UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

COMPREHENSIVE NEUROSURGICAL, P.A., **Plaintiff,** **v.** **BLUE CROSS/BLUE SHIELD OF MICHIGAN,** **Defendant.**	03-CIV-4117 (WJM) **OPINION** **HON. WILLIAM J. MARTINI**

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MARTINI, U.S.D.J.:

This matter comes before the Court on Defendant Blue Cross/Blue Shield of Michigan's ("Blue Cross") Objection to Magistrate Judge Ronald J. Hedges' February 27, 2004 Report and Recommendation, which grants Plaintiff Comprehensive Neurosurgical, P.A. ("Comprehensive")'s Motion to Remand the above-captioned matter to the New Jersey Superior Court, Bergen County.

For the reasons detailed herein, this Court adopts Magistrate Judge Hedges' February 27, 2004 Recommendation that the above-entitled action be expeditiously remanded to New Jersey Superior Court, Bergen County, from where it was removed. This Court, however, declines to adopt the reasoning submitted by Magistrate Judge Hedges in support of the remand.

BACKGROUND

For purposes of brevity, this Court need only detail the following facts: Comprehensive is a third party health care provider who rendered medical services to a General Motors employee. The employee (who is a non-party to this action) is a participant/beneficiary of the General Motors Hourly Plan, an ERISA plan that was administered by Blue Cross. It appears that Comprehensive received (from the employee) an assignment of payment of benefits from said employee's health insurance program.[1]

On January 16, 2003, Comprehensive made a customary inquiry by telephone to Blue Cross regarding the employee's insurance coverage - often referred to as "pre-determination" - to ascertain coverage for future medical services to be provided. Comprehensive alleges that it reasonably relied upon Blue Cross' predetermination that Comprehensive was entitled to eighty (80) percent of fair, usual and customary fees for medical services provided to the employee. Comprehensive provided the medical services, and subsequently received only a small portion of what was allegedly promised by Blue Cross. On July 18, 2003, Comprehensive filed suit against Blue Cross in New Jersey Superior Court, Bergen County, alleging breach of contract, breach of implied covenant of good faith and fair dealing, promissory estoppel, and negligent misrepresentation. (Compl., at Cts. I-IV).

On August 29, 2003, Blue Cross removed this action pursuant to 28 U.S.C. §§ 1441 and 1446. (See Def. Notice of Removal). On December 16, 2003, Plaintiff moved to remand the action back to Bergen County Superior Court. (See Pl. Motion to Remand). On February 27, 2004, Magistrate Judge Hedges recommended that Plaintiff's remand motion be granted, and made the

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[1] Neither the Complaint nor the Notice of Removal specifically alleges that Comprehensive is the assignee of the employee. (See generally, Compl.)

following recommended conclusions of law:

1. Plaintiff's Complaint was not removable under the well-pleaded complaint rule;

2. ERISA did not completely preempt Comprehensive's state-law contract claims against Blue Cross under 29 U.S.C. § 1132(a)(1)(B) or § 502(a)(1)(B); because even though

   (i) Comprehensive had standing to bring a claim under ERISA's civil enforcement provision codified at § 502 as an assignee,

   (ii) Plaintiff's Complaint did not invoke ERISA's civil enforcement provision and warrant removal, because: "Comprehensive's claims merely deal with the quality of the benefits received. Comprehensive does not claim that the plans erroneously withheld a benefit due under the plan."

(Mag. J. 2/27/04 R&R, at pp. 3-12).

On or around March 16, 2003, Blue Cross filed the herein Objection, asserting that Magistrate Judge Hedges' recommended legal conclusion that Comprehensive's claims merely dealt with the quality of the benefits received, was erroneous. "Because Plaintiff's claims unquestionably relate exclusively to the *amount of payment* Plaintiff received (or failed to receive) for medical services it provided, and does not involve or implicate the quality of the underlying medical services provided, Blue Cross contends that Plaintiff's claims must be found to involve the quantum of benefits due under a regulated employee welfare plan." (Def. Br., at p. 1)(emphasis in original). Therefore, Blue Cross posits that this matter should remain in federal court. This Court now turns to the merits of the herein application.

