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State Law Claims Against Health Plan Survive ERISA Preemption

The patient suffered from a serious medical condition and sought long-term acute care in a New Jersey hospital. Prior to the patient's admission, the hospital called the patient's group health plan to confirm that the patient was eligible for coverage under the terms of the plan. The representative of the health plan responded by indicating that, as long as the hospital was not a skilled nursing facility, the treatment would be covered at 100% for the first 31 days, and 80% thereafter. After the patient's treatment was completed, the hospital submitted its claim to the health plan, but the health plan refused to pay, pointing to the language of the plan that specifically excludes coverage for long-term acute care.

Consequently, this action commenced. The hospital sued the health plan in state court for $171,485, alleging: (1) fraudulent

misrepresentation, (2) negligent misrepresentation, and (3) promissory estoppel. The health plan successfully removed the matter to federal district court and argued that the hospital's three state law claims must be dismissed because they "relate to" an ERISA-governed group health plan and, therefore, they are preempted.

With respect to ERISA preemption, the court noted that "[ERISA] shall supersede any and all state laws insofar as they . . . 'relate to' any employee benefit plan." Further, the court observed, "[t]he purpose of this broad preemption clause is to ensure that plans . . . are subject to a uniform body of benefit law, minimizing the administrative and financial burden of complying with conflicting requirements of various states." However, "[a]s broad as ERISA preemption may be, it does not foreclose a plaintiff from pleading a state law claim based on a legal duty that is independent from ERISA or an ERISA-governed plan."

Here, the court found that the hospital does not seek recovery under the terms of the ERISA-governed plan and, therefore, this narrow exception to ERISA preemption applies. Indeed, nothing in the hospital's complaint alleges that the claim for long-term acute care was wrongfully rejected under the terms of the plan. Instead, the hospital alleges that, during its telephone call to the plan to confirm the patient's eligibility for coverage, the plan made certain representations about the patient's coverage under the plan, and the hospital reasonably relied upon those representations and expected to be paid for the services it provided. Thus, it was those representations, and not the plan or its actual terms, that form the legal basis for the hospital's state law claims.

Accordingly, the health plan's motion to dismiss the hospital's state law claims is denied.

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Full text of Kindred Hospitals v. Local 464A United Food and Commercial Workers Union Welfare Service Benefit Fund, 21-cv-10659 (D.N.J. Sept. 29, 2021) (Google Scholar)

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