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# Health Care Providers Meet ERISA: Are Provider Claims for Misrepresentation of Coverage Preempted?

Jeffrey A. Brauch\*

## I. INTRODUCTION

It happens every day. A patient enters a hospital or doctor's office seeking medical treatment. Before starting treatment, the health care provider tries to verify that it will be paid. Its first step is to ask the patient about any insurance coverage he or she may have. Often that coverage is provided under an employee welfare benefit plan established by the patient's employer. The provider usually takes one more step; it makes a telephone call to confirm that there is indeed coverage. It may call the patient's employer, the plan administrator, the insurer, or someone else associated with the plan. Upon assurance that there is coverage, the provider begins treatment.

When treatment is done, the provider submits a bill, expecting to be paid. Unfortunately, the assurance of coverage sometimes turns out to be wrong and the plan refuses to pay the bill. Frequently, the provider's only recourse to receive payment is to sue the plan or the party that misrepresented coverage under state law claims such as misrepresentation or promissory estoppel.<sup>1</sup>

But is a lawsuit itself a viable option? If the plan is an employee welfare benefit plan<sup>2</sup> under the Employment Retirement Income

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1. Although such claims may take various forms, they will be collectively referred to herein as "provider misrepresentation claims."

2. 29 U.S.C. § 1002(1)(A) (1988) defines an employee welfare benefit plan as

Security Act (ERISA),<sup>3</sup> the defendant will argue that a lawsuit is impermissible. The defendant will insist that ERISA preempts state law claims and seek their dismissal.

Controversy exists as to whether ERISA should preempt provider misrepresentation claims. In the last two and a half years, a number of courts, including three circuit courts of appeal, have struggled with this controversy. Their answers have varied greatly and there is now a conflict among the circuits. This Article examines the decisions of these courts and proposes the proper resolution to the preemption dilemma in light of federal case law that has defined the scope of ERISA preemption. The Article concludes that ERISA should not preempt provider misrepresentation claims.

## II. THE SCOPE OF ERISA PREEMPTION

### A. *Breadth of Preemption*

Congress's express purpose in creating ERISA was

to protect . . . the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.<sup>4</sup>

To further this purpose, Congress provided that ERISA preempts certain state laws that "relate to" any employee benefit plan, by stating that "[e]xcept as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."<sup>5</sup> This preemption provision protects beneficiaries

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follows:

[A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits.

*Id.*

3. Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (1988).

4. 29 U.S.C. § 1001(b) (1988).

5. 29 U.S.C. § 1144(a) (1988). Other provisions exempt certain laws from the application of this general preemption provision. For example, 29 U.S.C. § 1144(b)(2)(A) (1988) exempts some state laws regulating insurance, banking, or securities. 29 U.S.C. § 1144(b)(4) (1988) exempts generally applicable criminal laws. 29 U.S.C. § 1144(b)(7) (1988) exempts qualified domestic relations orders. None of these

by preventing duplication of the situation that existed before Congress enacted ERISA. Before ERISA's enactment, plans and plan sponsors faced a maze of different and often conflicting state laws and regulations that resulted in administrative inefficiencies and costs which ultimately hurt beneficiaries.<sup>6</sup> Through the preemption provision, Congress sought to make the regulation of pension and benefit plans an exclusively federal concern, which was subject to a single set of federal laws.<sup>7</sup>

The Supreme Court has broadly interpreted the preemption provision.<sup>8</sup> It has proclaimed that a state "law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."<sup>9</sup> The law in question need not be directed at an employee benefit plan; it may have only an indirect effect on the plan.<sup>10</sup> Nor must the law deal specifically with the subject matters covered by ERISA, such as reporting requirements or fiduciary duties.<sup>11</sup> ERISA may preempt a state law, even if that law provides for traditional state causes of action, such as breach of contract<sup>12</sup> or wrongful discharge.<sup>13</sup> The scope of preemption is so broad that ERISA may preempt even those laws that are consistent with its purposes.<sup>14</sup>

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provisions, however, affects whether ERISA should preempt provider misrepresentation claims.

6. See *Ingersoll-Rand Co. v. McClendon*, 111 S. Ct. 478, 484 (1990).

7. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987); David P. Kallus, *ERISA—Do Health Care Providers Have Standing to Bring A Civil Enforcement Action Under Section 1132(a)?*, 30 SANTA CLARA L. REV. 173, 174-76 (1990).

8. See *FMC Corp. v. Holliday*, 111 S. Ct. 403, 407 (1990) ("The pre-emption clause is conspicuous for its breadth."); see also *Ingersoll-Rand*, 111 S. Ct. at 482. Indeed, one federal court discussing preemption has warned that "[t]he ERISA quicksand is fast swallowing up everything that steps in it or near it." *Jordan v. Reliable Life Ins. Co.*, 694 F. Supp. 822, 827 (N.D. Ala. 1988).

9. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). See also *Pilot Life*, 481 U.S. at 47.

10. See *Pilot Life*, 481 U.S. at 47-48; *Shaw*, 463 U.S. at 98; see, e.g., *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981) (finding that ERISA preempts a New Jersey worker's compensation law that prohibits a pension plan from reducing benefits by amounts received in worker's compensation benefits even though the law effects an "indirect" regulation of a plan).

11. See *Shaw*, 463 U.S. at 98; see also *Ingersoll-Rand*, 111 S. Ct. at 483 (holding that ERISA preempts wrongful discharge law); *FMC*, 111 S. Ct. at 408 (finding that ERISA preempts anti-subrogation law).

12. See, e.g., *Pilot Life*, 481 U.S. at 57.

13. See, e.g., *Ingersoll-Rand*, 111 S. Ct. at 483.

14. See, e.g., *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988) (declaring that ERISA preempts a Georgia garnishment statute, even though it

## B. *The Tenuousness Exception*

With such a broad interpretation, it would seem that no state law could survive preemption because almost any law can affect an ERISA plan in some sense. Recognizing this, the Supreme Court created one important exception to the application of ERISA's preemption clause, in *Shaw v. Delta Air Lines, Inc.*:<sup>15</sup> "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."<sup>16</sup>

Having created this exception, the Court in *Shaw* said nothing about its application. The Court gave no guidance in how to distinguish a "tenuous" effect on a benefit plan from an effect which warrants preemption. It noted only that, under the facts before it, the law's relationship to the plan clearly warranted preemption.<sup>17</sup>

Since *Shaw*, the Supreme Court has left lower federal courts to determine when a law's effect on an employee benefit plan is too tenuous to warrant a finding of preemption. The federal courts have generally concluded that if the state law specifically refers, to or is directed at, employee benefit plans, then the relationship is not too tenuous to warrant preemption.<sup>18</sup> If, however, the law is one of general application that happens to impact an ERISA plan in a particular case, then an issue of tenuousness might arise.

Federal courts consider a variety of factors in determining when a generally applicable state law relates to an ERISA plan in so tenuous a manner that it does not warrant preemption.<sup>19</sup> This Article focuses on

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was enacted "to help effectuate ERISA's underlying purposes").

15. 463 U.S. 85 (1983).

16. *Id.* at 100 n.21.

17. *Id.*

18. See, e.g., *In re Dyke*, 943 F.2d 1435, 1448 (5th Cir. 1991) (finding that Texas law exempting retirement benefits from creditors' claims in bankruptcy relates to ERISA plans because it specifically refers to such plans); *McCoy v. Massachusetts Inst. of Technology*, 950 F.2d 13, 18 (1st Cir. 1991) (holding that ERISA preempts Massachusetts mechanics' lien statute that specifically gives rights to trustees of certain employee benefit plans, thus singling them out for special treatment), *cert. denied*, 112 S. Ct. 1939 (1992); see also *FMC Corp. v. Holliday*, 111 S. Ct. 403, 409 (1990); *Mackey*, 486 U.S. at 829.

19. Several circuit courts of appeal have developed a multifactor analysis to resolve such cases. In *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc.*, 793 F.2d 1456 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034 (1987), the Fifth Circuit determined that two principal factors govern whether a state law should be preempted: (1) whether it involves a traditional exercise of state authority, and (2) whether it affects relations among the "principal ERISA entities—the employer, the plan, the plan fiduciaries, and the beneficiaries." *Id.* at 1467. In *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987), the Sixth Circuit adopted two factors from *Sommers* and added a third: "The incidental nature of any possible effect of the state law on an ERISA plan." *Id.* at 556. In *Arkansas*

six of those factors both because federal courts frequently apply them in preemption cases and because they have particular relevance to the question of whether ERISA should preempt provider misrepresentation claims.

### C. Goal of Action

Often, the law at issue creates a state cause of action. In such cases, the first factor for the court to consider is the desired goal of a lawsuit to enforce the cause of action, or the effect of permitting the cause of action to go forward. If the plan participant brings an action seeking plan benefits or asserts that the plan improperly processed claims, ERISA will preempt the action.<sup>20</sup> ERISA itself provides an exclusive remedy for the resolution of such disputes.<sup>21</sup>

Closely related to such claims are participant misrepresentation claims in which plan participants allege that their employers orally promised certain benefits which the express terms of an ERISA plan do not provide. Most courts agree that permitting participants to bring misrepresentation claims would improperly allow an oral modification of a written ERISA plan.<sup>22</sup> One such case is *Lister v. Stark*.<sup>23</sup> In *Lister*, a plan par-

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Blue Cross & Blue Shield v. St. Mary's Hospital, Inc., 947 F.2d 1341 (8th Cir. 1991), cert. denied, 112 S. Ct. 2305 (1992), the Eighth Circuit found seven factors that are relevant to the preemption decision: (1) whether the state law negates an ERISA plan provision; (2) whether the state law affects relations between primary ERISA entities; (3) whether the state law impacts the structure of ERISA plans; (4) whether the state law impacts the administration of ERISA plans; (5) whether the state law has an economic impact on ERISA plans; (6) whether preemption of the state law is consistent with other ERISA provisions; and (7) whether the state law is an exercise of traditional state power. *Id.* at 1344-45.

20. See, e.g., *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62 (1987) (holding that ERISA preempts participant action for reinstatement of employee benefits); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) (concluding that ERISA preempts causes of action alleging insurer bad faith in handling claims); *Perkins v. Time Ins. Co.*, 898 F.2d 470, 473 (5th Cir. 1990) (stating that ERISA preempts action by participant against insurer for tortious breach of contract). The Seventh Circuit finds preemption so obvious in such cases that it has affirmed imposition of Rule 11 sanctions against attorneys who continue to bring such claims. See *Maciosek v. Blue Cross & Blue Shield United*, 930 F.2d 536, 541 (7th Cir. 1991) (imposing Rule 11 sanctions because of frivolous claims); *Tomczyk v. Blue Cross & Blue Shield United*, 951 F.2d 771, 779 (7th Cir. 1991) (stating that "entire manner in which [this] appeal has been pursued justifies sanctions"), cert. denied, 112 S. Ct. 2274 (1992).