ANALYSIS

Pursuant to Fed. R. Civ. P. 53 (e)-(f), this Court shall accept Magistrate Judge Hedges' reported findings of fact, unless they are clearly erroneous. See Levin v. Garfinkle, 540 F. Supp. 1228, 1236 (E.D. Pa. 1982) (citing Bennerson v. Joseph, 583 F.2d 633 (3d Cir. 1978)). However,

this Court will review, *de novo*, Magistrate Judge Hedges' conclusions of law, as they do not bind this Court; they are recommendations which the Court may consider. See In re Mifflin Chemical Corp., 123 F.2d 311 (3d Cir. 1941), cert. denied, 315 U.S. 815 (1942).

This Court agrees with Magistrate Judge Hedges' analysis that the herein action is not removable under the well-pleaded complaint rule. Comprehensive's Complaint does not present a federal question on its face, and clearly presents state-based contract and quasi-contract claims. This Court also agrees that the relevant query is whether the Complaint falls under the "complete preemption" exception of the well-pleaded complaint rule. As Magistrate Judge Hedges accurately posited, "only state law claims that come within ERISA's civil enforcement provision in [§ 1132(a)] are completely preempted such that removal to federal court is appropriate." (Mag. J. Hedges 2/27/04 R&R, at p. 4).

However, the Court in determining that § 1132 of ERISA does not completely preempt Comprehensive's contract-based state law claims, declines to adopt the Magistrate's recommended conclusion that an assignee could have standing under § 1132, as it runs counter to this Circuit's ruling in Northeast Department ILGWU Health & Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund, 764 F.2d 147 (3d Cir. 1985).

In Northeast, Mrs. Ruth Fazio, a union employee and participant in the ILGWU Fund and a beneficiary of a Teamsters Fund where her husband was a union employee and participant, was denied coverage for medical bills because both the ILGWU and Teamsters Funds identified each other for reimbursement.[2] (Id. at 150). After Mrs. Fazio filed suit in federal court naming both Funds

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[2] Each Fund contended that its applicable "other insurance" provision, that is, the language in its benefits plan purporting to exclude from coverage persons in Mrs. Fazio's position, was controlling. Northeast, 764 F.2d. at 150.

as defendants, an agreement was reached whereby the ILGWU Fund paid Mrs. Fazio's claim, and contemporaneously filed a declaratory judgment action against the Teamsters Fund to determine the rights and obligations of the two Funds regarding Mrs. Fazio's claims. (Id.) The Third Circuit panel of Judges Becker, Sloviter, and Fullam found jurisdiction in the Northeast matter on unrelated reasons. However, Judge Becker, in writing the majority opinion, briefly discussed the lack of assignee standing[3] in that case:

> First, Congress simply made no provision in § 1132(a)(1)(B) for *persons other than participants and beneficiaries to sue, including persons purporting to sue on their behalf.* Second, the intentions of the parties and the district court regarding federal jurisdiction are irrelevant to the determination whether such jurisdiction exists. Third, [Plaintiff] did not, in fact, make an assignment of her claim to the ILGWU Fund, and it is far from clear that, in litigating this case, the ILGWU Fund pursued only Mrs. Fazio's rights and not also its own interests. Moreover, even if Mrs. Fazio had actually assigned her claim to the IGLWU Fund, we have serious doubts whether she could assign along with her substantive rights her right to sue in federal court.

Northeast, 764 F.2d, at 154 (3d Cir. 1985)(emphasis supplied)(internal citations omitted).

In his February 27, 2004 Report & Recommendation, Magistrate Judge Hedges, in viewing Judge Becker's opinion on this issue as *dicta*, adopted the First Circuit's view that ERISA permits

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[3] Judge Becker was responding to Judge Fullam's concurrence that federal jurisdiction on the basis of assignee standing was permissible: "Everyone intended that the ILGWU plan be subrogated to Mrs. Fazio's rights against the Teamsters Plan. . . I respectfully suggest that there is a live, justiciable, controversy in this case *only because* of Mrs. Fazio's claims against the Teamsters fund. I do not believe a labor union, such as ILGWU, or the trustee of its plan, would have standing to seek a judgment declaring that some other pension plan was violating ERISA, unless such plaintiffs could demonstrate a particularized, concrete, financial impact upon the plaintiff plan. It is only because the ILGWU claimants are attempting to recoup from the Teamsters plan the amounts paid to Mrs. Fazio that there is a justiciable controversy in this case. Where the entitlements of an identifiable beneficiary are at issue, the federal courts are open to litigation under 28 U.S.C. § 1132(a)(1)(B), I suggest, regardless of whether the action is maintained in the name of the beneficiary, or in the name of a personal representative, assignee or subrogee." Northeast, 764 F.2d, at 167 (emphasis in original).

