North Shore-Long Is. Jewish Health Sys., Inc. v Local 463 Health Fund
2010 NY Slip Op 32258(U)
August 5, 2010
Supreme Court, Nassau County
Docket Number: 008427/07
Judge: Stephen A. Bucaria
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SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

Present:

HON. STEPHEN A. BUCARIA

Justice

TRIAL/IAS, PART 2
NASSAU COUNTY

NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEMS, INC.,

Plaintiff,

INDEX No. 008427/07

MOTION DATE: June 21, 2010
Motion Sequence # 003

-against-

LOCAL 463 HEALTH FUND,

Defendant.

The following papers read on this motion:

Notice of Motion.................................... X
Affirmation in Opposition......................... X
Affidavit in Support................................. XX
Memorandum of Law................................ XX
Reply Memorandum of Law....................... X

Motion by defendant Local 463 Health Fund for an order pursuant to CPLR 3212 granting it summary judgment dismissing plaintiff's complaint is **denied**. Motion by defendant for an order pursuant to CPLR 3211(e) granting it leave to amend its answer to add two affirmative defenses of failure to timely request arbitration and statute of limitations is **granted**.

Plaintiff commenced this action to recover damages for breach of contract, unjust enrichment and conversion.

Plaintiff North Shore-Long Island Jewish Health Systems, Inc. ("North Shore") is a New York not-for-profit corporation that operates hospitals in New York State, including Syosset Hospital and North Shore University Hospital. Defendant Local 463 Health Fund ("Local 463") is a licensed New York State health fund, which provides health care benefits to its members.

BACKGROUND

The Fund is governed by an Agreement and Declaration of Trust and other plan documents, including the Local 463 Health Plan Summary Plan Description ("SPD"). The SPD sets forth the eligibility requirements for coverage, the type of benefits provided, limitations on those benefits, the procedure for claiming benefits, and the procedure for appealing a decision of the Fund, including a denial of benefits. Elizabeth Copeland is the Fund Administrator.

As provided in the SPD, the Fund provides hospital and medical coverage and other health benefits to individuals who work in "covered employment." An individual works in "covered employment" where the individual's employer has signed a collective bargaining agreement with Local 463, IUE-CWA (the "Union"), which requires the employer to make contributions to the Fund for employees who are covered by the collective bargaining agreement.

The SPD provides for various health benefits, including hospital benefits, up to a maximum of $250,000 for a continuous hospital stay. The SPD provides, in pertinent part, as follows:

> "It is now mandatory, in states where no-fault auto insurance is in effect, that auto insurance pay its benefits for all reasonable and necessary medical expenses. This means that coverage by the Local 463 Health Fund applies only when no-fault auto insurance does not. Or the benefits provided through the no-fault insurance policy are exhausted".

The SPD also contains the following provision:

> "In addition to the limitations and exclusions contained

> in the MultiPlan contract and the Hospital Benefits section, no benefits are provided for:
>
> . . .
>
> Services for which benefits are payable through no-fault insurance coverage (SPD at A-49). In addition, hospital benefits are not provided for any loss, or portion hereof, for which mandatory automobile no-fault benefits are recovered or recoverable. (SPD at A-73)."

Elizabeth Copeland, the Fund Administrator, claims that the Fund has interpreted these provisions to deny all coverage in every instance in which a participant has no-fault insurance coverage, even if no-fault did not pay the entire bill.

The SPD further states that "[i]f we deny a claim, wholly or partly, you have the right to appeal our decision under the Employee Retirement Income Security Act of 1974 (ERISA). We will send you written notice why the claim was denied and you will have 60 days to submit a written request to review."

