

176. See *Home Health, Inc. v. Prudential Ins. Co. of Am.*, 101 F.3d 600, 604-07 (8th Cir. 1996); *Hospice of Metro Denver v. Grp. Health Ins. of Okla., Inc.*, 944 F.2d 752 (10th Cir. 1991); *Mem'l Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 243-50 (5th Cir. 1990); *Lordmann Enters., Inc. v. Equicor, Inc.*, 32 F.3d 1529 (11th Cir. 1994).

177. *Access Mediquip LLC v. UnitedHealthCare Ins. Co.*, 662 F.3d 376 (5th Cir. 2011).

Access would contact UnitedHealthcare to verify that the cost of the device would be reimbursed. UnitedHealthcare orally represented that the costs would in fact be covered. When later the claims were denied, Access sued asserting state law claims of promissory estoppel, negligent misrepresentation, and claims brought under the Texas Insurance Code.¹⁷⁸

The Fifth Circuit held that the state law claims were not completely preempted by ERISA.¹⁷⁹ In so holding, it relied on its prior opinion in *Memorial Hospital System v. Northbrook Life Insurance Co.*:¹⁸⁰

A defendant pleading preemption under 29 U.S.C. § 1144(a) must prove that: “(1) the state law claims address an area of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) the claims directly affect the relationships among traditional ERISA entities—the employer, the plan and its fiduciaries, and the participants and beneficiaries.”¹⁸¹

The second prong of this test—that the claims affect the relationships among traditional ERISA entities—distinguishes a state law claim brought by a medical provider, which is not preempted, and a similar state law claim brought by a participant, which is preempted. This distinction was highlighted more clearly in the unpublished opinion of *Werner v. Group Health Plan, Inc.*¹⁸²

Werner’s wife was pre-certified for a costly medical procedure.¹⁸³ Defendant Group Health (“Group Health”) repeatedly assured Werner that no premiums were due in connection with his plan.¹⁸⁴ Werner and his wife relied on these assurances, and she underwent the procedure. Later, the Defendant cancelled the coverage, requested repayment for the bills previously paid, and refused to pay any outstanding claims or negotiate or settle them.¹⁸⁵ Werner sued in state court alleging various state law claims, including promissory estoppel and negligent misrepresentation.¹⁸⁶ Group Health removed the case to federal court and asserted the claims were completely preempted by ERISA.¹⁸⁷

Werner argued the claims were not completely preempted,

178. *Id.* at 378-81.

179. *Id.* at 383-84.

180. *Mem’l Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990).

181. *Access*, 662 F.3d at 382 (quoting *Mem’l Hosp.*, 904 F.2d at 245).

182. *Werner v. Grp. Health Plan, Inc.*, No. 09-cv-891-JPG, 2010 WL 1640437 (S.D. Ill. April 20, 2010).

183. *Id.* at *1.

184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.*

relying on *Franciscan-Skemp*.¹⁸⁸ The court distinguished *Franciscan-Skemp* because in that case the claims were brought by a healthcare provider, whereas the Werners' claims were brought as a plan participant or beneficiary.¹⁸⁹ The court went on to declare flatly: "[p]ut simply, since the instant action is brought by Werner, not his wife's healthcare provider, a different set of legal principles is at play."¹⁹⁰ This different set of legal principles includes ERISA's limited remedies and the preemption of state law by § 514 of ERISA. Yet, nothing in the text of § 514 expressly requires that the identity of the plaintiff would lead to a different result, where the medical provider, but not the participant, has the right under state law to enforce its agreement with the plan (or employer).