21. 29 U.S.C. § 1132 (1988). See *Metropolitan Life*, 481 U.S. at 62-63.

22. See, e.g., *Degan v. Ford Motor Co.*, 869 F.2d 889, 895 (5th Cir. 1989) (stating

ticipant brought an action against his employer, benefit trust, and trustees seeking certain benefits.<sup>24</sup> He claimed that his employer convinced him, a recently terminated employee, to return to work by promising him that his small gap in employment would not affect the vesting of his pension benefits.<sup>25</sup> When the plan terms prevented the vesting his employer had promised, the participant sued for fraud and breach of an oral contract to modify the plan.<sup>26</sup> The court found that the participant wanted to enforce an oral modification of the pension plan and to collect unauthorized plan benefits.<sup>27</sup> The court stated that the proper route to seek benefits was through ERISA's own enforcement mechanism, 29 U.S.C. § 1132.<sup>28</sup> Therefore, ERISA would preempt any other claims for benefits.<sup>29</sup>

However, federal courts have refused to find that ERISA preempts certain causes of action that affect a plan as they would any other entity. The Supreme Court noted in *Mackey v. Lanier Collection Agency & Service, Inc.*<sup>30</sup> that ERISA would not preempt "lawsuits against ERISA plans for run-of-the-mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan."<sup>31</sup> As a result, lower courts have found that ERISA plans, like any other entity, should be liable for traditional torts and breaches of contract.<sup>32</sup> The federal courts

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that ERISA preempts a suit by a former employee against a former employer and union for breach of an oral contract to provide special early retirement benefits); *Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290, 1297 (5th Cir. 1989) (concluding that "§ 1102(a)(1) precludes the creation of a cause of action based on an oral contract under ERISA"); *Anderson v. John Morrell & Co.*, 830 F.2d 872, 875 (8th Cir. 1987) (holding that claimed common law contract right to have a plan modified relates to the plan such that ERISA preempts relevant state law); see also Richard P. Carr & Christine L. Thierfelder, *Talk is Cheap: Oral Misrepresentations as a Basis for Recovery from Employee Benefit Plans*, 3 BENEFITS L.J. 199 (1990); Comment, *Estoppel Claims Against ERISA Employee Benefit Plans*, 25 U.C. DAVIS L. REV. 487, 528-32 (1992).

23. 890 F.2d 941 (7th Cir. 1989), cert. denied, 111 S. Ct. 579 (1990).

24. *Id.* at 942.

25. *Id.* at 943. The plaintiff alleged that after working from 1964 to 1970 and leaving for nine months, the defendant promised him that he would credit the plaintiff upon his return for those years. *Id.*

26. *Id.* at 946.

27. *Id.* at 944-45.

28. *Id.*

29. *Id.* at 944.

30. 486 U.S. 825 (1988).

31. *Id.* at 833.

32. See, e.g., *National Health Plan Corp. v. Road Carriers Local 707 Welfare Fund*, 13 Employee Benefits Cas. (BNA) 2157 (S.D.N.Y. 1991) (asserting that ERISA does not preempt an administrative service provider's breach of contract claim against plan); *Abofreka v. Alston Tobacco Co.*, 341 S.E.2d 622 (S.C. 1986) (stating that ERISA does not preempt tort claim against plan).

have found that plans are subject to state laws which set the rates hospitals may charge.<sup>33</sup> Federal courts have also treated plans like any other employer and hold them subject to employment discrimination laws.<sup>34</sup> In such cases, the courts find that the state causes of action had too tenuous a relationship to the plan to warrant preemption.

Some federal courts have used this analysis to allow claims closely related to participant misrepresentation claims. These claims seek relief for misrepresentations that occurred *prior* to the formation of an ERISA plan or were made by someone other than the plan or its fiduciaries. The courts reason that the plaintiff's goal is not to recover plan benefits, but rather to seek a traditional remedy apart from the plan for the tort of misrepresentation.

For example, in *Perkins v. Time Insurance Co.*,<sup>35</sup> an ERISA health plan participant sued both the insurer of the plan and an independent insurance agent after his medical claim was denied under the plan because of a pre-existing condition.<sup>36</sup> The court held that ERISA preempted the tortious breach of contract action against the plan insurer because it was an improper attempt to recover benefits under the plan.<sup>37</sup> Conversely, the court found that ERISA did not preempt the action against the independent agent.<sup>38</sup> The action against the agent alleged that the agent induced the participant to surrender his existing coverage and to join the Time plan by representing to the participant that a pre-existing condition clause would not apply to his medical condition.<sup>39</sup> The court found that the participant was not seeking plan benefits from the agent, but rather damages due to a standard tort that the agent committed prior to the plan's formation and apart from the terms of the plan.<sup>40</sup>

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33. See, e.g., *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir. 1984), cert. denied, 472 U.S. 1088 (1985).

34. See, e.g., *Lane v. Goren*, 743 F.2d 1337, 1338 (9th Cir. 1984).

35. 898 F.2d 470 (5th Cir. 1990).

36. *Id.* at 472.

37. *Id.* at 473.

38. *Id.*

39. *Id.*

40. *Id.* Other courts confronted with similar facts have reached the same result. See, e.g., *Perry v. P.I.E. Nationwide, Inc.*, 872 F.2d 157, 162 (6th Cir. 1989) (stating that ERISA does not preempt a plan participant's state law fraudulent inducement claim against former employer when the participant based its action on pre-plan misconduct and did not seek plan benefits), cert. denied, 493 U.S. 1093 (1990); *Johnson v. Antioch Univ.*, 15 Employee Benefits Cas. (BNA) 1402, 1406 (D.D.C. 1992) (concluding that ERISA does not preempt a plan participant's state law fraudulent inducement claim against employer and union); *Isaac v. Life Investors Ins. Co.*, 749



#### D. Administrative Effect

In deciding whether a law has too tenuous a relationship to an employee benefit plan, the second major factor courts examine is the effect of its application on the plan's administration. The Supreme Court has identified the administrative burden created by differing and conflicting state laws as a primary reason for the preemption of state laws.<sup>41</sup>

Any state law, including a general tort or contract law, that applies to an ERISA plan has some administrative effect. Whether the administrative burden created by the law is sufficient to warrant preemption depends on both the amount of impact on plan administration and where that impact is felt. Obviously, the greater the impact on plan administration, the greater the likelihood that ERISA will preempt the law. In *Fort Halifax Packing Co. v. Coyne*,<sup>42</sup> the Supreme Court noted that a one-time lump sum payment of benefits does not raise the same kind of preemption concerns as an "ongoing administrative program" or "scheme."<sup>43</sup>

In keeping with this principle, courts have found that ERISA does not preempt state laws that have only an insignificant impact on an ERISA plan's administration. For example, in *Aetna Life Insurance Co. v. Borges*,<sup>44</sup> the Second Circuit held that ERISA did not preempt Connecticut's escheat law, even though it required the plan to pay issued benefits checks to the state if the checks remained unclaimed for three years.<sup>45</sup> The court concluded that the administrative effects of the law on the plan were "indirect" and "not substantial enough" to warrant preemption.<sup>46</sup>

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F. Supp. 855, 863-64 (E.D. Tenn. 1990) (holding that ERISA does not preempt state claim for fraudulent misrepresentation); *Greenblatt v. Budd Co.*, 666 F. Supp. 735, 742 (E.D. Pa. 1987) (stating that ERISA should not preempt misrepresentation cause of action).

41. *Ingersoll-Rand Co. v. McClendon*, 111 S. Ct. 478, 484 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987). See *supra* notes 6-7 and accompanying text.

42. 482 U.S. 1 (1987).

43. *Id.* at 11, 12.

44. 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989).

45. *Id.* at 147.

46. *Id.* Other cases similarly concluding that an administrative impact is insufficient to warrant preemption include: *Retirement Fund Trust v. Franchise Tax Board*, 909 F.2d 1266, 1282 (9th Cir. 1990) (stating that ERISA does not preempt California tax withholding procedures when they have "only a tangential impact on the administration of the plan"); *In re Seolas*, 140 B.R. 266, 273 (E.D. Cal. 1992) (explaining that ERISA does not preempt California general usury law when it has only incidentally affected the plan); *Tener v. Hoag*, 697 F. Supp. 196, 200 (W.D. Pa. 1988) (concluding that ERISA does not preempt Pennsylvania statute permitting employees to enforce agreements with employers to pay wages and fringe benefits when its enforcement does not subject plan to conflicting requirements or require plan to establish an

On the other hand, courts have preempted state laws that have a more significant and direct administrative effect. An example is *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*<sup>47</sup> In *Arkansas Blue Cross & Blue Shield*, the court ruled that ERISA preempted a New Jersey law that allowed beneficiaries to assign their rights under an ERISA plan to health care providers.<sup>48</sup> The law directly contradicted plan language that disallowed such assignments unless the plan approved of them.<sup>49</sup> The Eighth Circuit rejected the district court's conclusion that the administrative effect of the law was minor;<sup>50</sup> it found that to allow courts to apply such laws would subject the plan to different obligations in different states.<sup>51</sup>

In addition to the degree of a law's impact on a plan's administration, the part of the plan's administration that the law impacts is often key in determining whether preemption will occur. The Second Circuit stated, "What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit."<sup>52</sup>

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administrative scheme).

47. 947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 112 S. Ct. 2305 (1992).

48. *Id.* at 1348.

49. *Id.* at 1343.

50. *Id.* at 1348.

51. *Id.* Other courts have also preempted state laws imposing significant administrative burdens on ERISA plans. *See, e.g.*, *General Elec. Co. v. New York State Dep't of Labor*, 891 F.2d 25, 29 (2d Cir. 1989) (holding that ERISA preempts New York's prevailing wage law in cases in which it regulates contributions to the plan and the nature and amount of benefits provided under it), *cert. denied*, 496 U.S. 912 (1990); *MacLean v. Ford Motor Co.*, 831 F.2d 723, 728 (7th Cir. 1987) (concluding that ERISA preempts state testamentary transfer law in cases in which its application "would interfere with the administration of the Plan and violate its terms"); *Associated Builders & Contractors v. Baca*, 769 F. Supp. 1537, 1547 (N.D. Cal. 1991) (stating that ERISA preempts city and county prevailing wage ordinances when the ordinances require an ongoing administrative scheme to calculate wages and benefits paid to workers under the ordinances).