assignee standing, because when "the assignee seeking relief in court stands in the place of an assignor, there has been a substitution rather than an expansion of the parties." (Mag. Hedges 2/27/04 R&R, at p. 7-8, citing City of Hope Nat'l Med. Center v. Healthplus, Inc., 156 F.3d 223, 226 (1st Cir. 1998)). Magistrate Judge Hedges also posited that assignee standing "facilitates the receipt of medical services to the assignor and is consistent with Congressional intent. (Id. at p. 8).

This Court disagrees with Magistrate Judge Hedges' recommended ruling that ERISA contemplates assignee standing under 29 U.S.C. § 1132(a)(1)(B) or § 502(a)(1)(B). That portion of ERISA provides, in pertinent part, that: "(a) a civil action may be brought . . . (1) by a participant or beneficiary . . . (B) to recover benefits due to him under the terms of the plan, to enforce his right under the terms of the plan, or to clarify his rights to future benefits under the plan." Id.

ERISA defines a "participant" as "any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit." 29 U.S.C. § 1002(7). ERISA further defines a "beneficiary" as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8).

This Court believes that Judge Becker soundly reasoned against assignee standing in Northeast when he noted that the Third Circuit in New Jersey State AFL-CIO v. New Jersey, 747 F.2d 891 (3d Cir. 1984), "implicitly adopted the view that 29.U.S.C. § 1132 must be read narrowly and literally." Northeast, 764 F.2d, at 153. In reading § 1132(a)(1)(B) narrowly and literally, Judge Becker, in writing for the Third Circuit majority, found no basis for assignee or subrogee standing.

Id. At least one more Third Circuit case, Allstate v. 65 Security Plan, has also followed Northeast's lead in concluding that an assignment or subrogation of benefits does not authorize federal jurisdiction under the "beneficiary" verbiage of § 1132(a)(1)(B). 879 F.2d 90, 94 (3d. Cir 1989) (citing Northeast, 764 F.2d at 154). Lastly, this Court is also aware of a decision in this district, Comprehensive Neurosurgical, P.A. v. Blue Cross/Blue Shield of Texas, Civil No. 03-0420, where Judge Hochberg interpreted Northeast as precluding jurisdiction where "a non-enumerated party is an assignee of a participant or beneficiary."(Id. at p.3). Ironically, the herein facts and parties appear virtually identical to that case.

In light of the above Third Circuit and district court rulings, this Court finds no need to follow Magistrate Judge Hedges' adoption of the First Circuit's ruling that § 1132 of ERISA allows for assignee standing. Thus, while this Court adopts Magistrate Judge Hedges' February 27, 2004 Recommendation that the above-entitled action be expeditiously remanded to New Jersey Superior Court, Bergen County, from where it was removed, it declines to adopt the reasoning submitted by Magistrate Judge Hedges in support of the remand.

Instead, this Court finds that Comprehensive lacks standing to bring an ERISA action because it is neither a participant nor a beneficiary as defined by the statute. Thus, this Court is precluded from exercising jurisdiction in the herein matter. As this Court has determined that it cannot exercise jurisdiction in the instant matter, it need not reach the issue of whether Magistrate Judge Hedges properly determined whether Comprehensive's claims involve the quality or quantity of benefits received. Accord Przybowski v. U.S. Healthcare, Inc., 245 F. 3d 266, 273 (3d Cir. 2001).

CONCLUSION

For the reasons detailed above, this Court adopts Magistrate Judge Hedges' February 27,

2004 Recommendation, and **GRANTS** Plaintiff's Motion to Remand the above-entitled action to the New Jersey Superior Court, Bergen County, from where it was removed.