1. Provider Agreement Claims

The United States Court of Appeals for the Ninth Circuit analyzed Provider Agreement claims in *Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.*¹⁹¹ In *Anesthesia Care*, the court held that claims for breach of the provider agreements were not completely preempted, even though the providers obtained an assignment of benefit claims from participants in an ERISA plan. Relying on *Misic* to argue the claim was preempted, Blue Cross asserted the provider's right to payment under the agreement was, at least with respect to the ERISA participants, effectively a claim for benefits based on the assignment.¹⁹² The court found that *Misic* was not controlling.¹⁹³ Dr. Misic had no agreement and thus could recover payment only pursuant to the plan's terms.¹⁹⁴ In contrast, Blue Cross entered into separate agreement with the providers.¹⁹⁵ Because the provider was seeking payment under those separate agreements, the court distinguished between the right to payment, which could depend on the validity of the assignments, and the amount or level of payment that is measured by reference to the Provider Agreement.¹⁹⁶

Blue Cross also argued that the Provider Agreement claims were preempted because they affected relationships governed by

188. *Id.* at *4.

189. *Id.*

190. *Id.*

191. *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045 (9th Cir. 1999).

192. *Id.* at 1050.

193. *Id.*

194. *Id.*

195. *Id.*

196. *Id.* at 1051.

ERISA.¹⁹⁷ In *General American Life Insurance Co. v. Castonguay*, the Ninth Circuit declared:

The key to distinguishing between what ERISA preempts and what it does not lies . . . in recognizing that the statute comprehensively regulates certain relationships: for instance, the relationship between plan and plan member, between plan and employer, between employer and employee (to the extent an employee benefit plan is involved), and between plan and trustee. Because of ERISA's explicit language and because state laws regulating these relationships (or the obligations flowing from these relationships) are particularly likely to interfere with ERISA's scheme, these laws are presumptively preempted.¹⁹⁸

The Ninth Circuit rejected this argument by Blue Cross as well, finding that its payments under the Provider Agreements would not affect its status as an ERISA fiduciary or any participant's claims for benefits.¹⁹⁹

2. Hybrid Claims

In *Connecticut State Dental Association v. Anthem Health Plans, Inc.*, the Eleventh Circuit analyzed whether a complaint that combined assertions of improper claim denials with allegations of wrongful payments under a Provider Agreement was completely preempted.²⁰⁰ The plaintiffs alleged that Anthem Health Plans, Inc. ("Anthem") used improper payment methods under the guise of utilization review in order to pay less than was allegedly due under the Provider Agreement.²⁰¹ The court reviewed the complaint carefully and noted that the plaintiffs also alleged Anthem had improperly denied participant claims.²⁰² The court framed this combination as a hybrid claim "part of which is within § 502(a) and part of which is beyond the scope of ERISA."²⁰³ For the providers to bring ERISA claims, the court held, they must have derivative standing as an assignee.²⁰⁴ Thus, unlike in *Anesthesia Care*, where the assignments were not relevant, the existence of the assignments was relevant in *Connecticut State Dental*.²⁰⁵

197. *Id.* at 1053-54.

198. *Gen. Am. Life Ins. Co. v. Castonguay*, 984 F.2d 1518, 1521 (9th Cir. 1993) (internal citations omitted).

199. *Anesthesia Care*, 187 F.3d at 1053.

200. *Conn. State Dental Assoc. v. Anthem Health Plans, Inc.*, 591 F.3d 1337 (11th Cir. 2009).

201. *Id.* at 1342-43.

202. *Id.* at 1350.

203. *Id.* at 1351.

204. *Id.*

205. *Id.*

3. Summary

Connecticut State Dental provides a good summary “regarding complete preemption of medical service provider claims.”²⁰⁶ First, medical service providers are usually not completely preempted²⁰⁷ and are not usually subject to ERISA’s defensive preemption.²⁰⁸ “For example, a healthcare provider’s claims of negligent misrepresentation and estoppel based on a plan’s oral misrepresentations are not ERISA claims because they do not arise from the plan or its terms.”²⁰⁹ Second, the court notes it is well established that providers may obtain derivative standing via an assignment and the corresponding claim falls within the scope of ERISA § 502(a).²¹⁰ Third, a provider that has both an assigned claim and an independent claim can assert the assigned ERISA claim, the independent claim, or both.²¹¹

V. CONCLUSION

The courts’ analysis of medical provider state law claims against plans and employers for broken promises, misstatements, and misrepresentations contrasts sharply with how the courts handle almost identical claims raised by ERISA claimants. In seeking relief, medical providers have a significant advantage over plan participants. They can bring state law claims, ERISA claims, or both. Thus, depending on state law and the nature of the claim, they might be allowed to seek extra-contractual damages, punitive damages, and attorneys’ fees, as well as any remedies that are available under ERISA, however limited they may be. Moreover, under their state law claims, medical providers would not be subjected to the deferential review by the court that upholds a plan fiduciary’s denial so long as the fiduciary does not abuse its discretion.