MultiPlan, Inc. ("MultiPlan") is a preferred provider health organization which has agreements with various health care practitioners and health care facilities to provide services at a discounted rate. The Fund has an agreement with MultiPlan which provides that MultiPlan will re-price the claims of health care practitioners and providers made to the Fund, and that the Fund will pay a fee to MultiPlan for this service. (The Client Agreement is in the name of the Optical Workers Insurance Fund which has since merged into the Fund.) The Client Agreement states that:

> "MultiPlan acts exclusively as a consultant to Client and its duties are limited to assisting Client in negotiating Practitioners'/Providers' charges or fees. MultiPlan does not determine benefits, eligibility, or benefit availability for persons covered by Client's benefit plan. The parties agree that MultiPlan specifically does not exercise any discretion or control as to Client's benefit plans assets or with respect to policy, payment, interpretation, practices, or procedures, by virtue of this Agreement."

The Client Agreement between the Fund and MultiPlan, provides as follows:

> "Any unresolved dispute, difference or controversy rising under this Agreement may only be submitted to binding arbitration before the American Arbitration Association ('AAA') in accordance with the AAA's then current Commercial Arbitration Rules for a single Arbitrator. All hearings shall be held in New York County. The decision or award of the Arbitrator shall be final and binding and judgment thereon may be entered in any state or federal court within the State of New York to whose jurisdiction all parties hereby consent. It is understood that arbitration must be submitted to the other party and to AAA in writing within sixty (60) days of the date the facts giving rise to the dispute, difference or controversy, occurred or could reasonable [sic] have been discovered."

After a Fund participant receives treatment from a health care provider or hospital within the MultiPlan network, the provider/hospital sends a claim for payment to the Fund. The Fund forwards the claim to Multi-Plan which re-prices the claim in accordance with its agreement with the provider/hospital and sends a re-pricing sheet to the Fund that contains discounted charges for the services provided by the provider/hospital, to be paid by the Fund.

North Shore and MultiPlan have an agreement whereby North Shore agrees to accept payment at a set discount for services provided through North Shore's hospitals. The last amended agreement between North Shore and MultiPlan is dated January 1, 2006. The Fund is not a party to the agreement between North Shore and MultiPlan.

INSTANT ACTION

Michael Malloy ("Malloy") was a participant in the Fund. Malloy was involved in an automobile accident and was admitted to Syosset Hospital on September 28, 2005. Malloy remained in Syosset Hospital until February 10, 2006 when he was moved to a long-term care facility. Malloy was returned to Syosset Hospital four days later on February 14, 2006 where he remained as a patient until April 7, 2006. Malloy passed away in December, 2006.

North Shore submitted claims to the Fund for services provided to Malloy from

September 28, 2005 to February 10, 2006 and from February 14 to April 7, 2006 to the Fund. The Fund received the first claim on April 24, 2006 and received the second claim on June 6, 2006. North Shore's claims reflected payments from a no-fault insurer in the amount of $17,654.86. In addition, at least $168,537.56 of the bill was paid by Medicaid.

The Fund informed Malloy in writing on four occasions that the claims for his hospitalization at North Shore were denied because the claims were covered by no-fault automobile insurance. Neither Malloy, nor anyone on Malloy's behalf, filed an appeal to the Fund's Board of Trustees, challenging the Fund's decision to deny coverage for his hospital stay at North Shore. Nor has North Shore submitted its breach of contract claim to arbitration.

In the complaint, North Shore alleges damages in the amount of $1,214,623.88 for medical services provided to Mr. Malloy, now deceased, which should have allegedly been paid by Local 463.

Defendant moves for summary judgment dismissing the complaint on the grounds that plaintiff's claims are preempted under Section 514 of ERISA (29 §U.S.C. 1144[a]).

In opposition, plaintiff contends that the motion should be denied for various reasons. First, the law of the case doctrine is applicable here as this Court previously denied defendant's ERISA preemption arguments in its order dated November 19, 2009. Second, the present matter involves State law claims, sounding in breach of contract and unjust enrichment and are not subject to preemption under ERISA. Third, Local 463 Health Fund should be considered a Multiple Employer Welfare Fund fund under 29 U.S.C. §1444(b)(b)(A) and is patently exempt from ERISA preemption.