In addition to this interstate administrative effect, the court in *Arkansas Blue Cross & Blue Shield* referred to an intrastate administrative effect. *Arkansas Blue Cross & Blue Shield*, 947 F.2d at 1346. It noted that even in New Jersey, applying the assignment law would force plan administrators to monitor which plan beneficiaries had made assignments and to whom they were made. *Id.* at 1346-47. This added administrative burden further convinced the court that the law's relationship to the plan was close enough to warrant preemption.

52. *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146-47 (2d Cir.), *cert. denied*, 493

This principle also helps explain the results in cases like *Borges* and *Arkansas Blue Cross & Blue Shield*. The *Borges* court refused to find that ERISA preempted the escheat law in part because the administrative burden of sending unclaimed checks to the state did not impact primary functions, such as calculating benefits or determining eligibility.<sup>53</sup> On the other hand, in *Arkansas Blue Cross & Blue Shield*, the administrative impact created by the benefit assignment law most directly affected the payment of benefits.<sup>54</sup> The law required administrators to determine whether a third party payor was eligible for benefits under both the terms of the plan and a valid agreement of assignment.<sup>55</sup>

#### E. Economic Impact

Closely related to a state law's administrative impact upon an ERISA plan is its economic impact. State laws often impose costs on a plan, either by increasing the administrative tasks of the plan or by requiring it to make certain payments. As with administrative impact, ERISA does not preempt a law simply because it has some economic impact on a plan.<sup>56</sup> Thus, in *Mackey v. Lanier Collection Agency & Service, Inc.*,<sup>57</sup> the Supreme Court refused to find that ERISA preempts Georgia's general garnishment statute even though application of the law would impose costs on the plan and participants.<sup>58</sup>

As with administrative impact, the amount of the economic impact is important. In *Aetna Life Insurance Co. v. Borges*,<sup>59</sup> the Second Circuit conceded that application of Connecticut's escheat law would increase the cost of providing benefits.<sup>60</sup> However, it found that this economic

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U.S. 811 (1989).

53. *Id.* at 147. See also *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 841 (1988) (declaring that ERISA does not preempt Georgia's general garnishment statute); *Retirement Trust Fund v. Franchise Tax Bd.*, 909 F.2d 1266, 1282 (9th Cir. 1990) (holding that ERISA does not preempt California's tax withholding procedures); *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir. 1984) (stating that ERISA does not preempt a law prescribing rates hospitals can charge for in-patient care), *cert. denied*, 472 U.S. 1008 (1985).

54. *Arkansas Blue Cross & Blue Shield*, 947 F.2d at 1346.

55. *Id.* at 1347. The same reasoning is apparent in other preemption decisions. See, e.g., *MacLean*, 831 F.2d at 728; *Gilbert v. Burlington Indus., Inc.*, 765 F.2d 320, 327 (2d Cir. 1985) (stating that ERISA preempts state law claims to enforce severance pay policy when they would determine whether benefits would be paid and "directly affect the administration of benefits under the plan"); *General Elec.*, 891 F.2d at 29.

56. *Ingersoll-Rand v. McClendon*, 111 S. Ct. 478, 483 (1990); *Arkansas Blue Cross & Blue Shield*, 947 F.2d at 1348.

57. 486 U.S. 825 (1988).

58. *Id.* at 831-32.

59. 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989).

60. *Id.* at 147.

impact was indirect and insubstantial.<sup>61</sup>

In contrast, ERISA has preempted state laws imposing significant costs on ERISA plans. Illustrative is Texas' Administrative Service Tax Act,<sup>62</sup> which imposed a tax on the collection of administrative fees by various entities, including health benefit plans.<sup>63</sup> In *E-Systems, Inc. v. Pogue*,<sup>64</sup> the Fifth Circuit found that ERISA preempted a tax, which amounted to 2.5 percent of all claims paid and money disbursed by the plan, because it had a significant economic impact.<sup>65</sup> The net effect of the tax was to reduce plan assets and the plan's capability to pay benefits.<sup>66</sup>

When a state law permits a participant to bring a cause of action against a plan, there is an obvious economic impact because the plan will pay any judgment. However, this type of economic impact alone cannot justify preemption of a state law. ERISA itself permits actions to be brought against employee benefit plans.<sup>67</sup> Furthermore, the Supreme Court has recognized that plans can be sued for run-of-the-mill state law claims, such as the failure to pay rent or commission of a tort.<sup>68</sup>

Some courts consider it important that a plan does *not* have to pay a judgment in concluding that ERISA should not preempt a law or cause of action. In *Johnson v. Antioch University*,<sup>69</sup> the court held that ERISA did not preempt a fraudulent inducement claim when it did "not require relief directly from the plan itself but rather from the wrongdoers."<sup>70</sup>

61. *Id.* See *Nunez v. Wyatt Cafeterias, Inc.*, 771 F. Supp. 165, 169 (N.D. Tex. 1991) (stating that ERISA does not preempt negligence action when there is, "at most, an indirect economic impact" between common law rights and plan); *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir. 1984) (holding that ERISA does not preempt state control of in-patient hospital rates), *cert. denied*, 472 U.S. 1008 (1985).

62. TEX. INS. CODE ANN. art. 4.11A (West 1993).

63. *Id.*

64. 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991).

65. *Id.* at 1101, 1104.

66. *Id.* at 1103. See also *Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp. Inc.*, 947 F.2d 1341, 1348-49 (8th Cir. 1991) (finding that assignment of benefits law's economic impact on plan supports finding of preemption), *cert. denied*, 112 S. Ct. 2305 (1992); *Birdsong v. Olson*, 708 F. Supp. 792, 801 (W.D. Tex. 1989) (finding that ERISA preempted Texas Administrative Service Tax Act due to substantial economic impact on plan).

67. 29 U.S.C. § 1132.

68. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 833 (1988).

69. 15 Employee Benefits Cas. (BNA) 1402 (D.D.C. 1992).

70. *Id.* at 1406. See *Pizlo v. Bethlehem Steel Corp.*, 884 F.2d 116, 120-21 (4th Cir. 1989) (holding that ERISA does not preempt claim when employer, and not plan, is liable for damages); *Greenblatt v. Budd Co.*, 666 F. Supp. 735, 742 (E.D. Pa. 1987).

Some courts, however, do not consider whether the plan or a separate entity pays a judgment to be a factor. In *Cefalu v. B.F. Goodrich*,<sup>71</sup> the Fifth Circuit held to be "without merit" a contention that ERISA should not preempt a participant misrepresentation claim because the participant was seeking to recover benefits from his employer and not from the plan.<sup>72</sup>

#### *F. Role of Plan Document in Resolution of Dispute*

Often, a court must look to an ERISA plan document to resolve a dispute under a state law. The degree to which the plan document is used has been an additional factor in determining whether the relationship between a plan and a state law is too tenuous to warrant preemption. The plan document may be used either to establish liability or to calculate damages.

*Ingersoll-Rand v. McClendon*<sup>73</sup> serves as an example of using a plan document to establish liability. There, the Supreme Court held that ERISA preempted a state wrongful discharge claim because, in order to resolve the dispute, the Court would have had to examine the terms of an ERISA plan to decide if the employer had a pension-defeating motive when terminating the participant's employment.<sup>74</sup> Similarly, in *Van Camp v. AT&T Information Systems*,<sup>75</sup> the Sixth Circuit found that ERISA preempted sex and age discrimination claims which would have required the court to rule on the validity of a retirement agreement.<sup>76</sup>

A court is also more likely to find that ERISA preempts a state law claim when it must refer to the plan in calculating damages. In *Cefalu*, the most important consideration in the court's decision to preempt a plan participant's misrepresentation claim was that if the participant established that his former employer had misrepresented plan benefits, the court would compute the damages by reference to the plan under which the participant had worked.<sup>77</sup>

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71. 871 F.2d 1290 (5th Cir. 1989).

72. *Id.* at 1293. See *Lister v. Stark*, 890 F.2d 941, 945 n.10 (7th Cir. 1989) (finding in favor of preemption); *Carter v. Amax Coal Corp.*, 748 F. Supp. 812, 816 (D. Utah 1990) (rejecting argument that ERISA should not preempt claim because participant will recover damages from corporation, not from benefit plan fund).

73. 111 S. Ct. 478 (1990).

74. *Id.* at 483. See *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991) (holding that ERISA preempted widow's wrongful death action when she claimed that her husband's death resulted directly from improper termination of plan benefits).

75. 963 F.2d 119 (6th Cir.), *cert. denied*, 113 S. Ct. 365 (1992).

76. *Id.* at 123.

77. *Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290, 1294 (5th Cir. 1989). See *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209, 1219 (5th Cir.) (finding that ERISA preempted

### G. *Effect of Law on Relations Among Principal ERISA Entities*

A fifth important factor that courts consider in determining whether ERISA preempts a state law is the effect of the law on the relations among principal ERISA entities. The Fifth Circuit summarized the application of this principle as follows:

[T]he courts are more likely to find that a state law relates to a benefit plan if it affects relations among the principal ERISA entities—the employer, the plan, the plan fiduciaries, and the beneficiaries—than if it affects relations between one of these entities and an outside party, or between two outside parties with only an incidental effect on the plan.<sup>78</sup>

In *Firestone Tire & Rubber Co. v. Neusser*,<sup>79</sup> the Sixth Circuit found the relations among ERISA entities to be one of three key factors in determining whether a state law's relationship to a plan is too tenuous to warrant preemption.<sup>80</sup> Applying this factor, the court found that ERISA did not preempt an Akron city income tax even though it applied to compensation deferred under an ERISA savings trust benefit plan.<sup>81</sup> The court found that the law did not affect relations among ERISA entities, but rather affected individuals as employees without regard to their status as ERISA participants.<sup>82</sup> Similarly, in *Perkins v. Time Insurance Co.*,<sup>83</sup> the Fifth Circuit concluded that a participant's allegation of fraud by a non-fiduciary independent agent did not affect the relations among the principal ERISA entities.<sup>84</sup>

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various state law claims when the court will measure damages in part by reference to plan benefits), *cert. denied*, 113 S. Ct. 68 (1992); *E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1103 (5th Cir.) (finding preemption when the court will calculate the amount of tax awarded the state by reference to a plan and claims paid under it), *cert. denied*, 112 S. Ct. 585 (1991); *Birdsong v. Olson*, 708 F. Supp. 792, 801 (W.D. Tex. 1989) (preempting a tax act). *But see* *Pizlo v. Bethlehem Steel Corp.*, 884 F.2d 116, 120-21 (4th Cir. 1989) (holding that ERISA did not preempt state law claims when, although the court would measure damages in part by plan benefits, claim would not burden plan administration).