Dated:

WILLIAM J. MARTINI, U.S.D.J.

cc: Hon. Ronald J. Hedges, U.S.M.J.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

COMPREHENSIVE NEUROSURGICAL, P.A., **Plaintiff,** **v.** **BLUE CROSS/BLUE SHIELD OF MICHIGAN,** **Defendant.**	03-CIV-4117 (WJM) **ORDER** **HON. WILLIAM J. MARTINI**

THIS MATTER having been brought before the Court upon Defendant Blue Cross/Blue Shield of Michigan's Objection to Magistrate Judge Ronald J. Hedges' February 27, 2004 Report and Recommendation, which grants Plaintiff Comprehensive Neurosurgical, P.A.'s Motion to Remand the above-captioned matter to the New Jersey Superior Court, Bergen County; and this Court having read, and considered the parties' moving papers; and for reasons stated in the accompanying Opinion;

IT IS on this 24th day of May 2004,

ORDERED that Plaintiff Comprehensive Neurosurgical, P.A.'s Motion to Remand the above-captioned matter to the New Jersey Superior Court, Bergen County is **GRANTED**; and it is further

ORDERED that the above-entitled action be and hereby expeditiously remanded to the New Jersey Superior Court, Bergen County, from where it was removed.

WILLIAM J. MARTINI, U.S.D.J.

cc: Hon. Ronald J. Hedges, U.S.M.J.

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

COMPREHENSIVE NUEROSURGICAL P.A.,

Plaintiff

Vs

BLUE CROSS BLUE SHIELD OF MICHIGAN

Defendants

: Civil Action No. 03cv4117(WJM)

: Date: February 27, 2004

To: Eric D. Katz, Esq., Nagel Rice Dreifuss & Mazie, LL, 301 South Livingston Avenue, Suite 201, Lvingston, NJ 07039

Susan L Nardone, Esq., Gibbons, Del Deo, Dola, Griffing[er] & VE, One Riverfront Plaza, Newark, NJ 07102

Please be advised that the proposed findings and recommendations were filed with the Court by the Honorable Ronald J. Hedges United States Magistrate on February 27,2004

A copy of the proposed findings and recommendations are enclosed herewith.

You may serve on your adversary and file with the Court written objections to such proposed findings and recommendations within ten days of the receipt of a copy of the proposed findings and recommendations.

William T. Walsh
Clerk

By: Carmen Egipciaco
Deputy Clerk

enc.

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

COMPREHENSIVE NEUROSURGICAL, P.A.,	:	Civil Action No. 03-4117
Plaintiff,	:	Hon. William J. Martini, U.S.D.J.
v.	:	
BLUE CROSS BLUE SHIELD OF MICHIGAN,	:	**REPORT AND RECOMMENDATION**
Defendant.	:	

INTRODUCTION

This matter comes before me on plaintiff's motion for remand. I have considered the papers submitted in support of and in opposition to the motion. There was no oral argument. Rule 78.

STATEMENT OF FACTS

On July 18, 2003, plaintiff Comprehensive Neurosurgical, P.A. ("Comprehensive"), filed the Complaint in the Superior Court of New Jersey, Law Division, Bergen County, against defendant Blue Cross Blue Shield of Michigan ("BCBSM"). Comprehensive seeks payment from BCBSM for medical services provided to a BCBSM insured.

Comprehensive, a third-party health care provider, rendered medical services to a General Motors employee. The employee is covered by the General Motors Hourly Plan, a plan governed by ERISA. BCBSM is the administrator of this plan. Comprehensive is an out-of-network or non-participating provider of medical services under the plan. The employee is a non-party.

On January 16, 2003, Comprehensive made a customary inquiry by telephone to BCBSM

regarding the employee's insurance coverage – often referred as a pre-determination – to ascertain coverage for future medical services to be provided. Comprehensive alleges that the pre-determination communication included a promise of an 80% payout by BCBSM upon which Comprehensive relied to perform surgery. BCBSM's position is that a pre-determination is non-binding and any reimbursement for services is later determined pursuant to the terms of the plan. On March 5, 2003, Comprehensive performed surgery on the patient. Comprehensive claims the surgical procedure cost approximately $50,000 and BCBSM paid only $3,700.

