CLOSED CIVIL CASE

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

Case No.: 05-22265-GRAHAM/O'SULLIVAN

PALMETTO PATHOLOGY SERVICES, P.A., d/b/a FLORIDA PATHOLOGY SERVICES,

Plaintiff,

v.

HEALTH OPTIONS, INC., a Florida corporation,

Defendant.
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ORDER

THIS CAUSE came before the Court on Plaintiffs' Motion for Remand [D.E. 8].

I. BACKGROUND

Plaintiff originally brought this action in the Circuit Court of the Eleventh Judicial Circuit in and for Miami-Dade County, Florida, to recover payment for pathology services rendered to Defendant's subscribers. Plaintiff filed a Second Amended Complaint stating claims for declaratory relief, breach of implied contract, quantum meruit, open account, account stated, and breach of third party beneficiary contract.

In its third party beneficiary claim, Plaintiff claims that Defendant entered into valid and enforceable contracts with commercial/non-Medicare HMO subscriber Members (the "Members").

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Plaintiff claims that pursuant to the contracts between the Members and Defendant (the "Contracts") and Chapter 641, Florida Statutes, which becomes a part of the contracts, Defendant authorized Plaintiff's provision of covered professional component clinical pathology services to Defendant's subscriber Members, and authorized payment for said pathology services to Plaintiff. Plaintiff claims that by virtue of the Contracts, Defendant and the Members intended that the Contracts "primarily and directly benefit Plaintiff, as a third party beneficiary, for the payment of covered professional component clinical pathology services." Plaintiff alleges that Defendant has breached its contracts with the Members by accepting Plaintiff's pathology services without paying Plaintiff, "the intended third party beneficiary," for the covered professional component clinical pathology services.

On August 15, 2005, Defendant filed its petition for removal, asserting that this Court has federal question jurisdiction under 28 U.S.C. §1331, and claiming that the third party beneficiary claim is "completely preempted" by ERISA. Plaintiff subsequently filed the instant Motion to Remand, arguing that Plaintiff's third party beneficiary claim is not a claim for benefits under an ERISA plan and is not completely preempted by ERISA.

II. DISCUSSION

A. SUBJECT MATTER JURISDICTION

Federal courts are of limited jurisdiction and may only hear cases that they have been authorized to hear by the Constitution of the United States. See Kokkonen v. Guardian Life Ins. Co. of Am., 511 U.S. 375 (1994). The removal statute, 28 U.S.C. §1441(a), provides that any civil action first filed in state court may be removed by the defendant to federal court if the federal court has original jurisdiction over the case under either federal question or diversity jurisdiction. See id. A federal court has original federal jurisdiction over any action "arising under the Constitution, laws, or treaties of the United States." See 28 U.S.C. §1331.

In considering whether they possess subject matter jurisdiction over a case or controversy, federal district courts are guided by the well-pleaded complaint rule, which provides that the plaintiff's properly pled complaint governs the jurisdictional determination. See Louisville & Nashville R.R. v. Mottley, 211 U.S. 149, 152 (1908). Pursuant to this rule, a case may be removed on the basis of federal question jurisdiction only when the plaintiff's statement of his own cause of action shows that it is based on federal law. See Blab T.V. of Mobile, Inc. v. Comcast Cable Communications, Inc., 182 F.3d 851, 854 (11th Cir. 1999). In other words, only state-court actions that could have been filed in

federal court may be removed. Caterpillar, Inc. v. Williams, 482 U.S. 386, 392 (1987).

There is, however, an independent corollary to the well-pleaded complaint rule, known as the "complete preemption doctrine." This doctrine provides that "[c]ongress may so completely preempt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." See Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63 (1987). When this occurs, any claim based on the completely preempted state law will be converted into one stating a federal claim for purposes of the well-pleaded complaint rule. See id. at 65.