78. *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters. Inc.*, 793 F.2d 1456, 1467 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034 (1987).

79. 810 F.2d 550 (6th Cir. 1987).

80. *Id.* at 556. The other key factors are whether the state law involves an exercise of traditional state authority and the incidental nature of any possible effect of the state law on the plan. *See supra* note 19.

81. *Firestone*, 810 F.2d at 556.

82. *Id.*

83. 898 F.2d 470 (5th Cir. 1990).

84. *Id.* at 473. *See* *Johnson v. Antioch Univ.*, 15 Employee Benefits Cas. (BNA)

By contrast, the Eighth Circuit in *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*<sup>85</sup> found that application of this factor "strongly supports" the preemption of Arkansas' statute, which allows participants to assign benefits to health care providers.<sup>86</sup> It noted that the statute shifted control over who received payment of plan benefits from the plan administrator to participants, sufficiently affecting relations among ERISA entities to warrant preemption.<sup>87</sup>

#### H. Existence of Remedy

The final factor, which is probably the most controversial, is whether a claimant will be left without a remedy if a court finds that ERISA preempts state law or cause of action. Some courts consider it relevant to the preemption decision,<sup>88</sup> while others do not. Indeed, in *Perry v. P.I.E. Nationwide, Inc.*,<sup>89</sup> the Sixth Circuit held that the primary reason that ERISA should not preempt a participant's fraudulent inducement claim was because ERISA provided no cause of action to remedy the alleged wrong, leaving the participant without recourse if the court allowed preemption.<sup>90</sup>

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1402, 1406 (D.D.C. 1992) (holding that claims for breach of fiduciary duty and breach of contract affect relations among principal ERISA entities and are preempted, while claims for misrepresentation, gross negligence, and estoppel do not affect such relations and are not preempted).

85. 947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 112 S. Ct. 2305 (1992).

86. *Id.* at 1346.

87. *Id.* See *Cairns v. Bridgestone/Firestone, Inc.*, 15 Employee Benefits Cas. (BNA) 1702, 1711 (N.D. Ohio 1992) (declaring that ERISA preempts action for breach of settlement agreement when it affects relations among principal entities).

88. See *Isaac v. Life Investors Ins. Co.*, 749 F. Supp. 855, 863-64 (E.D. Tenn. 1990) (relying on lack of an alternative remedy in deciding to permit participant to bring a state law action for fraudulent inducement); *Greenblatt v. Budd Co.*, 666 F. Supp. 735, 742 (E.D. Pa. 1987) (same).

89. 872 F.2d 157 (6th Cir. 1989), *cert. denied*, 493 U.S. 1093 (1990).

90. *Id.* at 162. The issue of alternative remedies impacts the preemption question in another way. If ERISA provides a remedy for a given claim, ERISA almost certainly preempts any state law remedy for that claim. See *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989). Thus, the Supreme Court in *Ingersoll-Rand Co. v. McClendon*, 111 S. Ct. 478 (1990), held that ERISA preempted a state wrongful discharge that was based upon the employee's allegation that his discharge was based upon his employer's desire to avoid making contributions to his pension fund. *Id.* at 483. The Court noted that section 510 of ERISA, 29 U.S.C. § 1140 (1988), expressly provides relief in such situations. *Ingersoll-Rand*, 111 S. Ct. at 485. "By its terms, § 510 protects plan participants from termination motivated by an employer's desire to prevent a pension from vesting." *Id.* See also *Johnson v. Antioch Univ.*, 15 Employee Benefits Cas. (BNA) 1402, 1406 (D.D.C. 1992) (announcing that ERISA preempts state law breach of fiduciary duty claim because 29 U.S.C. § 1132 (1988) specifically provides a remedy for such claims); *Lister v. Stark*, 890 F.2d 941, 944 (7th Cir. 1989) (declaring that ERISA preempts a participant's

The majority rule, however, appears to be that the lack of a remedy is an invalid consideration in resolving whether ERISA preempts a participant's state law claim.<sup>91</sup> For example, in *Lister v. Stark*,<sup>92</sup> the Seventh Circuit preempted a plan participant's fraudulent inducement claim even though the ruling meant that the participant would have no legal recourse for the alleged misrepresentation.<sup>93</sup> The court conceded that the decision left the plaintiff without a remedy, but ruled that availability of a federal remedy is not a prerequisite for preemption of state laws.<sup>94</sup>

### III. ARE PROVIDER MISREPRESENTATION CLAIMS PREEMPTED?

It is against this backdrop that federal courts have addressed the question of whether ERISA preempts health care provider misrepresentation claims. They have answered this question in every way possible: yes, no, and maybe.

#### A. Yes

Leading the "Yes" group is the Sixth Circuit's decision in *Cromwell v. Equicor-Equitable HCA Corp.*<sup>95</sup> Within its three opinions, *Cromwell* contains a discussion of almost all of the preemption factors previously identified. *Cromwell* arose when Brenda Reinke, a Beckman Industries (Beckman) plan beneficiary, sought home health care from Heterodox Health Systems (Heterodox), a health care provider. Before agreeing to provide care, Heterodox called the Beckman plan administrator, Equicor-Equitable (Equicor) "to verify that the provision of such care to Mrs. Reinke would be covered by the Beckman plan. Allegedly, Equicor did verify this."<sup>96</sup>

Heterodox provided care to Mrs. Reinke for six months. Equicor paid

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misrepresentation claim because such a claim is, in essence, a claim for benefits is recoverable only under section 1132), *cert. denied*, 111 S. Ct. 579 (1990).

91. *See, e.g.*, *Degan v. Ford Motor Co.*, 869 F.2d 889, 895 (5th Cir. 1989); *Anderson v. John Morrell & Co.*, 830 F.2d 872, 875 (8th Cir. 1987); *see also*, *Cefalu v. B.F. Goodrich*, 871 F.2d 1290 (5th Cir. 1989).

92. 890 F.2d 941 (7th Cir. 1989), *cert. denied*, 111 S. Ct. 579 (1990).

93. *Id.* at 944. *See supra* notes 23-29 and accompanying text for a discussion of *Lister*.

94. *Lister*, 890 F.2d at 946.

95. 944 F.2d 1272 (6th Cir. 1991), *cert. denied*, 113 S. Ct. 2 (1992).

96. *Id.* at 1275.



Heterodox for its services for the first three and a half months. Equicor then learned that Reinke was not actually covered under the Beckman plan and, therefore, was not entitled to benefits.<sup>97</sup> Equicor stopped paying claims, although it did not notify Heterodox until nearly two and a half months later that it would no longer reimburse Heterodox for its services. At that point, Heterodox had unpaid invoices totaling \$22,700.08.<sup>98</sup>

When Equicor failed to pay this amount, Heterodox filed suit in state court alleging breach of contract, promissory estoppel, negligence, and breach of the duty of good faith.<sup>99</sup> Equicor removed the case to federal court and then moved for and received summary judgment on the ground that ERISA preempted the claims.<sup>100</sup>

On appeal, the Sixth Circuit affirmed the dismissal of the state law claims.<sup>101</sup> It specifically rejected Heterodox's argument that those claims arose under general state laws having only a tenuous or peripheral effect on an ERISA plan.<sup>102</sup> The court's rejection was based upon two principal arguments. First, the court emphasized the breadth of ERISA's preemption clause.<sup>103</sup> In this portion of the decision, the court specifically refused to concern itself with whether the plaintiff had an alternative remedy if ERISA preempted the statutory claims, concluding that this was not a valid factor for consideration.<sup>104</sup> The court insisted that it is not relevant "to an analysis of the scope of federal preemption that appellants may be left without a remedy."<sup>105</sup>

The *Cromwell* court found that the most important factor was the goal of the action. The court declared that the state law claims were simply claims seeking the recovery of an ERISA plan benefit.<sup>106</sup> Although it did not cite them, the court employed the same reasoning that courts have used in participant misrepresentation cases such as *Lister v. Stark*<sup>107</sup> and *Cefalu v. B.F. Goodrich Co.*:<sup>108</sup> a misrepresentation claim is simply an attempt to modify the terms of a plan and recover benefits that the plan fails to provide. *Cromwell* also briefly addressed the principal ERISA entities factor and concluded that "appellants' state law claims are

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97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.* at 1275-76.

104. *Id.*

105. *Id.* at 1276.

106. *Id.*

107. 890 F.2d 941 (7th Cir. 1989), *cert. denied*, 111 S. Ct. 579 (1990).

108. 871 F.2d 1290 (5th Cir. 1989).

at the very heart of issues within the scope of ERISA's exclusive regulation and, if allowed, would affect the relationship between plan principals by extending coverage beyond the terms of the plan. Clearly, appellant's claims are preempted by ERISA.<sup>109</sup>

In his concurring opinion, Judge Suhrheinrich outlined additional reasons why the plaintiff's claims should be preempted. He considered the economic and administrative impact of the causes of action on the plan and found that the impact would be negative in three ways. First, the plan would pay any judgment, leaving fewer funds available to pay claims of beneficiaries.<sup>110</sup> Second, the payment of a damage award would require actuarial adjustments "since such a judgment will not have been a factor in the plan's projections."<sup>111</sup> Third, the plan would be subject to varying laws of different states concerning the types of damages recoverable in tort.<sup>112</sup> Judge Suhrheinrich also noted that failing to preempt the claim would allow parties to accomplish through tort law that which they could not accomplish through contract law.<sup>113</sup>

Judge Jones dissented, decrying what he considered to be the majority's "boiler-plate unreflective approach to ERISA preemption."<sup>114</sup> He noted that the result of such an approach "is to frequently leave deserving claimants without recourse in state or federal court."<sup>115</sup> Judge Jones relied heavily on *Memorial Hospital System v. Northbrook Life Insurance Co.*,<sup>116</sup> in which the Fifth Circuit determined that ERISA did not preempt a provider's misrepresentation claim.<sup>117</sup> He agreed with the Fifth Circuit's finding that provider misrepresentation actions do not involve a claim for coverage under the plan; rather, they involve a claim brought for damages because there is no coverage under the plan.<sup>118</sup> Judge Jones also agreed that such claims do not affect the relations among principal ERISA entities. Instead, they are actions between a non-ERISA entity and the plan.<sup>119</sup> Finally, Judge Jones discussed the purpose

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109. *Cromwell*, 944 F.2d at 1276.