As to the branch of the motion which seeks leave to add two additional affirmative defenses pursuant to CPLR 3211(e), plaintiff argues that such defenses are untimely and patently lacking in merit.

RULING OF THE COURT

Preliminarily, "the Fund admits that it is a health fund covered by the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq., and that it provides health care benefits to its members" (¶ 2 of answer).

"The law of case doctrine is part of a larger family of kindred concepts, which includes *res judicata* (claim preclusion) and collateral estoppel (issue preclusion)" (***People v Evans***, 94 NY2d 499 [2000], *rearg den.* 96 NY2d 755 [2001]). Further, "[l]aw of the case addresses the potentially preclusive effect of judicial determinations made in the course of a single litigation before final judgment" (***McGrath v Gold***, 36 NY2d 406, 413 [1975]; ***People v Evans***, ***supra***). The doctrine "is a judicially crafted policy that expresses the practice of courts generally to refuse to reopen what has been decided, [and is] not a limit to their power" (***Messinger v Anderson***, 225 U.S. 436, 444 [1912]).

By order dated November 19, 2009, the court granted plaintiff's motion to restore the action pursuant to NYCRR §202.27 and denied defendant's request to strike plaintiff's discovery responses and requests. In so holding, the court noted that "plaintiff has demonstrated a meritorious cause of action by the affidavit of merit submitted."

While it did not expressly make a determination as to whether plaintiff's claims were pre-empted by ERISA, this Court considered the following arguments raised by the parties regarding this issue.

Plaintiff argued that:

> "[D]efendant seeks to avoid liability by contending that plaintiff's claims are pre-empted by the Employment Retirement Income Security Act (ERISA) 29 USC §§ 1001 et. Seq. Defendant has not stated any facts that would bring this simple collection matter under ERISA.
>
> A party can only pursue a claim under §1132(a) of ERISA if such party is either a plan participant or a beneficiary (*see* 29 U.S.C. § 1132[a][a]). North Shore is neither, and hence it has no standing to bring an ERISA claim. Instead, plaintiff has brought state law claims alleging that it is the third-party beneficiary of an agreement entered into between Local 463 and a company called Medigroup Inc. (Medigroup). Such claims are separate and distinct from ERISA and are not pre-empted by that law" (*see e.g.* ***Passack Valley Hospital v Local 646A Welfare Reimbursement Plan Passack Valley Hospital***, 388 F3d 393, 401 [3rd Cir. 2004]).

In response, defendant argued, in pertinent part, as follows:

> "The Fund is an employee benefit fund subject to the Employee Retirement Income Security Act (ERISA) 29 U.S.C. §§ 1001, *et seq*. State actions against the Fund for failure to pay benefits under the Fund's provisions are pre-empted by ERISA. Section 514 of ERISA provides that the statute's provisions 'supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan' (29 U.S.C. § 1144[a]). A law 'relates to' an employee benefit plan, 'in the normal sense of the word, if it has a connection with or reference to such a plan' (***Aetna Life Ins. Co. v Borges***, 869 F2d 142, 146 [2nd Cr. 1989]). The preemption clause if not limited to state laws specifically designed to affect employee benefit plans (***Pilot Life Ins. Co. v Dedeaux***, 481 U.S. 41,47-48 [1987]). A state law of general application, with only an indirect effect on an ERISA-governed plan, may nevertheless be considered to 'relate to' that plan for preemption purposes (*see* ***Smith v Dunham-Bush, Inc.***, 959 F2d 6, 9 [2nd Cir. 1992]). State laws that provide an alternative cause of action to collect benefits protected by ERISA are among those laws that are preempted (*see* ***Borges***, 869 F2d at 146). ERISA's civil enforcement remedies are intended to be exclusive remedies for enforcing rights in ERISA-governed plans (*see* ***Pilot Life***, 481 U.S. at 52). Consequently, 'any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted' (***Aetna Health Inc.v Davila***, 542 U.S. 200, 209 [2004]; *see also* ***Reichelt v Emhart Corp***., 921 F2d 425, 431 [2nd Cir. 1990]."