The doctrine of complete preemption is distinguished from ordinary preemption. Complete preemption is used to establish a federal court's subject matter jurisdiction over a case, while ordinary preemption is merely a defense to the application of state law. See Ramirez v. Humana, Inc., 199 F.Supp.2d 1307 (M.D. Fla. 2000). The Eleventh Circuit has defined the difference between complete preemption and ordinary preemption as follows:

> complete preemption functions as a narrowly drawn means of assessing federal removal jurisdiction, while ordinary preemption operates to dismiss state claims on the merits and may be invoked in either federal or state court.

Smith v. GTE Corp., 236 F.3d 1292, 1313 (11th Cir. 2001). The Court cannot decide an ordinary preemption defense before it determines whether it has subject matter jurisdiction. See Kemp v.

International Business Machines Corp., 109 F.3d 708, 713 (11th Cir. 1997) ("Without any basis for federal jurisdiction over a case, a federal court cannot decide a preemption defense. Any defensive preemption arguments [defendant] seeks to raise will have to be decided, if at all, in state court.").

B. COMPLETE PREEMPTION AND ERISA

In the ERISA context, complete preemption results from Congress' creation of a comprehensive remedial scheme in ERISA's civil enforcement provision, ERISA Section 502. See Butero v. Royal Maccabees Life Ins. Co., 174 F.3d 1207, 1211 (11th Cir. 1999). Section 502 authorizes an action by a plan or beneficiary to recover benefits or to enforce or clarify rights under the terms of an ERISA plan.[1] Accordingly, "ERISA superpreemption exists only when the plaintiff is seeking relief that is available under [Section 502]." Butero, 174 F.3d at 1212.

In order for complete preemption to exist, four elements must be satisfied. The Supreme Court has summarized these elements as follows:

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[1] Specifically, Section 502 provides that a civil action may be brought:

(1) by a participant or beneficiary -
  (A) for the relief provided for in subsection (c) of this section or
  (B) to recover benefits due to 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.

> First, there must be a relevant ERISA plan. Second, the plaintiff must have standing to sue under that plan. Third, the defendant must be an ERISA entity. Finally, the complaint must seek compensatory relief akin to that available under [Section 502]; often this will be a claim for benefits due under a plan.

Id.

The Court now turns to examine these elements.

1. **ERISA PLAN**

ERISA Section 514(a) preempts all state laws insofar as they "relate to" any employee benefit covered by the Act. In the removal context, the defendant must first adequately demonstrate that the subject plan, fund or program is covered by ERISA. Lordmann v. Enters., Inc. v. Equicor, Inc., 32 F.3d 1529, 1533-34 (11th Cir. 1994). For an employee welfare plan to fall within ERISA's scope, there must be: (1) a plan, fund or program; (2) established or maintained; (3) by an employer or by an employee organization, or both; (4) to provide participants or their beneficiaries; (5) medical, surgical, hospital care, benefits. Slamen v. Paul Revere Life Ins. Co., 166 F.3d 1102, 1104 (11th Cir. 1999).

The mere purchase of insurance does not conclusively establish a plan, fund or program covered by ERISA. Id. A plan, fund or program is established "if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of funding, and procedures for receiving benefits." Id. at 1104. Not all welfare benefit plans meet the

criteria established by ERISA. Id. For example, in order for the plan to fall within the ambit of ERISA, it must cover participants because of their employee status in an employment relationship. Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982).

Here, Defendant fails to provide sufficient evidence that the subject plan was designed to cover participants because of their employee status in an employment relationship. Defendant submitted the affidavit of one employee, Patricia Lauramore, together with internal business records. The Court, however, cannot ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits. Id. at 1104. Thus, Defendant has failed to meet its burden on removal of demonstrating the existence of federal jurisdiction based upon ERISA complete preemption.