110. *Id.* at 1279 (Suhrheinrich, J., concurring).

111. *Id.* (Suhrheinrich, J., concurring).

112. *Id.* (Suhrheinrich, J., concurring).

113. *Id.* (Suhrheinrich, J., concurring).

114. *Id.* (Jones, J., dissenting).

115. *Id.* (Jones, J., dissenting).

116. 904 F.2d 236 (5th Cir. 1990). For a detailed discussion of *Memorial Hospital*, see *infra* text accompanying notes 139-72.

117. *Memorial Hosp.*, 904 F.2d at 250.

118. *Cromwell*, 944 F.2d at 1284 (Jones, J., dissenting).

119. *Id.* (Jones, J., dissenting).

of ERISA and concluded that the law was meant to enhance coverage for employees, not to immunize plans and administrators from state law claims tenuously related to the plan.<sup>120</sup>

Another major case finding that ERISA preempts a provider misrepresentation claim is *Beaumont Neurological Hospital v. Humana, Inc.*<sup>121</sup> In *Beaumont*, the hospital alleged that Humana “verified health insurance coverage at the time when three patients were admitted” for substance abuse treatment.<sup>122</sup> Humana later denied coverage, insisting that the treatment was not medically necessary under the terms of Humana’s group health plan.<sup>123</sup> The hospital sued Humana in Texas state court, alleging that Humana negligently verified coverage and breached a contract.<sup>124</sup> The hospital sued as an assignee of the patient’s rights under the Humana plan.<sup>125</sup> Humana removed the case to federal court and then moved for and received summary judgment on the ground that ERISA preempted the state law claims.<sup>126</sup>

The analysis in *Beaumont* was essentially the same as that used in

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120. *Id.* (Jones, J., dissenting).

121. 780 F. Supp. 1134 (E.D. Tex. 1991).

122. *Id.* at 1135.

123. *Id.*

124. *Id.*

125. *Id.* Assignment of benefits agreements between participants and providers can have the effect of permitting a provider to sue under ERISA itself. *See, e.g.,* Psychiatric Inst., Inc. v. Connecticut Gen. Life Ins. Co., 780 F. Supp. 24, 30 (D.D.C. 1992) (finding that a health care provider has derivative standing to sue as an assignee of an ERISA plan participant or beneficiary); *Hermann Hosp. v. MEBA Medical & Benefits Plan*, 845 F.2d 1286, 1289-90 (5th Cir. 1988) (stating that ERISA contained no express language forbidding such assignments); *Kallus, supra* note 7, at 220.

However, plans may prohibit the use of such clauses by placing anti-assignment provisions in the plan document. Courts have held that such anti-assignment provisions are enforceable. *See, e.g.,* *Arkansas Blue Cross & Blue Shield v. St. Mary’s Hosp., Inc.*, 947 F.2d 1341, 1351 (8th Cir. 1991) (declaring that state “assignment statute ‘relates to’ ERISA plans”), *cert. denied*, 112 S. Ct. 2305 (1992); *Davidowitz v. Delta Dental Plan, Inc.*, 946 F.2d 1476, 1481 (9th Cir. 1991) (holding that “ERISA welfare plan payments are not assignable in the face of an express non-assignment clause in the plan”).

Further, some courts have held that health care providers have no standing to sue even if there has been an assignment. *See, e.g.,* *Health Scan, Ltd. v. Travelers Ins. Co.*, 725 F. Supp. 268, 269 (E.D. Pa. 1989) (asserting that Congress has enacted no provision to include the standing to sue by assignees); *Nationwide Mut. Ins. Co. v. Teamsters Health & Welfare Fund*, 695 F. Supp. 181, 184 (E.D. Pa. 1988) (reiterating that only participants and beneficiaries have legal right to sue).

In *Beaumont*, even though the provider relied on the assignment, the court treated the claims as state law claims rather than claims under ERISA, noting that the complaint was “devoid of any reference to ERISA.” *Beaumont*, 780 F. Supp. at 1135 n.1.

126. *Beaumont*, 780 F. Supp. at 1137.

*Cromwell*. The *Beaumont* court began by reviewing Supreme Court preemption decisions and emphasizing the breadth of the preemption doctrine.<sup>127</sup> Like the Sixth Circuit in *Cromwell*, the *Beaumont* court focused primarily on the goal of the hospital's action. It found that the hospital brought the action to recover plan benefits promised in an oral modification of the plan.<sup>128</sup> Upon making this finding, the court simply concluded that there was "no question that [the hospital's] state law claims relate to an employee benefit plan under ERISA and are preempted pursuant to § 514(a) of the same act."<sup>129</sup>

A related case is *Alexian Brothers Medical Center v. Will County Local 174 Carpenters Welfare Fund*.<sup>130</sup> In that case, Alexian Brothers, the plaintiff health care provider, claimed that it had contacted the defendants, a welfare fund and a health fund, prior to providing medical services for Theodore Irmick;<sup>131</sup> the defendants allegedly confirmed that Irmick was entitled to benefits.<sup>132</sup> Relying on this confirmation, Alexian Brothers provided treatment.<sup>133</sup> When the defendants later denied coverage, Alexian Brothers brought several state law claims against them, including negligent misrepresentation and equitable estoppel.<sup>134</sup> The defendants removed the case to federal court and then brought a motion to dismiss on the ground that ERISA preempted the misrepresentation and estoppel claims.<sup>135</sup>

The district court agreed.<sup>136</sup> It dismissed the claims on two grounds. First, it concluded that permitting the claims to proceed could have a significant economic impact on the plan—if benefits were to be paid out,

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127. *Id.* at 1136-37. It also referred to two Fifth Circuit decisions to further emphasize the "broad sweep" of the preemption clause. *Id.* at 1137. One of those decisions was *Memorial Hospital System v. Northbrook Life Insurance*, 904 F.2d 236 (5th Cir. 1990), a leading case against preemption of provider claims. Interestingly, the court ignored *Memorial Hospital* and referred to a statement in the case that ERISA preempts state law claims "that have the effect of orally modifying the express terms of an ERISA plan and increasing plan benefits for participants or beneficiaries who claim to have been misled." *Beaumont*, 780 F. Supp. at 1137.

128. *Beaumont*, 780 F. Supp. at 1137.

129. *Id.*

130. No. 91-C3777, 1992 U.S. Dist. LEXIS 1178 (N.D. Ill. Feb. 5, 1992).

131. *Id.* at \*2.

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.* at \*1.

136. *Id.* at \*6.

the actuarial soundness of the plan might be harmed.<sup>137</sup> Second, it concluded that the medical center's ultimate goal in the estoppel action was to orally modify the plan and receive benefits that were not recoverable under the plan as written.<sup>138</sup>

## B. No

Just as a number of courts emphatically answer "Yes" when asked if ERISA preempts provider misrepresentation claims, others answer with an equally emphatic "no." The leading case in the "No" group is the Fifth Circuit's decision in *Memorial Hospital System v. Northbrook Life Insurance Co.*<sup>139</sup> The case also contains the most comprehensive analysis of the preemption question. In *Memorial Hospital*, defendant Noff's, Inc. (Noff's) sponsored an employee health plan insured and administered by Northbrook Life Insurance.<sup>140</sup> Before providing treatment to Gloria Echols, the spouse of a Noff's employee, Memorial Hospital (Memorial) called Noff's to verify coverage under the health plan.<sup>141</sup> According to the complaint, a Noff's employee "verified that coverage was in effect

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137. *Id.* at \*5.

138. *Id.* at \*6. The precedential value of *Alexian Brothers* for the preemption of provider misrepresentation claims is unclear. The court did not state whether the estoppel claim was a state law claim or an estoppel claim under ERISA. Several factors indicate it was probably the latter. First, the court noted that *Alexian Brothers* was not suing as a non-ERISA entity, but rather as an assignee of Theodore Irmick's claim. *Id.* at \*1. Second, the court intended its decision to reject *Alexian Brothers*' claim that the Seventh Circuit permitted "estoppel claims to go forward in the ERISA context." *Id.* at \*4. It appears that *Alexian Brothers* may have considered its claim one for estoppel under ERISA's common law. Indeed, the case most discussed and analyzed in the decision was *Black v. TIC Investment Corp.*, 900 F.2d 112 (7th Cir. 1990), a case in which the Seventh Circuit permitted an equitable estoppel claim to be brought under ERISA.

An additional decision is somewhat related to the others in the "Yes" category. In *Optimal Health Care Servs., Inc. v. Travelers Ins. Co.*, 791 F. Supp. 163 (E.D. Tex. 1992), the court found that ERISA preempted a health care provider's state law claims for breach of contract, breach of duty of good faith and fair dealing, and breach of Texas' Deceptive Trade Practices Act. *Id.* at 164. The provider sued Travelers, the insurer for a group health plan, as an assignee from the plan participant. *Id.* The court granted the insurer summary judgment on the ground that the claims were simply state law actions to enforce rights under a plan and were thus preempted. *Id.*

*Optimal Health Care* is of limited value for purposes of the analysis in this Article. First, as in *Alexian Brothers*, the provider sued as an assignee of a principal ERISA entity, not as a third party with no rights under ERISA. *Id.* More importantly, nothing in the reported decision indicates that the insurer had misrepresented the coverage.

139. 904 F.2d 236 (5th Cir. 1990).

140. *Id.* at 238.

141. *Id.*

and available for Echols' hospital care.<sup>142</sup> Relying on this assurance of coverage, Memorial provided services costing approximately \$111,000.<sup>143</sup> When Memorial requested payment, Northbrook denied coverage.<sup>144</sup>

Memorial then sued both Northbrook and Noff's in state court alleging breach of contract, negligent misrepresentation, equitable estoppel, and a violation of Texas' Deceptive and Unfair Trade Practices Act<sup>145</sup> (statutory misrepresentation). Memorial brought the breach of contract claim for benefits under the plan based upon an assignment of benefits executed by Gloria Echols.<sup>146</sup> Memorial brought the remaining claims without regard to the assignment.<sup>147</sup> The lawsuit was removed to the District Court for the Southern District of Texas. The court dismissed the breach of contract and statutory claims on the ground that ERISA preempted them and remanded the estoppel and misrepresentation claims to state court.<sup>148</sup>

Memorial appealed the dismissal of the breach of contract and statutory misrepresentation claims. The Fifth Circuit affirmed the dismissal of the breach of contract claim, but vacated the dismissal of the statutory misrepresentation claim.<sup>149</sup> The court found that the breach of contract claim was merely one for benefits under an ERISA plan.<sup>150</sup> However, it concluded that the statutory misrepresentation claim was not one for benefits under the plan; rather, it was a claim by the hospital for damages resulting from the misrepresentation.<sup>151</sup>

The court began its analysis of the statutory misrepresentation claim by reviewing the principles governing preemption. It noted that, while the scope of preemption is broad, it is not limitless, and some state actions may affect plans in too tenuous a manner to warrant preemption.<sup>152</sup> The court concluded that state laws warranting preemption have

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142. *Id.*

143. *Id.*

144. *Id.*

145. TEX. INS. CODE ANN. art. 21.21 (West 1993).

146. *Memorial Hosp.*, 904 F.2d at 238.

