SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

Present:

HON. STEPHEN A. BUCARIA
Justice

TRIAL/IAS, PART 1
NASSAU COUNTY

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

Plaintiff,

INDEX No. 008427/07

MOTION DATE: Nov. 30, 2010
Motion Sequence # 005

-against-

LOCAL 463 HEALTH FUND,

Defendant.

The following papers read on this motion:

Notice of Motion..... X
Affirmation in Opposition..... X

Motion by defendant to preclude plaintiff from introducing evidence at trial is **granted** and **denied** to the extent indicated below.

This is an action for breach of contract. Plaintiff North Shore-Long Island Jewish Health Systems ("North Shore") operates North Shore University and Syosset Hospitals. North Shore is a party to a "Participation Provider Agreement" with Multiplan, Inc. Pursuant to the provider agreement, North Shore submits claims to Multiplan, who then processes the claims with "payors," such as insurance companies or employee benefit funds.

Defendant Local 463 Health Fund ("Health Fund") provides hospital and medical coverage to employees covered by collective bargaining agreements between Local 463,

IUE-CWA and certain employers. Health Fund's summary plan description provides that its coverage "applies only when no fault auto insurance does not. Or the benefits provided through the 'no fault' insurance are exhausted."

Michael Malloy, an employee covered by a Local 463 collective bargaining agreement, was injured in an automobile accident. Malloy received treatment at Syosset Hospital from September 28, 2005 to February 10, 2006. Plaintiff's charges for that hospital stay were $816,625.74, of which $17,654.86 was paid by no fault insurance. Malloy was readmitted to Syosset Hospital from February 14 to April 7, 2006. Plaintiff's charges for Malloy's second stay were $415,048, of which no part was paid by no fault. North Shore submitted claims to Health Fund for these services, apparently submitting the claims through Multiplan.

On May 8, 2006, Health Fund denied North Shore's claim for Malloy's first hospital stay. On June 9, 2006, Health Fund denied North Shore's claim for Malloy's second hospital stay. The basis for the denial of both claims was that Health Fund does not "supplement no fault insurance."

On May 15, 2007, plaintiff commenced this action against Health Fund for breach of contract, unjust enrichment, and conversion. Although defendant interprets plaintiff's breach of contract claim as based upon the agreement with Multiplan, the complaint may also be read as asserting a third party beneficiary claim based upon Health Fund's summary plan description. By order dated August 5, 2010, the court denied defendant's motion for summary judgment dismissing the complaint on the ground of ERISA preemption (See ***Pascack Valley Hospital v Local 464A Welfare Reimbursement Plan***, 388 F.3d 393 [3d Cir. 2004]).

By order dated December 23, 2010, the court granted defendant summary judgment dismissing plaintiff's claims for unjust enrichment and conversion but denied defendant summary judgment dismissing plaintiff's breach of contract claim. Defendant had sought dismissal of the breach of contract claim on the theory that plaintiff had failed to seek arbitration as required by the terms of the Multiplan agreement. In denying dismissal of plaintiff's contract claim, the court construed the arbitration provision as applying only to disputes between "payors" and Multiplan, not disputes between payors and health care providers. As an alternative ground for denying dismissal, the court determined that defendant had waived the right to arbitration by making its previous summary judgment motion.

Defendant moves to preclude plaintiff from offering any evidence contrary to defendant's own interpretation of the summary plan description. Thus, defendant argues that plaintiff is bound by Health Fund's determinations that the maximum coverage for any single hospital stay is $250,000, that Malloy's treatment at Syosset constituted a single hospital stay, and there is no coverage for an injury caused by an automobile accident. Defendant argues that the court may not review the Fund's determinations as to these issues because ERISA § 514 supercedes state laws that "relate to" an employee benefit plan (29 U.S.C.§ 1144[a]).

In opposition, plaintiff argues that defendant's *in limine* motion is untimely because it was not made within ten days of the pretrial conference. Alternatively, plaintiff argues that the court's determination that the action is not preempted by ERISA is law of the case with respect to defendant's preclusion motion.

Rule 27 of the Rules of the Commercial Division provides that, "The parties shall make all motions *in limine* no later than ten days prior to the scheduled pre-trial conference date, and the motions shall be returnable on the date of the pretrial conference, unless otherwise directed by the court" (22 NYCRR § 202.70). Although the pre-trial conference was originally scheduled for August 13, 2010, it was adjourned to November 30, 2010, and then to February 14, 2011, because of the pendency of defendant's second summary judgment motion. Since defendant's *in limine* motion was made on November 23, 2010, more than ten days prior to the February 14, 2011 pretrial conference, the motion is timely.

ERISA § 502(a) provides that a "participant or beneficiary" may bring a civil action "to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan" 29 U.S.C. § 1132(a)(1)(B). State law causes of action that are within the scope of § 502(a) are completely pre-empted (***Pascack Valley Hospital v Welfare Reimbursement Plan***, 388 F.3d 393, 400 [3d Cir. 2004]). Because a health care provider is not a participant or a beneficiary, it lacks standing under ERISA, and thus its state law claims are not pre-empted (Id). There is a narrow exception to this rule. If the beneficiary assigns his claim to a health care provider, the health care provider will have standing to sue under ERISA § 502 and its state law claims would be pre-empted (***Simon v General Electric***, 263 F.3d 176, 177-78 [2d Cir. 2001]). However, North Shore has not alleged that it received an assignment of Malloy's claim.

Under ERISA, where a benefit plan gives the administrator discretionary authority both to determine eligibility for benefits and to construe the terms of the plan, the court will

review a fund's denial of benefits under an arbitrary and capricious standard (***Pagan v NYNEX Pension Plan***, 52 F.3d 438, 442 [2d Cir 1995]). In a state law action by a health care provider for breach of the plan documents, the court should accord a similar deference to the plan administrator. Thus, defendant's motion to preclude is **granted** to the extent that plaintiff seeks a broader review of the Fund's determination.

Since the summary plan description provides that Health Fund's benefits apply only when no fault coverage is "exhausted," it is clear that Health Fund coverage is excess to no fault benefits. However, Health Fund's determination that coverage is unavailable for an injury caused by an automobile accident, simply because there is no fault coverage, is arbitrary, capricious, and contrary to the plain meaning of the summary plan description. Accordingly, defendant's motion to preclude is **denied** to the extent that it is based upon a purported automobile exclusion for hospital benefits.

Health Fund's summary plan description provides that, "The Trustees adopted a $250,000 maximum for claims due to a continuous hospital stay" (Deft Ex. C at D0065). Since this provision was effective January 1, 2005, it applies to Malloy's treatment.

While the $250,000 limit should apply to each hospital stay, neither Malloy nor the hospital had the right to circumvent the maximum benefit by their own unilateral action. The time between Malloy's two hospital stays was brief, and the circumstances surrounding his discharge and readmission to the hospital have not been explained. If the Fund can show that it was a departure from accepted medical practice to discharge the patient, or that Malloy left the hospital against his doctor's advice, his two visits to Syosset Hospital could be considered a "continuous stay." However, defendant's motion to preclude is **denied** to the extent that it seeks to preclude plaintiff from showing that Malloy's initial discharge from the hospital was approved by his physician and in accord with good and accepted medical practice.

So ordered.

Dated JAN 25 2011

Stephen A. Bucaria
J.S.C.

ENTERED

FEB 01 2011

NASSAU COUNTY
COUNTY CLERK'S OFFICE