Plaintiff's reliance on the law of the case doctrine is misplaced. This doctrine is inapplicable here as the previous motion was a motion to restore pursuant to NYCRR §202.27 while the instant motion is one for summary judgment. This court did not actually adjudicate the merits of the ERISA claim on the prior motion to restore and strike discovery requests. Thus, the issue applicable to each motion is distinct (*see* ***Bernard v Grenci***, 48 AD3d 722 [2nd Dept. 2008]; *see* ***Riddick v City of New York***, 4 AD3d 243, 245 [1st Dept.

2004]; *see* ***Guggenheimer v Ginzburg***, 43 NY2d 268, 275 [1977]).

This court will now address the issue of whether the state claim actions are barred by ERISA.

Initially, we note that the Fund does not and has not sought to remove this action to federal court pursuant to § 502(a) of ERISA, which provides for complete preemption of any claim to recover benefits due from an employee welfare plan. The Fund recognizes that complete preemption under ERISA § 502(a) is an exception to the well-pleaded complaint rule that has jurisdictional consequences since it recharacterizes state law claims as claims arising under federal law (*see* ***Metropolitan Life Ins. Co. v Taylor***, 481 U.S. 58, 64-67 [1987]; ***Rice v Panchal***, 65 F3d 637, 641 [7th Cir. 1995]).

Rather, the Fund is arguing that conflict preemption under ERISA § 514(a) which does not recharacterize claims as arising under federal law is applicable here and preemption under ERISA § 514(a) serves as a defense to a state law claim (*see e.g.* ***Cleghorn v Blue Shield of*** **California**, 408 F3d 1222 [9th Cir. 2005]).

ERISA "supercede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" (29 U.S.C. § 1144[a]). This provision, the Supreme Court has observed, is "deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern' " (***Pilot Life Ins. Co. v Dedeaux***, 481 U.S. 41, 45-46 [1987], quoting ***Alessi v Raybestos-Manhattan, Inc.***, 451 U.S. 85, 97 [1981]). In ***Shaw v Delta Air Lines, Inc.*** (463 U.S. 85, 97 [1983]) "[t]he phrase 'relate to' was given its broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.' " (***Metropolitan Life Ins. Co. v Massachusetts***, 471 U.S. 724, 739 [1985]). It has been held, however, that 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." (***Shaw v Delta Air Lines***, ***supra***, at 100 footnote 21 [1983]). Thus, the act does not preempt lawsuits against ERISA pension plans for "run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by ERISA plans." (***Mackey v Lanier Collection Agency & Service Inc.***, 486 U.S. 825, 833 [1988]).

Generally, "[t]he presence or absence of federal-question jurisdiction is governed by the 'well-pleaded complaint rule,' which provides that federal jurisdiction exists only when a federal question is presented on the face of the plaintiff's properly pleaded complaint"

(***Caterpillar Inc. v Williams***, 482 U.S. 386, 392 [1987]). However, one corollary to the well-pleaded complaint rule is the doctrine of complete preemption, which provides that "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character" (***Metropolitan Life Ins. Co. v Taylor, supra***). Thus, "when a federal statute wholly displaces the state-law cause of action through complete pre-emption, the state claim can be removed" (**Aetna Health Inc. v Davila**, 542 U.S. 200 at p. 207; ***Montefiore Medical Center v Teamsters Local 272***, 2009 WL3787209 [S.D.N.Y. 2009]).

ERISA's pre-emptive effect was "intended to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans" (***New York State Conference of Blue Cross & Blue Shield Plans v Travelers Ins. Co.***, 514 U.S. 645, 657-658 [1995]).

Under ***Aetna Health Inc. v Davila, supra*** at p. 210, a state law cause of action is preempted by ERISA if (1) "an individual at some point in time would have brought the claim under ERISA § 502(a)(1)(B)" and (2) "where there is no other independent legal duty that is implicated by a defendant's actions" (***Turnbow v Tall Tree Administrators LLC***, 2009 WL 3824731 [E.D. Cal. 2009]). If both factors are satisfied, the state law claim is preempted.