147. *Id.* at 239.

148. *Id.*

149. *Id.* at 250.

150. *Id.* at 243, 250.

151. *Id.* at 244, 250.

152. *Id.* at 244-45. The court also summarized the types of cases which ERISA preempts: participant claims alleging improper processing of claims or participant misrepresentation claims "that have the effect of orally modifying the express terms of an ERISA plan and increasing plan benefits for participants or beneficiaries who

"two unifying characteristics."<sup>153</sup> It used these characteristics to create a two-part test to determine whether ERISA preempts a state law.<sup>154</sup> Those characteristics are as follows:(1) the state law claims address areas 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 relationship among the traditional ERISA entities—the employer, the plan and its fiduciaries, and the participants and beneficiaries.<sup>155</sup>

Applying the first part of its test, the court determined that the statutory misrepresentation cause of action did not implicate the federal concerns underlying ERISA.<sup>156</sup> Instead, that cause of action was predicated on the "classically important state interest" in allocating risks and apportioning damages between commercial entities operating within a state.<sup>157</sup> The court focused on what it called the "commercial realities" of the situation: a health care provider was simply seeking to have another commercial entity (the plan) accept the consequences of making a false representation of coverage upon which the provider relied.<sup>158</sup> The court considered the goal of the action and insisted that the statutory misrepresentation claim was not one for benefits under the plan and would in no way expand the parties' rights under the plan.<sup>159</sup> Instead, the claim sought damages for a tort committed by the plan. The court concluded that "[a] provider's state law action under these circumstances would not arise due to the patient's coverage under an ERISA plan, but precisely because there is no ERISA plan coverage."<sup>160</sup>

The court then addressed two arguments made by the defendants in their attempt to show that the misrepresentation claim did relate to an ERISA plan. First, the defendants argued that they were fiduciaries and thus subject to the fiduciary duties of ERISA.<sup>161</sup> The court rejected this argument on the basis that none of the defendants' fiduciary duties ran to third parties, such as Memorial.<sup>162</sup> Second, the defendants argued that the plan would play a significant role in the case.<sup>163</sup> They insisted that the claim related to an ERISA plan because the court would measure Memorial's damages, if any, by the amount of benefits provided to

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claim to have been misled." *Id.* at 245.

153. *Id.*

154. *Id.*

155. *Id.*

156. *Id.* at 247.

157. *Id.* at 246.

158. *Id.*

159. *Id.*

160. *Id.*

161. *Id.* at 247.

162. *Id.*

163. *Id.*

covered individuals under the terms of the plan.<sup>164</sup> The court conceded that this was a close question but was unpersuaded.<sup>165</sup> It found significant that while they might be measured by plan benefits, the damages did not consist of actual benefits.<sup>166</sup>

In completing its analysis of congressional intent, the court concluded that to preempt the cause of action would actually frustrate Congress' intent behind ERISA: to protect the interests of employees and their beneficiaries.<sup>167</sup> It noted that if providers were unable to bring claims like this, they would be less likely to provide medical services freely and might require payment by beneficiaries before offering treatment.<sup>168</sup>

The court concluded its opinion by applying the second prong of its two-part test: whether the claim affects the relationships among principal ERISA entities.<sup>169</sup> It noted that this was the most important factor in determining whether a law has too tenuous a relationship to a plan to warrant preemption.<sup>170</sup> Applying this factor, the court found that Memorial was neither a principal ERISA entity nor a party to the bargain that Congress had created in enacting ERISA—a bargain under which plan participants and beneficiaries received certain protections in exchange for foregoing certain potential remedies.<sup>171</sup> Instead, Memorial was simply an ERISA outsider trying to recover money lost as a result of a commercial entity's misrepresentation.<sup>172</sup>

The Tenth Circuit Court of Appeals also ruled against the preemption of provider claims in *Hospice of Metro Denver, Inc. v. Group Health Insurance, Inc.*,<sup>173</sup> a case decided just one day before *Cromwell*. In *Hospice*, the plaintiff health care provider rendered four months of post-

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164. *Id.*

165. *Id.*

166. *Id.* The court addressed the administrative burden factor at this point of the opinion as well and concluded that a one-time damage payment would not affect the ongoing administration of the plan as would, for example, an action seeking additional pension benefits. *Id.*

167. *Id.*

168. *Id.*

169. *Id.* at 248. It noted that two types of actions can be brought against ERISA plans: (1) actions under 29 U.S.C. § 1132 brought by ERISA entities and (2) run-of-the-mill state law claims (such as torts) brought by non-ERISA entities. *Memorial Hosp.*, 904 F.2d at 248. While the latter cases have some relationship to a plan, the court insisted that they did not raise preemptive concerns. *Id.*

170. *Memorial Hosp.*, 904 F.2d at 249.

171. *Id.*

172. *Id.* at 250.

173. 944 F.2d 752 (10th Cir. 1991) (per curiam).



surgery medical treatment to an infant.<sup>174</sup> It alleged that it had contacted Blue Cross, the insurer for the ERISA plan covering the infant, about insurance coverage before admitting the infant. According to the complaint, Blue Cross informed Hospice that “coverage was available.”<sup>175</sup> Further, Blue Cross “repeatedly assured [the health care provider] that the care was covered” during the course of the treatment.<sup>176</sup> Following the infant’s discharge, Blue Cross refused to pay for the care, claiming that the infant was not covered because of the policy’s preexisting condition exclusion.<sup>177</sup>

Hospice sued Blue Cross in state court, alleging promissory estoppel, *quantum meruit*, and claims as a third-party beneficiary.<sup>178</sup> Blue Cross removed the case to federal court and filed a motion to dismiss. The trial court dismissed all claims.<sup>179</sup> On appeal, the focus was on whether ERISA preempted the promissory estoppel claim, thus justifying the dismissal of the claims.

The Tenth Circuit answered that question “No.”<sup>180</sup> Like the Fifth Circuit in *Memorial Hospital*, it found that the claim was too tenuously related to an ERISA plan to warrant preemption.<sup>181</sup> To support its finding, the court first identified the goal of the action. It concluded that the action did not seek plan benefits or a modification of the terms of the plan.<sup>182</sup>

The court agreed with *Memorial Hospital* that provider suits do not arise due to coverage under a plan, but rather because there is no coverage.<sup>183</sup> It also agreed that the “commercial realities” of the situation are such that if health care providers are left without a remedy, they will be reluctant to provide care without prepayment.<sup>184</sup> The court recognized that according to the majority rule, the lack of alternative remedies is irrelevant for purposes of preemption of a participant’s claim; however, it concluded that the lack of alternative remedies should matter for a non-ERISA entity like Hospice.<sup>185</sup>

In concluding, the court addressed two additional issues. First, it considered the economic and administrative impact of its decision on the

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174. *Id.* at 753.

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.* at 756.

181. *Id.* at 754.

182. *Id.*

183. *Id.* at 755.

184. *Id.*

185. *Id.*

operation of the plan.<sup>186</sup> Earlier, the court had noted that permitting the cause of action to proceed would not subject the plan to inconsistent or conflicting state and local regulations.<sup>187</sup> Here, the court concluded that the result would merely force the plan to make a one-time, lump-sum payment the court would measure according to benefits provided by the plan, an effect it considered "not consequential enough to connect the action with[,] or relate the action to, the plan."<sup>188</sup> Second, the court considered ERISA's purpose and concluded that it would not be furthered by preempting misrepresentation claims of a third party provider who is not one of ERISA's principal entities.<sup>189</sup>

Two district courts reached the same conclusion regarding preemption of provider claims as the Fifth and Tenth Circuits. One was the Eastern District of Pennsylvania in *Horsham Clinic, Inc. v. Principal Mutual Life Insurance Co.*<sup>190</sup> The action was based on an alleged misrepresentation of coverage made by an insurer for an ERISA plan, Principal Mutual Life Insurance Co. (Principal Mutual) to a health care provider, the Horsham Clinic (Horsham).

Horsham brought the claim in state court. Principal Mutual removed the case to federal court, claiming that ERISA preempted it. On Horsham's motion to remand, the court disagreed on two grounds,<sup>191</sup> which this Article discussed in greater depth above. First, it concluded that Horsham's action was not one for benefits under the terms of the plan; rather, it was a claim for damages resulting from misrepresentations made apart from the plan.<sup>192</sup> Second, it found that it would not advance ERISA's purpose by preempting the claim.<sup>193</sup>

The District Court for the Southern District of New York reached the same result in *National Expert Care Consultants, Inc. v. United Air Lines, Inc.*<sup>194</sup> It, too, remanded to state court a health care provider's misrepresentation claim on the ground that the claim's relationship to an ERISA plan was too tenuous to warrant preemption.<sup>195</sup> Like the courts

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186. *Id.*

187. *Id.* at 754.

188. *Id.* at 755.

189. *Id.* at 756.

190. No. 92-1003, 1992 U.S. Dist. LEXIS 8284 (E.D. Pa. June 12, 1992).

191. *Id.* at \*10.

192. *Id.* at \*6.

193. *Id.* at \*6-7.

194. No. 90 Civ. 5390 (JFK), 1991 U.S. Dist. LEXIS 2050 (S.D.N.Y. Feb. 22, 1991).

195. *Id.* at \*2055-56.

of appeal in *Memorial Hospital and Hospice*,<sup>196</sup> the *National Expert Care* court relied heavily on the fact that the plaintiff, National Expert Care Consultants, Inc. (National), was not a principal ERISA entity seeking to recover benefits. It had no fiduciary relationship with the defendant, United Air Lines (United), and had no entitlement to benefits.<sup>197</sup> The court also found that any recovery would not affect the plan. In fact, the court concluded that the plan would play a minimal role in the case. Rather than interpret the plan, the court would focus its inquiry on the communications between the parties.<sup>198</sup>

In addition to these factors, this court employed one factor not considered in the other cases above. It found significant that the plaintiff sued United as a corporation, not as an employer or a plan agent.<sup>199</sup> The action was premised on a corporation committing the tort of misrepresentation, rather than on a plan fiduciary improperly administering the plan.<sup>200</sup>

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196. See *supra* notes 139-89 and accompanying text for a detailed discussion of *Memorial Hospital and Hospice*.

