The U.S. Court of Appeals for the Ninth Circuit has always been full of surprises and last month was no exception when it ruled that ERISA health plans can sue in state courts under state contract law to enforce plan provisions requiring participants to reimburse the plans for medical expenses paid by third parties after a plan has already paid the same medical expenses. In effect, breach of contract actions initiated by ERISA health plans in state courts are NOT preempted by ERISA (at least not in the states included in the Ninth Circuit – see below).

The citation for this case is: Providence Health Plan v. McDowell (Gary and Roselea), U.S. Court of Appeals, Ninth Circuit, filed 3/24/2004. Or, go to http://www.findlaw.com/casemate, scroll down to U.S. Courts of Appeals – Opinions & Web Sites and click on “9th.” Under Recent Cases and Party Name Search enter “McDowell” and click on Search.


BACKGROUND

The plan documents of many (perhaps most) group health plans provide for the right of the plan to be reimbursed if a participant recovers damages from a third party (such as an auto insurer) that includes payments for the participant’s medical expenses when the medical expenses have already been paid by the plan. These so-called subrogation clauses and/or reimbursement clauses are designed to preclude “double-dipping” by the participant (i.e., receiving reimbursement for the same medical expenses from both a liability insurer and the group health plan). Such provisions are also designed to save the plan money without sacrificing the health care provided to a participant by a group health plan.
The plan’s right to reimbursement has often collided with participants who wish to challenge that right in state and/or federal courts. The result has been conflicting state and federal court decisions along with increased attorneys’ for group health plans when they seek to enforce the terms of the plan. (For a review of some of the most important cases, see the Research Department’s Topical Index, January 2004, pages 11 and 12.)

In 2002 the U.S. Supreme Court rendered a landmark decision in Great-West Life and Annuity Co. v. Knudson concluding that an ERISA health plan may NOT seek recovery of medical expenses under ERISA section 502(a)(2) which permits a plan fiduciary to pursue “appropriate equitable relief” under ERISA section 409. In this case the Supreme Court draws a sharp distinction between equitable relief and monetary relief declaring that the latter is not available under ERISA. (For details on the Great-West case, see Client Bulletin 2002-7, 1/18/02.)

Recently, however, the U.S. Court of Appeals for the Ninth Circuit picks up on certain wording in the Great-West case and concludes that monetary relief may be pursued by an ERISA health plan under a State contract law which often provides for monetary relief. Such litigation is NOT preempted by ERISA. Following are the facts and the reasoning behind the Ninth Circuit decision.

**THE FACTS: PROVIDENT HEALTH PLAN v. GARY & ROSELEA MCDOWELL**

On **February 13, 2000** the McDowell’s were injured in an automobile accident. Providence Health Plan, which covered both parties, paid benefits of $18,742 for Gary’s medical care and $13,687 for Roselea’s care.

On **May 25, 2000** the McDowell’s each signed agreements directing their attorney to reimburse Providence for benefits paid by the plan in the event that “any recovery” was received from a third party by the participants. The Plan contained a reimbursement provision that clearly stated the Plan’s right to be reimbursed for medical expenses if those expenses were also recovered from a third party less proportionate attorney’s fees.

In this case the McDowell’s received a settlement from a third party auto insurer of **approximately $500,000**. Following the settlement, Providence sought reimbursement from the McDowell’s **in the amount of $21,728** under the terms of the reimbursement agreement signed earlier by the McDowell’s. The McDowell’s refused to pay.

In **October of 2001**, Providence filed its first action against the McDowell’s **in a state court alleging breach of contract**. According to Providence, the McDowell’s agreed in their reimbursement agreement with the Plan that if they received money “through any recovery action,” they would reimburse the plan “for the full value of benefits paid by Providence, less reasonable attorney’s fees.” Providence contended that it was entitled to $21,727 pursuant to this provision. The McDowell’s removed the contract dispute to a federal district court on the grounds that the plan was an ERISA plan and that under ERISA the Plan was not entitled to monetary relief. In response, Providence filed a motion asking the federal district court to remand the case to the state court.
On January 29, 2002 the district court denied the plan’s motion to remand and granted the McDowell’s motion to have the case heard by the federal district court which, in turn, concluded that ERISA preemption barred Providence’s claim. The case was dismissed.

In response to this dismissal, on April 12, 2002, Providence brought its second action in the U.S. District Court for the District of Oregon under ERISA 502(a)(3)(B) which allows a plan fiduciary to seek “appropriate equitable relief” in a claim involving a claims dispute. Providence alleged that it was entitled to an equitable remedy of specific performance under ERISA section 502(a)(3)(B) “because it [currently] did not have any other adequate legal remedy.” Specifically Providence sought a court order mandating that the McDowell’s comply with the reimbursement agreement which they had signed.

On August 28, 2002 the district court dismissed this second action concluding that Providence “was in reality seeking monetary relief couching its request in equity.” (The same reasoning as prevailed in the Great-West case.) Providence timely appealed both dismissals to the U.S. Court of Appeals for the Ninth Circuit. Both dismissals were handled under a de novo review procedure.