In ***Pascack Valley Hosp., v Local 464A UFCW Welfare Reimbursement Plan*** (388 F3d 393 [3rd Cir. 2004]), the Third Circuit applied the *Davila* test and first concluded that the treating hospital was neither a "participant" nor a "beneficiary" under the plan, and hence, could not have brought its breach of contract claim under ERISA. Next, the Court of Appeals in ***Pascack*** concluded that the hospital's state-law claims were predicated on a legal duty independent of ERISA. While the Court recognized that the hospital's claims derived from an ERISA plan and existed "only because" of that plan (*Id.* at 402), the Court noted that the "crux" of the dispute was the meaning of § 2.1 of the Subscriber Agreement. The Court then concluded that resolution of the lawsuit would require interpretation of the managed-care contract, not the ERISA plan. Specifically, the Court at p. 402 held that "[t]he hospital's right of recovery, if it exists, depends entirely on the operation of third-party contracts executed by the Plan that are independent of the Plan itself" (*see* ***St. Luke's Episcopal Hospital v Acordia National & Knust SBO***, 2006 WL 3093132 [S.D. Tex. 2006]).

The Fund denied the claims submitted by North Shore for Malloy's care because the Fund has consistently interpreted the SPD to exclude from coverage any treatment or care

that is incurred as a result of an auto accident covered by no-fault insurance. North Shore did not exhaust the Fund's administrative remedies and did not obtain an assignment of benefits from the patient.

Under the circumstances, we conclude that the hospital's state claims for breach of contract, unjust enrichment and conversion do not fall within the exclusive jurisdiction of ERISA and are, therefore, not preempted (*see* ***Marin General Hosp. v Modesto & Empire Traction Co.***, 581 F3d 941, 949 [9th Cir. 2009]).

The branch of the motion which seeks leave to amend its answer to add the affirmative defenses of failure to timely request arbitration (sixth) and statute of limitations of time (seventh) is **granted**.

A motion for leave to amend a pleading should be freely granted "provided that the amendment is not palpably insufficient, does not prejudice or surprise the opposing party, and is not patently devoid of merit" (***Gitlin v Chirinkin***, 60 AD3d 901 [2nd Dept. 2009]; ***Maspeth Federal Savings & Loan Ass'n v Simon-Erdan***, 67 AD3d 750 [2nd Dept. 2009]; *see* ***Janssen v Incorporated Village of Rockville Centre***, 59 AD3d 15 [2nd Dept. 2008]; ***Scofield v DeGroodt***, 54 AD3d 1017 [2nd Dept. 2008]). The Supreme Court has broad discretion in determining whether to grant such leave, and the exercise of that discretion will not be lightly disturbed (***Gitlin v Chirinkin***, ***supra***; *see* ***Ingrami v Rovner***, 45 AD3d 806, 808 [2nd Dept. 2007]). However, where the proposed amendment plainly lacks merit, "amendment of a pleading would serve no purpose but needlessly to complicate discovery and trial," the motion should be denied (***Thomas Crimmins Contracting Co., Inc., v City of New York***, 74 NY2d 166, 170 [1989]).

The proposed amendments are not palpably insufficient or patently devoid of merit, and plaintiff did not establish that it would be prejudiced or surprised by the amendment (*see* ***Malanga v Chamberlain***, 71 AD3d 644 [2nd Dept. 2010]; ***Gitlin v Chirinkin***, ***supra***). Accordingly, the proposed first amended answer should be deemed served upon service of a copy of this order upon plaintiff's attorney.

In view of the foregoing, the branch of the motion which seeks summary judgment is **denied** and the branch which seeks leave to amend is **granted**.

This constitutes the order and judgment of this Court.

ENTERED
AUG 10 2010
NASSAU COUNTY
COUNTY CLERK'S OFFICE

Dated AUG 05 2010

J.S.C.