On December 17, 2003, BCBSM removed this civil action pursuant to 28 U.S.C. §§ 1441 and 1446. BCBSM argues that this Court has subject matter jurisdiction pursuant to the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*

DISCUSSION

Removal

A defendant may remove an action to federal court that a plaintiff originally files in State court if the federal court would have jurisdiction at the time of filing. See 28 U.S.C. § 1441(c). The removal statutes are to be strictly construed with doubt as to the propriety of removal resolved in favor of remand. See, e.g., Sun Buick, Inc. v. Saab Cars USA, Inc., 26 F.3d 1259, 1267 (3d Cir. 1994).

The Complaint here reveals that there is no diversity jurisdiction, and thus removal must be predicated on the existence of a federal question. Under the well-pleaded complaint rule, the proper inquiry is to determine whether any federal question is presented on the face of the Complaint. See Dukes v. U.S. Healthcare, Inc., 57 F. 3d 350, 353 (3d Cir. 1995). As explained in Dukes,

> [u]nder the well-pleaded complaint rule, a cause of action 'arises under' federal law, and removal is proper, only if a federal question is presented on the face of the plaintiff's properly pleaded complaint... . A federal defense to a plaintiff's state law cause of action ordinarily does not appear on the face of the well-pleaded complaint, and, therefore, usually is insufficient to warrant removal to federal court... . Thus, it is well-established that the defense of preemption ordinarily is insufficient justification to permit removal to federal court.

57 F.3d at 353-54. Accord In re U.S. Healthcare, Inc., 193 F.3d 151, 160 (3d Cir. 1999). The plaintiff is the master of the claim and may "avoid federal jurisdiction by exclusive reliance on state law." Caterpillar Inc. v. Williams, 482 U.S. 386, 392 (1987) (footnote omitted). "[A] case may not be removed to a federal court on the basis of a federal defense." Allstate Ins. Co. v. 65 Sec. Plan, 879 F.2d 90, 93 (3d Cir. 1989). Here, the Complaint presents a State law cause of action in contract or quasicontract and does not present a federal question on its face. Therefore, this civil action is not removable under the well-pleaded complaint rule.

"Complete Preemption" Exception to the Well-Pleaded Complaint Rule

BCBSM seeks to fall within the narrow exception to the well-pleaded complaint rule, the complete preemption doctrine. Is there "complete preemption"?

"Complete preemption occurs when federal law so completely preempts an entire area of law that the state cause of action is entirely displaced by federal law. If this doctrine applies, the district court has removal jurisdiction, even if the well-pleaded complaint rule is not satisfied." Joyce v. RJR Nabisco Holdings Corp., 126 F.3d 166, 171 (3d Cir. 1997). "However, if a state claim does not come within this doctrine, the well-pleaded complaint rule still applies, and the district court does not have removal jurisdiction unless a federal cause of action is pled." 126 F.3d at 171.

ERISA preemption under Section 514 of ERISA, standing alone, does not create federal removal jurisdiction over a claim pled under State law in State court. Franchise Tax Bd. of California v. Construction Laborers Vacation Trust, 463 U.S. 1, 25 (1983).[1] Only State law claims that come within ERISA's civil enforcement provision in Section 502(a) are completely preempted such that removal to federal court is appropriate. Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63-65 (1987). Thus,

> [s]ection 514 of ERISA defines the scope of ERISA preemption... . The Metropolitan Life complete-preemption exception, on the other hand, is concerned with a more limited set of state laws, those which fall within the scope of ERISA's civil enforcement provision, § 502. State law claims which fall outside of the scope of § 502, even if preempted by § 514(a), are still governed by the well-pleaded complaint rule and, therefore, are not removable under the complete-preemption principles established in Metropolitan Life.

Dukes, 57 F.3d at 355. Therefore, under Dukes and Metropolitan Life, the first question is whether Comprehensive's State law claims fall within the scope of ERISA's civil enforcement provision, §502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B), not whether these are preempted under ERISA § 514(a), 29 U.S.C. §1144(a).

Assignment Under ERISA'S Civil Enforcement Provision

ERISA's civil enforcement provision, §502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), states in pertinent part:

> (a) Persons empowered to bring a civil action. A civil action may be brought --
> (1) by a participant or beneficiary –
> . . .
> (B) to recover benefits due to him under the terms of his plan, to enforce

[1] Section 514(a) states that ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

> his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . ..

