Insurer's State Law Claims Against Providers Upheld in New Jersey and Not Preempted by ERISA

by Daniel Meier

Federal preemption of Employee Retirement Income Security Act (ERISA) plans is not absolute. While it certainly covers the issues of benefit determinations, particularly between the plan administrator and the beneficiary, it is not determinative regarding the plan's relationship with providers.

It is well settled that rights to benefits under ERISA plans[1] may only be enforced pursuant to ERISA §502(a), 29 U.S.C. § 1132(a). In fact, ERISA's federal preemption explicitly states, "the provisions of this subchapter...shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."[2] Plan rights may, therefore, not be enforced via state law if they fall under the scope of ERISA §502(a), as this alternative enforcement will be otherwise preempted. Accordingly, state law claims may not be made against an insurer under an ERISA plan for adverse benefit determinations (*i.e.,* for the insurer's decision to deny, reduce or terminate a healthcare service or payment or an individual's eligibility for coverage).

Providers, such as doctors, dentists, hospitals, surgery centers, drug and alcohol treatment centers, and medical equipment suppliers, need to be aware in their relations with the plan's insurer or administrator that an insurer's state law claims against a provider may not necessarily be so preempted. In fact, New Jersey federal courts have recently found that neither ERISA §502(a) nor ERISA §514(a) provide for complete preemption of an insurer's state law causes of action against providers that arises out of claims such as statutory fraud, common law fraud, civil Racketeer Influenced and Corrupt Organizations Act (RICO),[3] and negligent misrepresentation, especially when the insurer commences an action on its own behalf and not as a plan fiduciary or on behalf of an ERISA plan, its participants and/or beneficiaries.

Insurer's State Law Claims Found Not to be Completely Preempted by ERISA

Uniformly, the U.S. District Court for the District of New Jersey has held in a series of decisions that ERISA §502(a) does not completely preempt an insurer's state law fraud claims against providers, including medical, dental, mental health and durable medical equipment suppliers. Most recently, U.S. District Court Judge Joel Pisano found that "ERISA does not completely preempt claims brought by an insurer who sues a provider for fraudulent or negligent misbilling."[4]

In *Association of New Jersey Chiropractors*, Aetna asserted counterclaims against a class of providers for various violations, including common law fraud, negligent misrepresentation, unjust enrichment and violations of the New Jersey Insurance Fraud Prevention Act.[5] Aetna alleged that the providers submitted fraudulent or negligent bills through conduct involving upcoding, unbundling, miscoding, concealing services, falsely billing, failing to have proper documentary support for claims, and waiving patient cost share obligations.[6] The district court denied the providers' motion to dismiss the counterclaims on the grounds that they were preempted by ERISA.

In fact, the district court, in *Association of New Jersey Chiropractors*, found that the state law violations were not preempted since Aetna did not bring its counterclaims in its capacity as a fiduciary. Rather, the district court found that the claims were brought on Aetna's own behalf as a victim of the providers' alleged fraudulent or negligent bills.[7] Further, the district court found that even if Aetna had been acting as a fiduciary, the claims arose from independent legal duties that arise under New Jersey's insurance fraud statute and common law, which prohibit providers from committing this type of fraud.[8] Aetna's claims were, therefore, not "derived

entirely from the particular rights and obligations established" by the ERISA plans.[9]

Similarly, in *Horizon Blue Cross Blue Shield of New Jersey v. Transitions Recovery*, U.S. District Court Judge Robert Kugler also denied the provider's argument that the insurer's state law causes of action were completely preempted by ERISA because the insurer could not obtain relief by bringing a claim under ERISA §502(a).[10] The district court held that the insurer could seek both compensatory and punitive damages for the alleged falsification of insurance claims because such relief could not be sought under ERISA §502(a)(3), and thus was not completely preempted by ERISA as a matter of law.[11]

U.S. District Court Judge Pisano also recently held an insurer's actions failed to implicate ERISA in *TRI3 Enterprises, LLC v. Aetna Inc*. because "when an insurer believes a provider has misrepresented the nature of its services, and the insurer has made payments to the provider based upon the misrepresentation, the insurer may file a lawsuit seeking recovery of those monies without implicating ERISA."[12]