2. **STANDING**

Even if Defendant had demonstrated that the plans at issue are ERISA plans, Defendant has failed to show that Plaintiff has standing to sue under the plans. "Under the doctrine of complete preemption, a plaintiff must have standing to sue under a relevant ERISA plan before a state law claim can be recharacterized as arising under federal law subject to federal court jurisdiction." Hobbs v. Blue Cross Blue Shield of Ala., 276 F.3d 1236, 1240-41 (11th Cir. 2001). Only plan participants and plan beneficiaries, as defined by statute, have standing to sue for benefits under

ERISA. Id.; 29 U.S.C. §§ 1002(7) & 1002(8). To be a "participant," one must be an "employee or former employee of an employer, or any member or former member of an employee organization." 29 U.S.C. §1002(7). A "beneficiary" is "a person designated by a participant or by the terms of an employment benefit plan, who is or may become entitled to a benefit thereunder." Id. at §1002(8).

Defendant argues that Plaintiff is a "beneficiary" under ERISA. Generally, a medical provider does not have independent standing to sue under ERISA and is not considered a "participant" or a "beneficiary" under ERISA. Hobbs, 276 F.3d at 1241. Defendant asserts, however, that "[t]he entire theory behind Plaintiff's 'Breach of Third Party Beneficiary Contract' claim rests on the notion that Plaintiff has been designated 'by the terms' of the underlying HMO plans as a party that is 'entitled to a benefit.'" In this regard, Defendant relies on Plaintiff's allegation that by virtue of the plan terms, Defendant and its Members 'clearly and manifestly intended that their contracts primarily and directly benefit Plaintiff." The Court finds that Plaintiff is not a plan participant or beneficiary, as those terms are defined in ERISA. The fact that Plaintiff may be entitled to payment from Defendant as a result of the Members' participation in the insurance plan does not make Plaintiff a beneficiary for the purposes of ERISA standing. See Ward v. Alternative Health

Delivery Sys., Inc., 261 F.3d 624 (6th Cir. 2001); National Medical Care, Inc. v. United Health Care of Fla., Inc., 2001 WL 268205 at *2 (S.D. Fla. Jan. 26, 2001).

In addition, Defendant argues that Plaintiff has standing to sue as an assignee of benefits. In Cagle v. Bruner, 112 F.3d 1510 (11th Cir. 1997), the Eleventh Circuit held that a healthcare provider had derivative standing to bring an action against an ERISA plan insurance fund where the record showed that the provider had been assigned the right to payment of medical benefits. To establish such derivative standing, the defendant must prove the assignment by a preponderance of the evidence. Hobbs, 276 F.3d at 1242 (finding no standing and thus no removal jurisdiction where the provider failed to establish with evidence that an assignment had occurred). For the reasons discussed below, the Court finds that Defendant failed to meet this burden.

Here, Defendant filed the Affidavit of Patricia Lauramore to prove that Plaintiff has standing under the plans. Attached to the affidavit are various printouts of screens from Defendant's claim system. In the affidavit, Ms. Lauramore states that the presence of a checkmark in the "assign benefits" box on the screen printouts indicates an assignment of benefits by the patient to Plaintiff. No other proof of valid assignments is provided. There is no indication as to whether the insurance contracts contain anti-assignability provisions. Nor is there any proof that the supposed

assignments relate to benefits under an ERISA plan, that the benefits under the plans can be validly assigned, or the extent of the supposed assignments. Nor are the claims asserted by Plaintiff based upon the existence of an assignment.

Defendant also asserts that the Supreme Court, in Aetna Health Inc. v. Davila, 124 S.Ct. 2488, 2495 (2004), requires that state law claims be entirely independent of ERISA plans in order to survive complete preemption. According to Defendant, "[i]f the potential liability of the defendant derives from the particular rights and obligations established by an employee welfare benefit plan, as it does in this case, then the claim is not 'entirely' independent of ERISA." The cases before the Court in Davila were brought by a participant and a beneficiary who alleged that they suffered injuries as a result of their HMO's decisions not to provide coverage for treatment or services recommended by the patients' treating physicians. By contrast, Plaintiff is a group of medical providers who has brought its own claim as a creditor to recover money owed to it by Defendants. Accordingly, Defendant's reliance on Davila is misplaced.