The applicable statute defines to be "participant:"

> Any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

29 U.S.C. § 1002(7). The General Motors employee is defined as a participant under ERISA.

The applicable statute defines "beneficiary" as:

> A person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

29 U.S.C. § 1002(8).

BCBSM alleges that Comprehensive is a beneficiary because of an assignment of benefits from the employee patient. Even if this Court were to find a valid assignment exists, would an assignee constitute a beneficiary under ERISA?

The Third Circuit briefly discussed whether a third-party health care provider has standing under ERISA through assignment as a beneficiary in Northeast Department ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund, 764 F.2d 147 (3d Cir. 1985). While the majority held that subject matter jurisdiction existed on other grounds, Judge Fullam, in a concurrence, concluded that jurisdiction existed under ERISA's civil enforcement provision. 764 F.2d at 166. The majority commented on Judge Fullam's concurrence:

> Judge Fullam's conclusion--that there is jurisdiction in this case under 28 U.S.C. § 1132(a)(1)(B) because the ILGWU Fund is the 'assignee or subrogee' ...is appealing because of its simplicity, but we find

> ourselves unable to subscribe to it on several grounds. First, Congress simply made no provision in § 1132(a)(1)(B) for persons other than participants and beneficiaries to sue, including persons purporting to sue on their behalf. Second, the intentions of the parties and the district court regarding federal jurisdiction are irrelevant to the determination whether such jurisdiction exists. Third, Mrs. Fazio did not, in fact, make an assignment of her claim to the ILGWU Fund, and it is far from clear that, in litigating this case, the ILGWU Fund pursued only Mrs. Fazio's rights and not also its own interests. Moreover, even if Mrs. Fazio had actually assigned her claim to the IGLWU Fund, we have serious doubts whether she could assign along with her substantive rights her right to sue in federal court. Cf. McSparran v. Weist, 402 F.2d 867 (3d Cir 1968) (minor cannot manufacture diversity jurisdiction by appointing out-of-state guardian).

764 F.2d at 154; see, e.g., Allstate Insurance Company, 879 F.2d. at 94. The court in Northeast also noted that another panel had implicitly adopted the view that 29 U.S.C. § 1132 must be read narrowly and literally. 764 F.2d at 152; see New Jersey State AFL-CIO v. New Jersey, 747 F.2d 891, 892 (3d Cir. 1984) ("[i]t is clear from the statute that labor unions are neither participants nor beneficiaries, and consequently plaintiff does not fall within this provision"); see also Ins. of Pa. Hosp. v. Blue Cross & Blue Shield, No. 96-3041, 1996 WL 729847 at *3-4 (E.D. Pa. Dec. 10, 1996); Allergy Diagnostics Lab v. The Eq., 785 F. Supp. 523, 526-27 (W.D. Pa. Dec. 17, 1991); Solomon v. Geraci, No. 89-8607, 1989 WL 156372, at *1 (E.D. Pa. Dec. 19, 1989).

Some district courts have held that an assignee has standing as a beneficiary. See Charter Fairmont Institute, Inc., v. Alta Health Strategies, 835 F.Supp. 233, (E.D.Pa. 1993) (hospital as assignee is a beneficiary with derivative standing to sue under ERISA); Children's Hosp. Of Pittsburgh v. 84 Lumber Co. Medical Benefits Plan, 834 F. Supp. 866, (W.D. Pa. 1993) (hospital has standing as a beneficiary to assert a claim under ERISA as result of assignment); Winter Garden Medical Center v. Montrose Foods Products of Pa., Inc., 1991 WL 124577, (E.D. Pa. 1991) (Northeast's proposition that assignees are not empowered to bring suit under ERISA is

mere dicta); Hahnemann Med. College & Hosp. v. Stone, 1987 WL 17568 *3, (E.D. Pa. 1987) ("[i]f Congress had intended to create confusion and increased costs for ERISA beneficiaries by precluding the relaitvely simple assignment procedure so widely used in the health care industry, Congress would have said so in large black letters").

The First Circuit rejected Northeast in City of Hope National Medical Center v. Healthplus, Inc., 156 F.3d 223, 226 (1st Cir. 1998). The First Circuit noted:

> In light of ERISA's comprehensiveness and the Supreme Court's admonition to avoid expanding ERISA's class of plaintiffs, the Third Circuit has refused to recognize assignee standing under ERISA [citing Northeast]...Although set forth as dicta because the court went on to find that the patient 'did not, in fact, make an assignment of her claim,' this language has led to the rejection of assignee standing within district courts of that circuit.