**Reasoning Of The Ninth Circuit**

**Dismissal No. 1** This earlier dismissal by the district court was denied by the appellate court because the Ninth Circuit concluded that ERISA did NOT preempt the Plan’s filing of the original claim in a state court. According to the Ninth Circuit:

The district court erred in this respect because Providence’s action for breach of contract does not have the requisite “connection with” or “reference to” an ERISA plan. Providence is simply attempting, through contract law, to enforce [the Plan’s] reimbursement provision. Adjudication of its claim does not require interpreting the plan or dictate any sort of distribution of benefits. Providence has already paid the benefits on behalf of the McDowell’s, and they are not disputing the correctness of the benefit paid. (emphasis added)

The appellate court relied on the U.S. Supreme Court’s reasoning in *N.Y. State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Company* (1995) in which the Supreme Court warned that just because a particular state law affected an ERISA health plan in some fashion (i.e., was “related to” or “connected with” an ERISA plan) did NOT automatically mean that ERISA or federal common law does NOT always supersede state laws and that the term “supersede” found in ERISA section 514 “is to be read practically, with an eye toward the action’s actual relationship to the subject plan.” (As you may recall, in the *Travelers* case the State of New York was permitted to impose a surcharge on hospital billings, which ultimately were sent to ERISA health plans for payment.) As far as the Supreme Court was concerned, just because an ERISA plan ends up paying some state taxes, either directly or indirectly, such taxation is NOT preempted by ERISA.
In the *McDowell* case, the appellate court saw nothing wrong with an ERISA plan attempting to enforce a reimbursement contract in a non-federal court and that the preemption provisions of ERISA do NOT foreclose such action. According to the appellate court:

**Providence is simply attempting, through [state] contract law, to enforce the [Plan’s] reimbursement provision. Adjudication of its claim does not require interpreting the plan or dictate any sort of benefits on behalf of the McDowell’s and they are not disputing the correctness of the benefits paid.**

The appellate court also noted the impractical effect of the Supreme Court’s decision in the *Great-West* case under some conditions by making it difficult for a health plan to obtain monetary relief or legal relief under ERISA section 502(a) which allows only for “appropriate equitable relief” (if the reimbursement amount is segregated in a constructive trust and resides solely in the hands of the participant. However, as the appellate court observes:

… the [Supreme] Court **left open the issue** that we decide today: whether a direct action by petitioners against respondents **asserting state-law claims such as breach of contract would [be] preempted by ERISA.** (emphasis added)

The appellate court answers this question with the statement that:

… Providence is seeking ordinary damages – monetary relief – based upon contractual remedies that arise under state law.

For this reason, the appellate court concludes that the factual circumstances of this case are such that no relief is available to the plan under the civil enforcement provisions of ERISA (even though it is an ERISA plan) and therefore, it is reasonable for the plan to seek monetary relief **under state law** [in this case Oregon law]. As a result, the court remanded the case “with instructions” back to state court for final resolution.

**Dismissal 2** Once the district court had decided that the claim filed by the plan was preempted by ERISA, the plan was forced to rely on ERISA provisions (namely sections 502 and 514) and to seek reimbursement in the form of “equitable relief” under ERISA. The district court rejected Providence’s “lawyerly inventiveness” and dismissed Providence’s action stating that “Plaintiffs ERISA action, brought “in equity” but seeking monetary relief, cannot proceed.”

The appellate court agreed with the district court’s reasoning on this issue and cited the Supreme Court’s wording from the *Great-West* case as reflective of the appellate court’s final position, namely:

The basis for petitioner’s claim is … that petitioners are contractually entitled to some funds for benefits that they conferred. The kind of restitution that petitioners seek therefore, is not equitable – the imposition of a constructive trust or equitable lien on particular property – but legal – the imposition of personal liability for the benefits they conferred upon respondents.… Clearly the claim for monetary damages
against the McDowell’s is a claim for legal remedy, despite Providence’s attempt to disguise this claim in equitable clothes. (emphasis added)

The appellate court upheld the action of the district court to dismiss the case on the grounds that ERISA does not recognize a case seeking monetary damages as a form of equitable relief.

**CONCLUDING OBSERVATIONS**

Although this decision in and of itself has limited transference to any of the other ten U.S. Circuit Courts, it does provide some useful guidance to trustees and their fund counsel regarding the limitations of litigation when trying to recover medical expenses paid for by both the plan and by a third party.

It appears that generally speaking, some thought must be given by trustees and their fund counsel to pursuing action in state courts under state contract law especially if the recovery amounts have already been disbursed to the participant and are not sitting quietly in a trust somewhere.

Of course, state contract laws may vary along with the speed with which subrogation litigation occurs in state versus federal courts. Seeking recovery in a state court may not always be the ideal solution.

There has been and will continue to be a great deal of litigation on subrogation issues with applications of both state and federal law generating somewhat conflicting opinions. For a partial list and review of recent subrogation cases (the year 2000 to date), see the TIC Research Department’s *Topical Index* dated January, 2004, pages 11 and 12, which lists seventeen individual reports on subrogation litigation. The Research Department will keep you informed about any new decisions, like the one reported in this *Benefit News Briefs*, that seem to break new ground.