In addition, the Supreme Court in Davila held that a cause of action is completely preempted by ERISA if (1) "an individual, at some point in time, could have brought his claim under ERISA §502(a)(1)(B)," and (2) "there is no other independent legal duty that is implicated by a defendant's actions." Id. at 2496. Here,

Plaintiff has alleged the violation of the independent legal duty owed to it as a third party beneficiary. The Davila requirements have not been met, as Plaintiff could not have brought its claims under Section 502 because it is not a plan beneficiary or participant, and Defendant's actions implicate an independent legal duty to Plaintiff as a third party beneficiary.

The Court finds that complete preemption does not exist because the required element of standing to sue is not present in this case. Plaintiff is neither a beneficiary nor a participant. Plaintiff cannot be deemed to have standing by virtue of any assignment of benefits because Plaintiff is not asserting any claims as an assignee of benefits. Nor has Defendant shown that Plaintiff is an assignee. Accordingly, the Court must conclude that Plaintiff's claims are not completely preempted by ERISA, and that remand of this action is required.

3. ERISA Entity

Even if the plans at issue were ERISA plans and Plaintiff had standing, Defendant has not met its burden of showing that it is an ERISA entity. ERISA entities are the employer, the plan, the plan fiduciaries, and the beneficiaries under the plan. Morstein v. National Ins. Servs. Inc., 93 F.3d 715 (11th Cir. 1996). There is no preemption where the defendant is not an ERISA entity and the claims do not affect relations among principal ERISA entities as such. Id. at 722. An insurer may be a plan fiduciary, but only if

it has exclusive authority to determine eligibility for benefits under the plan and to review denied claims. Engelhardt v. Paul Revere Life Insurance Company, 139 F.3d 1346, 1352 (11th Cir. 1998).

Here, Defendant has presented no evidence in the petition for removal to establish that Defendant is an ERISA entity with respect to the plans at issue in this case. Accordingly, the Court finds that Defendant has failed to meet its burden of removal.

4. Whether The Complaint Seeks Compensatory Relief Akin To That Available Under Section 502

Defendant must show that the Complaint seeks compensatory relief akin to that available under Section 1132(a). Butero, 174 F.3d at 1212. Section 1132(a)(1)(B) "permits a civil action by a participant or beneficiary 'to recover benefits due to 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...." Ervast, 346 F.3d at 1014.

Here, Plaintiff is not seeking recovery as a plan participant or beneficiary. Rather, Plaintiff seeks recovery as an aggrieved health care provider. See Lordmann Enterprises, 32 F.3d at 1534 ("ERISA does not provide a cause of action for aggrieved health care providers that treat ERISA participants."). Plaintiff does not seek to clarify its rights to future benefits under the terms of a plan. Instead, Plaintiff seeks to enforce its independent right as a third party provider to be paid for services it rendered

to Defendant by providing services which Defendant was contractually and statutorily required to provide to its subscriber members. The compensatory relief sought in the Complaint is not "akin to" relief available under this ERISA provision and, accordingly, complete preemption does not exist.

III. CONCLUSION

Based on the foregoing discussion, it is

ORDERED AND ADJUDGED that Plaintiffs' Motion to Remand is hereby **GRANTED**. It is further,

ORDERED AND ADJUDGED that the above styled cause is **REMANDED** to the Eleventh Judicial Circuit in and for Miami-Dade County, Florida. In addition, it is

ORDERED AND ADJUDGED that this case is **CLOSED** for administrative purposes and any pending motions are **DENIED** as moot.

DONE AND ORDERED in Chambers at Miami, Florida, this 14th day of January, 2006

DONALD L. GRAHAM
UNITED STATES DISTRICT JUDGE

cc: Magistrate Judge O'Sullivan
Counsel of Record