156 F.3d at 226. While the First Circuit rejected the expansion of enumerated parties, the court adopted standing through assignment, stating when the "assignee seeking relief in court stands in the place of an assignor, there has been a substitution rather than an expansion of the parties." 156 F.3d at 228.

The district court in City of Hope recognized that, "[t]he Fifth, Seventh, Eighth, Ninth, and Eleventh Circuits have held that an assignee has derivative standing to sue an ERISA covered medical benefits plan." City of Hope National Medical Center v. Seguros de Servicios de Salud de Peurto Rico, Inc., 983 F. Supp. 68, 72 (D.P.R. 1997), aff'd, 156 F.3d 223 (1st Cir. 1998). The First Circuit in City of Hope recognized that where Congress specifically prohibited assignment or alienation of benefits under *pension* plans, the omission of a similar prohibition under *welfare* plans constituted an implicit acceptance of such practice. Cf. Mackey v. Lanier

Collection Agency & Service, Inc., 486 U.S. 825, 837 (1988) (emphasis added) (noting that ERISA implicitly permitted the assignment or alienation of benefits under an ERISA-regulated welfare plan by not enacting a similar prohibition that was promulgated for ERISA-regulated pension plans).[2] City of Hope explained that the intention of Congress in prohibiting assignment under pension plans was to ensure availability of funds for retirement purposes, while in contrast, under welfare plans the effect of assignment is to facilitate the receipt of medical services and this is consistent with the omission of a similar assignment prohibition. City of Hope, 156 F.3d at 226. The Fifth Circuit similarly explained that Congressional intent is to permit assignment, noting "assignment to a health care provider facilitates rather than hampers the employee's receipt of health benefits." Herman Hosp. v. MEBA Med. and Benefits Plan, 845 F.2d 1286, 1289 (5th Cir. 1988).

I choose to adopt the well-reasoned decision in City of Hope despite Third Circuit dicta, because allowing an assignee to proceed represents only a substitution rather than an expansion, of an ERISA "beneficiary." The First Circuit's adoption of assignee standing facilitates the receipt of medical services to the assignor and is consistent with Congressional intent. Thus, Comprehensive has standing under ERISA's civil enforcement provision, § 502. The litigants are entitled to dispute the merits of the actual assignment.

Does ERISA Completely Preempt Comprehensive's Claims?

In Dukes, the Third Circuit distinguished between two types of claims:

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[2] City of Hope recognized Mackey for addressing whether ERISA allowed or prohibited the garnishment of benefits under ERISA-regulated welfare plans. City of Hope, 156 F.3d at 225.

> (1) state-law claims directed to the quality of benefits provided, which are not completely preempted, and
>
> (2) claims "that the plans erroneously withheld benefits due" or that seek "to enforce [plaintiffs'] rights under their respective plans or to clarify their rights to future benefits," which are subject to complete preemption.

Dukes at 162; In re U.S. Healthcare, Inc. 193 F.3d at 356. Regardless of the language used, the ultimate distinction to make for purposes of complete preemption is whether the claim challenges the quality of the medical treatment performed, which may be the subject of a state action, or the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted. Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266, 273 (3d Cir. 2001).

Comprehensive argues that it seeks compensation based on a predetermination communication and not to enforce the patient's rights, such that a state law claim arises from the dealings directly between Comprehensive and BCBSM. BCBSM argues that the claims of Comprehensive seek to vindicate the interest of the patient based on the communication.[3]

The First Count of the Complaint, breach of contract, alleges:

> 1. Defendant failed to compensate plaintiff for the appropriate fees for the medical services provided. The defendant's failure to properly compensate the plaintiff was a breach of contract.
>
> 2. Comprehensive Neurosurgical has suffered significant economic losses as a direct and proximate result of said breach of contract.

The Second Count,breach of the implied covenant of good faith and fair dealing, alleges:

[3] The pre-determination communication is a requisite to full compensation under the GM plan.