Specifically, in *TRI3 Enterprises, LLC*, Aetna had conducted an audit and found that the plaintiff, a provider of durable medical equipment, used the wrong coding for certain products, which were not covered by Aetna, and requested reimbursement of claims paid based on this improper billing.[13] After a few years, the plaintiff sued Aetna alleging that it had violated ERISA by not making payment on its claims.[14] Aetna moved to dismiss the complaint, arguing that the actions arose "in the context of fraud prevention and recovery."[15] Aetna argued that suits are permitted to recover monies paid by medical providers as a result of fraud and improper billings practices, without implicating ERISA, and therefore it could also "take steps short of a lawsuit to recover such monies without implicating ERISA."[16] Ultimately, the provider's conduct was found to be the focal point of the insurer's claims, and mere references to the plans were held to be insufficient to bring Aetna's actions into the purview of ERISA.

Yet another District Court of New Jersey opinion recently held that an insurer's causes of action alleging fraud by healthcare providers do not implicate ERISA.[17] In *Health Goals*, an in-network healthcare provider entered into a scheme to defraud the insurer and submitted insurance claims to plaintiffs for services which, among other things: 1) contained knowingly false and misleading information, 2) misrepresented the services performed, and 3) failed to disclose information affecting the plaintiff's right to payment.[18] According to the insurer, the claims submitted included "excessive, phantom and duplicate charges."[19] Specifically, the insurer claimed the defendants committed common law fraud, statutory fraud and negligent misrepresentation of their services when they submitted their claims.[20] The provider not only billed for services it had not performed, but "upcoded" its bills to the plaintiff using improper billing codes to receive a higher level of payment.

Ultimately, the district court utilized the two-part test promulgated by the Third Circuit in *Pascack Valley Hosp., Inc. v. Local 464A UFCW Welfare Reimbursement Plan* to determine whether ERISA §502 completely preempts a state law claim, namely that "a defendant seeking removal must prove that: (1) the plaintiff could have originally brought the claim under [§]502 and (2) no other legal duty supports the claim."[21] Under this two-part test, U.S. District Court Judge Noel Hillman found that the insurer's state law claims were not preempted by ERISA because the insurer was not bringing a claim on behalf of any employee benefit plans or the plan's participants, and therefore could not have originally brought its claim under §502. Accordingly, an independent legal duty other than ERISA governed the relationship between the insurers and providers.[22]

Insurers' Claims That Providers Wrongly Waived Patient Financial Responsibility Found Not to be Preempted by ERISA

Along similar lines, the District Court of New Jersey also recently addressed the question of whether ERISA preempts causes of action brought under state law by health plans against providers who routinely waive plan participants' copayments, co-insurance and deductible obligations under ERISA-governed employee health plans.[23] In *East Brunswick*, the defendant provider terminated its agreement with the plaintiff insurer, making it a "non-participating" provider, and then continued to provide services to the insurer's subscribers on an out-of-network basis. However, the provider increased its charges for services to the subscribers and waived payment of coinsurance, deductibles and other patient financial responsibilities to induce the subscribers to use its out-of-network services. Ultimately, the insurer sued the provider for fraudulently and tortiously interfering with its in-network health benefit plans.

Horizon's causes of action were based, in part, on the principle long-recognized by New Jersey courts, that a provider's waiver of coinsurance gives the provider an unfair advantage over other providers by "improper means" that "should be barred."[24] "Doubtless, [the provider's] methods gave him a competitive advantage. They permit him to relieve patients of the burden of cash outlays that copayment plans normally require. To the patient, [the provider's] services are free or much reduced in cost. All other things being equal, patients will be attracted to a dental office that offers services that are, to them, free or cheaper than elsewhere."[25]