197. *National Expert Care*, No. 90 Civ. 5390 (JFK), 1991 U.S. Dist. LEXIS at 2055.

198. *Id.* at \*2057.

199. *Id.* at \*2054.

200. *Id.* This factor also played a role in a related district court decision to remand to a state court a claim arising out of a misrepresentation made to a provider. In *AMS Properties, Inc. v. Fortis Corporation*, No. 92-C-385 (E.D. Wis. Aug. 3, 1992), the complaint alleged that an employer, Charles Industries, and its agent, Fortis, contacted the plaintiff provider and asked it to treat a Charles Industries employee. Before rendering care, the provider raised the issue of payment and the parties executed a written agreement whereupon Charles Industries would reimburse the provider \$630.00 per day for 120 days. The agreement did not refer to an ERISA plan or coverage under it. When the provider tried to collect its treatment costs, Charles Industries refused to pay, claiming that the treatment was not covered under the terms of its employee benefit plan.

The provider sued Charles Industries and Fortis in state court for breach of contract and promissory estoppel. The defendants removed the case to federal court and moved for a dismissal of the claims. The provider opposed the dismissal and moved the court to remand the case. In a joint decision remanding the case to state court and denying the motion to dismiss, the court found that ERISA did not preempt the claims. *Id.*, slip op. at 5. Unlike the cases above, the main focus of the court's analysis was that the record did not reveal the existence of any plan. *Id.*, slip op. at 3. Because there was no plan, ERISA was not implicated. *Id.*, slip op. at 4.

The court then concluded that, even allowing for the "conjecture" that Charles Industries agreed to make payments because of the existence of some plan, ERISA would still not preempt the claims. *Id.* It did so on two grounds. First, the court concurred with the court in *National Expert Care* and found that AMS was merely suing Charles Industries as a corporation; it was not attempting to recover from any plan. *Id.* "Charles Industries' stockholders, not participants in any ERISA plan the company may have, are the ones who will be adversely affected by a judgment in this case." *Id.* Second, the court found that the identity of the party bringing the claim—a third-party health care provider—was significant. *Id.* Citing *Hospice and Memorial Hospital*, the court simply stated that "[u]nder circumstances like this,

### C. *Maybe*

Two district courts have tried to create a middle ground on the preemption question.<sup>201</sup> They draw a distinction between misrepresentations regarding the existence of coverage and misrepresentations regarding a plan's specific benefits. According to these courts, ERISA preempts state law claims alleging the latter, while it does not preempt those alleging the former.

The District Court for the Western District of Missouri was the first to make this distinction in *Coonce v. Aetna Life Insurance Co.*<sup>202</sup> In *Coonce*, Tina Coonce, a beneficiary of an ERISA plan, received both in-patient and out-patient psychiatric treatment. In May 1989, Tina Coonce's parents sought to transfer her to the San Marcos Treatment Center (San Marcos). In June and July of 1989, the trustees of the plan amended the plan to reduce the psychiatric benefits payable. Between May and July 1989, San Marcos had a series of conversations with the plan trustees and plan insurer, Aetna Life Insurance Co. (Aetna), regarding whether these benefit reductions would apply to Tina Coonce. Based upon Aetna's oral representations that Tina Coonce's coverage would remain intact, San Marcos admitted her as a patient and treated her for more than a year. Aetna later refused to pay for treatments beyond those provided in an initial two-week stay.<sup>203</sup>

When Tina Coonce's parents sued Aetna and the plan trustees, San Marcos intervened. San Marcos brought, among other claims,<sup>204</sup> state law claims for negligent misrepresentation and a violation of Texas' Deceptive Trade Practices Act<sup>205</sup> (statutory misrepresentation). Both sides filed motions for summary judgment on these claims. Finding that ERISA preempted the claims, the court granted summary judgment to the defendants.<sup>206</sup>

The court concluded that the goal of the lawsuit was merely to enforce

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there is no preemption." *Id.*, slip op. at 4-5.

201. *Parkside Lutheran Hosp. v. R.J. Zeltner & Assocs., Inc. ERISA Plan*, 788 F. Supp. 1002 (N.D. Ill. 1992); *Coonce v. Aetna Life Ins. Co.*, 777 F. Supp. 759 (W.D. Mo. 1991).

202. 777 F. Supp. 759.

203. *Id.* at 762-63.

204. Some of the claims were predicated upon an assignment of benefits. *Id.* at 772.

205. TEX. INS. CODE ANN. art. 21.21 (West 1993).

206. *Coonce*, 777 F. Supp. at 768.

an oral modification of the terms of the plan.<sup>207</sup> It found the case no different from *Anderson v. John Morrell & Co.*,<sup>208</sup> in which a participant brought a breach of contract claim to enforce an oral promise regarding benefits.

The court then distinguished *Memorial Hospital System v. Northbrook Life Insurance Co.*<sup>209</sup> It noted that in *Memorial Hospital* the health care provider simply verified that a prospective patient had coverage, whereas in the present case, the parties engaged in a series of discussions "for the express purpose of determining whether Tina would continue to receive benefits based on pre-July 1989 limits."<sup>210</sup>

The District Court for the Northern District of Illinois expanded on the *Coonce* distinction in *Parkside Lutheran Hospital v. R.J. Zeltner & Associates, Inc. ERISA Plan*.<sup>211</sup> In *Parkside*, an ERISA plan beneficiary, Linda Zeltner, received medical treatment at Parkside Lutheran Hospital (Parkside). The complaint alleged that an employee of Parkside contacted the defendant ERISA plan and "confirmed that Linda Zeltner had health benefit coverage under that plan."<sup>212</sup> The plan paid a portion of the bill, but refused to pay the rest.

Parkside then sued in state court under several theories. First, it brought an action under ERISA based upon an agreement wherein Linda Zeltner had assigned her plan benefits to Parkside.<sup>213</sup> Second, it brought state law actions for equitable estoppel and negligent misrepresentation based upon the incorrect verification of coverage.<sup>214</sup> After removing the case to federal court, the defendant moved to dismiss all claims.<sup>215</sup> The court dismissed the ERISA claim on the ground that the plan terms prohibited the assignment of benefits.<sup>216</sup> The court also dismissed the state law claims, but granted the plaintiff leave to amend the complaint to provide more detail about the alleged misrepresentation underlying the claims.<sup>217</sup>

When addressing the estoppel and misrepresentation claims, the court cited *Memorial Hospital*,<sup>218</sup> *Hospice*,<sup>219</sup> and Judge Jones' dissent in

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207. *Id.*

208. *Id.* at 767 (citing *Anderson v. John Morrell & Co.*, 830 F.2d 872, 877 (8th Cir. 1987) (holding that participant breach of contract claim was preempted)).

209. 904 F.2d 236 (5th Cir. 1990). See *supra* notes 139-72 and accompanying text for a discussion of *Memorial Hospital*.

210. *Coonce*, 777 F. Supp. at 768.

211. 788 F. Supp. 1002 (N.D. Ill. 1992).

212. *Id.* at 1003.

213. *Id.*

214. *Id.*

215. *Id.* at 1004.

216. *Id.* at 1005.

217. *Id.* at 1007.

218. See *supra* notes 139-72 and accompanying text for a discussion of *Memorial*

*Cromwell*<sup>220</sup> with favor, agreeing that provider claims based upon misrepresentations of coverage often do not relate to an ERISA plan and should not be preempted.<sup>221</sup> It concluded that preemption would not occur when misrepresentations create duties that exist outside of an ERISA plan and do not interfere with duties within the plan.<sup>222</sup> However, citing *Coonce*, the court also found that when representations to a provider modify the terms of a plan, ERISA would preempt a claim based upon those representations.<sup>223</sup> The court found that the preemption decision turned on the nature of the misrepresentations:

if it was merely involving a verification of coverage and, quite apart from the policy itself, created a duty between insurer and provider, the plan is not involved and the action does not "relate to" the plan; however, if the conversations concerned the nature of the coverage under the plan—e.g., whether an illness was a pre-existing condition or whether a given procedure was covered under the policy—they do "relate to" the plan for ERISA pre-emption purposes.<sup>224</sup>

Having created the distinction, the court dismissed the claims with leave to amend because the complaint was not clear as to the nature of the misrepresentations.<sup>225</sup>

#### IV. SHOULD ERISA PREEMPT PROVIDER CLAIMS?

Federal courts have answered the preemption question in every way possible, leaving observers with a final question: which answer is correct? This Article concludes that ERISA should not preempt provider misrepresentation claims. It also concludes that courts cannot maintain the distinction between misrepresentations of coverage and misrepresentations of benefits available (the *Coonce/Parkside* distinction), despite the distinction's "emotional appeal."<sup>226</sup>

The *Coonce/Parkside* distinction has an emotional appeal because the relationship between the state law claim and the plan seems stronger when misrepresentations concern specific plan terms. The distinction

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#### *Hospital.*

219. See *supra* notes 173-89 and accompanying text for a discussion of *Hospice*.

220. See *supra* notes 114-20 and accompanying text for a discussion of *Cromwell*.

221. *Parkside*, 788 F. Supp. at 1005-06.

222. *Id.* at 1006.

223. *Id.*

224. *Id.* at 1007.

225. *Id.*

226. Victoria F. Davis, *Duking It Out With The Doctors: Litigation Between Providers and Payers*, 5 BENEFITS L.J. 175, 183 (1992).

also has appeal because of cases such as *Coonce*.<sup>227</sup> Unlike *Memorial Hospital* or *Hospice*, *Coonce* involved a series of conversations between the plan and a provider regarding whether specific plan changes would apply to an individual.<sup>228</sup> The plan and its terms played a large role in the representations and in the court's decision.