Turning back to the hypothetical, the hospital’s state law claim based on the employer’s promise *to the hospital* to pay for the executive’s operation would not be preempted. However, because the hospital never spoke with the employer about the husband’s operation, it could only bring a claim under ERISA as an assignee. The § 502(a)(1)(B) claim would fail, because the benefit would not be due under the terms of the plan and the standard rule that oral promises cannot modify a plan’s terms

206. *Id.* at 1346.

207. *Id.* (citing *Hobbs v. Blue Cross Blue Shield of Ala.*, 276 F.3d 1236, 1241 (11th Cir. 2001)).

208. *Id.* at 1344 n.7 (citing *Lordmann Enters.*, 32 F.3d at 1533).

209. *Id.*

210. *Id.*

211. *Id.*

would likely prevail. Even if the hospital or the husband were to file a § 502(a)(3) claim, unless *Amara* were to make a difference, it too would likely fail because of ERISA's limited remedies.

Congress adopted ERISA for the express purpose of protecting the interests of participants and benefits in employee benefits plans.²¹² Yet arguably participants are worse off now than they were before Congress enacted ERISA.²¹³ Under ERISA's scheme of preemption and limited remedies, employers are released from their promises and employees are left to pay for employers' mistakes.²¹⁴ The most frequently cited rationale for this is to encourage the formation of employee benefit plans.²¹⁵ It would seem this rationale should apply with equal force whether the claim is brought by a participant or a medical provider.

The existing case law also discourages effective communications between plans and medical providers. Any misstatement by a plan to a medical provider could be actionable, depending on the appropriate state law standards that govern misrepresentations. Under ERISA, the misstatement would generally have to rise to the level of a breach of fiduciary duties to be actionable. Under *Frahm*, the fiduciary breach may have to be as egregious as the deceptive behavior described in *Varity*. Moreover, as a general rule, ERISA's fiduciary standard of care looks more to the process and less to the result. Thus, by imposing a higher standard of care on plan fiduciaries, Congress has insulated plans from the consequences of their poor results. In contrast, because ERISA does not regulate the relationship between plans and medical providers—in other words, because ERISA does not impose a higher standard of care on plans vis-à-vis medical providers—plans can be held liable for their poor results if they affect medical providers. It seems odd that a higher standard of care results in less exposure to liability. The difference in exposure will depend, of course, on how the standard of care required under applicable state law—such as the common law governing negligent misrepresentations or the statutory requirements under a deceptive trade practices act—compares to ERISA's fiduciary standard of care, and how the remedies that are available under applicable state law compare to ERISA's remedies.

Whether plans should be held liable to participants for something less than a fiduciary breach, and whether they should be protected from liability for “slipups” that are merely “bad advice

212. ERISA § 2(b); 29 U.S.C. § 1001(b).

213. *Davila*, 542 U.S. at 222 (Ginsburg, J., concurring); Stumpff, *supra* note 73.

214. *Young v. Verizon's Bell Atl. Cash Balance Plan*, 615 F.3d 808, 812 (7th Cir. 2010) (“People make mistakes. Even administrators of ERISA plans”).

215. *Graham v. Balcor Co.*, 1046 F.3d 1052, 1055 (9th Cir. 1998).

delivered verbally,"²¹⁶ is for Congress and, where the claim is not preempted (or should Congress exit the field), the states to decide. *Amara* may offer relief to ERISA claimants who, in the future, rely on a plan's misstatements. But then again, it may not.

216. *Frahm*, 137 F.3d at 959-61.