1. Plaintiff repeats and realleges each and every allegation set forth above as if set forth in full herein.

2. Implied in the aforementioned contractual relationship was and is a covenant of good faith and fair dealing.

3. The defendant's breach of contract through acts of commission and omission was wrongful and without justification.

The Third Count for promissory estoppel alleges:

1. Plaintiff repeats and realleges each and every allegation set forth above as if set forth in full herein.

2. BCBS promised to pay plaintiff its Usual and customary fee for the services rendered. This payment promise was made when Comprehensive Neurosurgical obtained approval from BCBS, by way of pre-authorization for treatment and pre-certification of coverage, with respect to [patient] prior to performing 'medically necessary' surgical procedures and prior to providing 'medically necessary' treatment on said patient.

3. In reliance upon said payment promise, pre-authorization, pre-certification or other similar approval from BCBS, plaintiff provided the patient with 'medically necessary' care and treatment.

4. At no time did BCBS ever withdraw its payment promise, pre-authorization, pre-certification or similar approval.

5. Despite the defendant's continued authorization or similar approval of treatment and its continued certification and confirmation of insurance coverage to pay for such treatment at plaintiff's Usual and customary rate, BCBS has not appropriately paid Comprehensive Neurosurgical for the medical services rendered to the defendant's subscriber.

6. BCBS's actions have therefore caused Comprehensive Neurosurgical to suffer a detriment of a substantial nature in reliance upon defendant's promise to pay for the medical services rendered pursuant to its pre-authorization, pre-certification or similar approval, thus constituting an actionable claim pursuant to the doctrine of promissory estoppel. This claim arises independently of any purported assignment of benefits from the subscriber.

7. Comprehensive Neurosurgical has suffered significant damages as a result.

The Fourth Count, negligent misrepresentation, alleges:

1. Plaintiff repeats and realleges each and every allegation set forth above as if set forth in full herein.

2. Despite its payment promise made when plaintiff obtained pre-authorization of treatment and pre-certification of coverage, BCBS negligently refused to pay the subject claim appropriately, and, in addition, negligently used and/or manipulated data that understated the Usual and customary fees for the medical services provided by Comprehensive Neurosurgical. Because of BCBS's negligence, Comprehensive Neurosurgical was paid less than the amount than an accurate Usual and customary allowance computation would have yielded, in accordance with the pre-certification of coverage, or was not paid at all.

3. BCBS's negligent false promise to pay the claim appropriately and its negligent manipulation and skewing of the data utilized in determining the Usual and customary fee, which resulted in payment to the plaintiff of less than the appropriate Usual and customary fee or nothing at all, was unknown to the plaintiff at the time it agreed to perform medical services for the subscriber. Plaintiff reasonably expected and relied upon what it believed to be BCBS's honest representations that the plaintiff would be properly compensated in accordance with the pre-certification of coverage.

The first two counts allege breach of contract and breach of the implied covenant of good faith and fair dealing. Plaintiff's breach of contract claim is a simple allegation seeking non-payment of medical service fees without mention of a federal question. Plaintiff's second claim is similarly characterized as derivative of the First Count.

The last two counts allege promissory estoppel and negligent misrepresentation in connection with the pre-determination communication. The promissory estoppel count alleges that Comprehensive relied on BCBSM's promise of payment made during the pre-determination

communication. Comprehensive's final count for negligent misrepresentation claims that BCBSM's alleged promise misrepresented the amount of compensation Comprehensive would be paid.

Congress sought to assure that promised benefits would be available when plan participants had need of them and Section 502 was intended to provide each individual participant with a remedy in the event that promises made by the plan were not kept. Pryzbowski, 245 F.3d at 279. However, here, the patient received the requested medical treatment. Although BCBSM argues that the factual account lends to a characterization of placing the interests of a participant at issue, the Complaint does not state specific facts or make allegations to invoke ERISA's civil enforcement provision. The Complaint does not allege any claim that demands complete preemption and is insufficient to warrant removal. Comprehensive's claims merely deal with quality of the benefits received. Comprehensive does not claim that the plans erroneously withheld a benefit due under the plan. As a result, Comprehensive's claims fall outside of the scope of Section 502 and this case must be remanded.

CONCLUSION

For the reasons set forth above, I recommend that the motion for remand be GRANTED.

Pursuant to Local Civil Rule 72.1(c)(2), the parties have ten (10) days from service to file and serve objections.

S/ Ronald J. Hedges
United States Magistrate Judge

Original: Clerk

Copy: Judge William J. Martini
File