In *East Brunswick*, U.S. District Court Judge Freda Wolfson found that the insurer's claims were not preempted by ERISA, and therefore remanded the case back to state court. The district court held that there is a difference between a "health provider *seeking* reimbursement on behalf of plan participants based on ERISA benefit plans," and "a health plan, in sole furtherance of its own business interests, seeking to protect its contractual agreements with in-network providers."[26] The district court found that Horizon was not seeking to deny or control benefits as a fiduciary, but rather was seeking to protect the "integrity of its two-tiered provider system."[27] The district court agreed that Horizon had the right to protect its two-tiered, in-network and out-of-network, provider system. Further, the district court found that protecting the relationship between the insurer and its out-of-network and in-network providers does not implicate ERISA preemption.[28]

New Jersey courts have also similarly found that while insurance companies often act as ERISA plan fiduciaries, this does not mean that they are acting as a fiduciary when initiating a suit based on independent legal basis for state law fraud claims.[29] Notably, the district court stated in *Srinivasan* that the test a court may use to determine "whether ERISA preempts a plaintiff's complaint differs based upon whether that lawsuit was initiated by a beneficiary or fiduciary."[30] Ultimately, the district court in *East Brunswick* found that the insurer was not acting as a fiduciary with respect to its state law claims because the benefit plans' terms will not affect the resolution of the causes of action.[31] The district court held that the "[p]laintiff's legal theory and allegations go far beyond a simple dispute over benefits due or not due to a plan participant under ERISA but involve the intricate arrangements between health care plans and providers."[32]

Based on the foregoing analysis, it will be instructive for providers to be aware that in New Jersey, alleged fraudulent enrollment or billing practices may not be preempted by ERISA and insurers may, therefore, take advantage of this posture to proactively litigate against providers using claims other than ERISA.

Daniel Meier is an associate with the health care practice group at Benesch, Friedlander, Coplan and Aronoff LLP.

Endnotes

1. Generally, ERISA plans are those that are regularly conducted, employment-based programs or practices, whose purpose is to afford certain kinds of benefits to employees. ERISA § 3(1)-(3).
2. ERISA §514(a); 29 U.S.C. § 1144(a).
3. 18 U.S.C. § 1962(c).
4. *See Assoc. of New Jersey Chiropractors v. Aetna, Inc.*, No. 09-3761 (JAP), 2012 WL 1639166, at *6 (D.N.J. May 8, 2012).
5. *Id.* at *2-3.
6. *Id.*
7. *Id.* at *7.
8. *Id.*
9. *Id.*
10. No. 10-3197, 2011 WL 2413173 (D.N.J. June 10, 2011).
11. *Transitions Recovery*, 2011 WL 2413173, at *4.
12. No. 11-cv-03921, 2012 WL 1416530, at *4 (D.N.J. April 24, 2012).

13. *Id*. at *1-2.
14. *Id*. at *2.
15. *Id*. at *4.
16. *Id*.
17. *Aetna Health Inc. v. Health Goals Chiropractic Center,* No. 10-5216-NLH-JS, 2011 WL 1343047 (D.N.J. April 7, 2011).
18. *Id*. at *1.
19. *Id*. at *2.
20. *Id*.
21. *Pascack Valley Hosp., Inc. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 400 (3d Cir. 2004).
22. *See Id*. at *5-6.
23. *See, e.g., Horizon Blue Cross Blue Shield of New Jersey v. East Brunswick Surgery Center*, 623 F. Supp. 2d 568 (D.N.J. 2009).
24. *Feiler v. New Jersey Dental Ass'n*, 191 N.J. Super. 426 (Super. Ct. 1983).
25. *Id*. at 439-40.
26. *Id*. at 577; *see also Health Goals Chiropractic Center*, 2011 WL 1343047, at *4.
27. *Id*. at 577.
28. *Id*.
29. *See Id; see also Aetna Health Inc. v. Srinivasan*, No. 10-4858 (FSH), 2010 WL 5392697, at *3 (D.N.J. Dec. 22, 2010) ("The mere fact that Aetna might act as an ERISA fiduciary in other circumstances does not alter its role in bringing the instant action.").
30. *See Id.* at *4, n.3.
31. *East Brunswick*, 623 F. Supp. 2d at 577.
32. *Id*. at 578.