Upon closer scrutiny, however, the distinction cannot survive. There is no real difference between a representation that there is coverage for a person and a representation that coverage exists for a specific type of treatment. In both instances, plan terms are equally involved. The terms of a plan determine who is covered just as they determine what is covered.<sup>229</sup> Further, contrary to the conclusion in *Parkside*,<sup>230</sup> the goal of the lawsuit is not different depending upon the nature of the misrepresentation. It is not true that a misrepresentation about coverage creates an independent duty resulting in standard tort damages, whereas a misrepresentation about specific plan terms results in an oral modification of the plan. In both circumstances, a third-party provider seeks damages caused by the misrepresentation, not coverage under the plan. In both circumstances, although damages resemble benefits, they are tort damages that are independent of the plan's obligations.

Finally, the *Coonce/Parkside* distinction may often be unworkable. It is not always clear when a representation relates solely to whether an individual is covered and when it relates to whether coverage is provided for the individual for a specific treatment. The issues are often interrelated.

The real question, then, is whether ERISA should preempt health care provider claims based upon misrepresentations about coverage (whether an individual or of a treatment). It is not an easy question because there is no doubt that misrepresentation claims bear some relationship to an employee benefit plan. The answer to the question turns on whether that relationship is close enough to warrant preemption.

Several of the factors discussed tend to support the view that the relationship is close enough to warrant preemption. First, the plan usually plays a role in a court's resolution of a misrepresentation claim. While the plan is not necessary to determine liability, it is often necessary to calculate damages. Damages may equal the amount to which a plan participant would be entitled under the terms of the plan if there were coverage.<sup>231</sup>

For that reason, a second factor comes into play. One can fairly argue

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227. See *supra* notes 202-10 and accompanying text for a discussion of *Coonce*.

228. *Coonce v. Aetna Life Ins. Co.*, 777 F. Supp. 757, 762-63 (W.D. Mo. 1991).

229. *Davis*, *supra* note 226, at 183.

230. See *supra* notes 211-25 and accompanying text for a discussion of *Parkside*.

231. The court in *Memorial Hospital* recognized that this factor was a difficult one in its finding of non-preemption. *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 247 (5th Cir. 1990).

that the goal of a lawsuit that seeks such damages is to orally modify the plan: to obtain benefits that the plan expressly prohibits. In this way, the cases are similar to those such as *Lister v. Stark*<sup>232</sup> and *Cefalu v. B.F. Goodrich Co.*,<sup>233</sup> in which courts have refused to permit plan participants to bring misrepresentation actions to avoid permitting oral modification of the plan. Regardless of what they are called, the damages a plan must pay closely resemble plan benefits in a successful misrepresentation claim, even when a third-party provider sues.<sup>234</sup>

Additionally, while the administrative impact of the state law claims is not great,<sup>235</sup> that impact is felt in the area of one of ERISA's core concerns: the payment of benefits under a plan. Thus, under the analysis of *Aetna Life Insurance Co. v. Borges*,<sup>236</sup> preemption is more likely.

While these factors support a finding of preemption, they are outweighed by the remaining factors. First, the administrative and economic impact of such claims on the plan is not great. Administratively, they do not subject plans to differing state laws.<sup>237</sup> Laws that prohibit misrepresentation and provide causes of action to enforce them are standard. There is no need to vary the terms or operation of a benefit plan from state to state. In all states, the plan must make truthful representations to outsiders, just as it must obey anti-discrimination laws when it deals with its employees.<sup>238</sup>

232. 890 F.2d 941 (7th Cir. 1989), *cert. denied*, 111 S. Ct. 579 (1990).

233. 871 F.2d 1290 (5th Cir. 1989).

234. Note that these factors do not exist in all provider cases. For example, in *AMS Properties, Inc. v. Fortis Corp.*, No. 92-C-385 (E.D. Wis. Aug. 3, 1992), an ERISA plan was not involved at all. In *AMS Properties*, the plaintiff was seeking to recover a fixed amount of money that the defendant had agreed to pay in writing. The action was only concerned with the interpretation of this agreement and any damages could be calculated and paid wholly apart from the terms of an ERISA plan. For a discussion of *AMS Properties*, see *supra* note 200.

235. See *infra* text accompanying notes 237-40.

236. 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989). See *supra* text accompanying notes 44-55.

237. This was one of the main reasons for the creation of ERISA. See *supra* text accompanying notes 6-7. In his *Cromwell* concurrence, Judge Suhrheinrich argues that such claims do subject plans to varying state laws because each state has different laws regarding damages for misrepresentation or estoppel. *Cromwell v. Equitor-Equitable HCA Corp.*, 977 F.2d 1272, 1279 (6th Cir. 1991) (Suhrheinrich, J., concurring), *cert. denied*, 113 S. Ct. 2 (1992). But such laws do not affect the administration of the plan, which was Congress's concern with the effect of varying state laws. See *Ingersoll-Rand v. McClendon*, 111 S. Ct. 478, 484 (1990).

238. See *Lane v. Goren*, 743 F.2d 1337, 1341 (9th Cir. 1984).



Similarly, subjecting plans or insurers to misrepresentation claims does not require the plan to maintain an ongoing administrative scheme, the type with which the Supreme Court was concerned in *Fort Halifax Packing Co. v. Coyne*.<sup>239</sup> The only administrative and economic result of permitting such claims is that a court may force the plan to make a one-time, lump-sum payment of damages.<sup>240</sup> There is no requirement of ongoing supervision, nor is there an ongoing obligation of payment. Here, the goal of the action becomes important. Administratively and economically, a provider misrepresentation claim is much more like a standard tort or contract claim brought by an outsider against the plan than like a participant's claim for benefits.

The administrative and economic factors support the conclusion that ERISA should preempt provider misrepresentation claims. But these factors alone might not justify that conclusion absent the two remaining factors: whether the suit affects the relations among principal ERISA entities and whether alternative remedies exist for providers. Courts have consistently been much more reluctant to preempt state laws when they do not affect the relations among principal entities such as the employer, the plan, the plan fiduciaries, and the beneficiaries.<sup>241</sup> The reason is that the connection with an ERISA plan and its principal concerns is clearly less when the plan deals with the outside world in a standard business context than when it deals with its beneficiaries on internal plan matters. This principle helps explain why the Supreme Court has found that ERISA plans can be sued for traditional run-of-the-mill state law claims.<sup>242</sup>

The argument against preemption of provider claims is even more compelling given that the effect of preempting a provider's claim leaves a non-ERISA entity without a remedy. The Sixth Circuit may well be correct in its assertion that the lack of an alternative remedy usually does not matter for purposes of an ERISA participant's claims.<sup>243</sup> However,

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239. 482 U.S. 1 (1987).

240. Note that this is not always the case. There may be no economic effect at all when the employer is sued as a corporation. See *National Expert Care Consultants, Inc. v. United Air Lines, Inc.*, No. 80 Civ. 5390 (JFK), 1991 U.S. Dist. LEXIS 2050, 2054 (S.D.N.Y. Feb. 22, 1991); see also Robert N. Eccles & David E. Gordon, *Betrayal With Remedy—Can Medical Service Providers Recover When The Administrator Falsely States That Medical Services Are Covered?*, 6 ERISA LITIG. REP. 14, 16 (1992) (addressing the decisions in *Hospice* and *Cromwell* and concluding that a key factor in determining whether ERISA should preempt provider misrepresentation claims is whether the plan or the plan administrator in its individual capacity will pay a judgment).

241. See *supra* notes 78-89 and accompanying text.

242. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 833 (1988).

243. *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1276 (6th Cir. 1991), *cert. denied*, 113 S. Ct. 2 (1992).

there is obvious discomfort among courts with this result. In *Degan v. Ford Motor Co.*,<sup>244</sup> the Fifth Circuit described its result of preempting a participant's misrepresentation claim and leaving it without a remedy as its "Unhappy Denouement."<sup>245</sup> The discomfort even affects commentators who defend ERISA plans and would be expected to applaud a broad preemption doctrine.<sup>246</sup>

One can explain the lack of a remedy for participants, however, based upon what some have called the ERISA "bargain."<sup>247</sup> As a part of that bargain, plan participants gave up certain remedies and causes of action, such as those for bad faith and punitive damages. This was in return for a comprehensive federal scheme, including enforcement provisions, that would eliminate inefficiencies, provide reporting, disclosure, and fiduciary requirements, and facilitate the full and consistent payment of benefits.<sup>248</sup> It can be said that although beneficiaries may be left without a remedy in rare circumstances, they enjoy the overall benefits of ERISA and the bargain they entered.

However, as *Memorial Hospital* correctly points out, third party medical care providers were not a part of this bargain.<sup>249</sup> They receive none of ERISA's protections or rights which would justify a finding that they should give up certain standard state law remedies. A provider is an ERISA outsider who encounters an ERISA plan in a business context and a loss occurs. In this context, the question of preemption involves an allocation of the risk of that loss. The performance of that allocation is a classic state law function that involves few of the concerns of ERISA or

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244. 869 F.2d 889 (5th Cir. 1989).

245. *Id.* at 895.

246. See Robert N. Eccles & David E. Gordon, "Betrayal Without Remedy": Part IV, 1 ERISA LITIG. REP. 14 (1991). The authors argue that the lack of a remedy in certain cases "appears so indefensible as a policy matter that judicial failure to provide a solution will almost certainly result in Congressional intervention." *Id.* at 14. They propose that courts in participant misrepresentation cases find that a promise to provide benefits that a plan does not provide results in the "creation of a separate, unfunded ERISA plan to pay the promised benefits." *Id.* at 15. While this might resolve participation misrepresentation issues, it would not help health care providers who lack standing under ERISA and who are subject to anti-assignment clauses which prevent derivative standing.

247. *Williams v. Caterpillar, Inc.*, 720 F. Supp. 148, 152 (N.D. Cal. 1989), *aff'd*, 944 F.2d 653 (1991); *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 249 (5th Cir. 1990).

248. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53-54 (1987).

249. *Memorial Hosp.*, 904 F.2d at 249-50. See *supra* notes 171-72 and accompanying text.

matters that relate to an ERISA plan. There is no reason to believe that Congress, in enacting ERISA, intended to deprive wronged outsiders of remedies and to shield ERISA plans from the consequences of their wrongful actions against such outsiders.

#### V. CONCLUSION

Health care providers seeking to recover for misrepresentations of coverage made to them by ERISA plan representatives face a great deal of uncertainty. Federal courts have reached every possible result on whether ERISA preempts such claims.

The proper result is that ERISA should not preempt provider misrepresentation claims. Such claims have an insignificant economic and administrative impact on ERISA plans. More importantly, they are brought by ERISA outsiders as a result of a loss incurred in the course of their traditional business dealings. The claims have too tenuous a relationship to an ERISA plan to warrant preemption.