IN THE CHANCERY COURT FOR DAVIDSON COUNTY, TENNESSEE
AT NASHVILLE

FILED 2014 JAN -9 PM 4:15 CLERK & MASTER CHANCERY CT. DC&M

HCA HEALTH SERVICES OF TENNESSEE, INC., HENDERSONVILLE HOSPITAL CORPORATION, CENTRAL TENNESSEE HOSPITAL CORPORATION AND HTI MEMORIAL HOSPITAL CORPORATION,[1]

Plaintiffs,

vs. NF No. 10-896-II

BLUECROSS BLUESHIELD OF TENNESSEE, INC.,[2]

Defendant.

MEMORANDUM AND ORDER

This case presents a number of difficult legal issues arising under the Employee Retirement Income Security Act of 1974 ("ERISA"), the Emergency Medical Treatment and Active Labor Act of 1986 ("EMTALA") and a Tennessee statute regulating insurance companies. The Plaintiffs, a group of Hospitals, filed suit to secure reimbursement from the Defendant, BlueCross/BlueShield, for the emergency medical services they provided to medically-insured patients/enrollees when the Hospitals had no contractual relationship with BlueCross/BlueShield, the patients/enrollees' insurance carrier. The Hospitals also request that the Court declare the proper reimbursement method to be used in emergency situations and seek a declaratory judgment regarding BlueCross/BlueShield's coverage, claims and appeals policies. However, before the Court may

[1] The Plaintiffs shall be referred to as "the Hospitals," "health care providers," "providers" or "Plaintiffs" throughout this Memorandum and Order

address these issues, it must find that the Hospitals' claims are not pre-empted by federal legislation.

The parties' cross-motions for partial summary judgment were argued on August 14, 2013. The Hospitals aı e not participants in and are not approved health care providers in BlueCross/Blue Shield's Network S plan (or its other plans)[3] and are therefore classified by BlueCross/Blue Shield as out-of-network.[4] BlueCı oss/Blue Shield says that it has properly reimbursed the Hospitals for the emeı gency services they ıendered to enı ollees/patients in Network S, and that the Hospitals, as assignees of enrollees/patients[5] in the Network S plan, seek to recover unjustified, additional reimbursement for emergency out-of-network health care services. The insurer also states that the Hospitals seek to rewrite the payment provisions of its contract plans. The insuı er seeks dismissal of a majority of the Hospitals' claims of alleged underpayment because (1) the Hospitals' state-law claims are pıe-empted by federal law; (2) the Hospitals, as assignees, failed to exhaust their administrative remedies under the plan in all but 145 individual ERISA claims; (3) federal courts have exclusive jurisdiction to provide the equitable relief of a declaratory judgment in this case, not state courts; (4) the Hospitals lack standing to assert a claim for declaratory relief, and the requested

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2 The Defendant shall be ıefeı red to as "BlueCı oss/BlueShıeld," "ınsurance caııer," "ınsurer" oı "carı ıer."

3 BlueCı oss/BlueShıeld has a numbeı of other ERISA-goveı ned employeı -sponsored health ınsurance plans that aı e involved ın thıs lıtıgatıon, but foı puı poses of the ıssues raısed ın the motıons foı partial summary judgment, refeı ence will only be made to Network S as representative of ıts ERISA plans

4 Insuı eı s negotıate ıates wıth doctoı s, dentısts, hospıtals and other health caı e provıders to contain the expense of medıcal services and to save money. In negotıatıng with employers, the ınsuı eı s identıfy those provıders who wıll paı ticipate ın the plan The insuı er ıefers to those provıders as beıng "in-netwoı k," ı e , the pı ovıdeı s agı ee to accept the negotıated ıate ın exchange foı the volume of medıcal busıness that wıll result from the employeı puı chasing the ınsuı eı 's plan

Some plans may not pay foı medıcal seı vıces ıendered by pı ovideı s who are not in-network Howeveı, many plans may pay reduced benefits for out-of-network seı vıces based on what ıs called the "ı easonable," "usual and customaı y" or "pı evaılıng" charge These provıdeı s are labeled "out-of-netwoı k" because the cost of the seı vice was not negotıated wıth the ınsuı er and was not part of the plan offered to the employeı foı its enrollees/employees The ınsureı 's health care plan/contı act wıth the employer may pı ovıde fewer or no benefits for an enı ollee who uses an out-of-netwoı k pı ovıdeı The enrollee may be requıred to pay the ı emaınıng chaı ges for an out-of-network provider's medıcal seı vıces whıch are not coveı ed by the deductıble or the ınsurer's portıon of the charge

5 In ıts brıef, BlueCı oss stated that ıts motıon for partıal summaı y judgment addressed the 4,037 ERISA claıms out of the approximately 4,700 claıms at ıssue At oı al aı gument, counsel foı the ınsureı stated that the Hospitals dıd not dıspute that the enı ollees/patıents whose claıms aı e at ıssue weı e covered under ERISA plans and therefoı e, the Court dıd not need to reach a conclusıon that the plans aı e ERISA plans and that the claımants [enı ollees/patıents] are goveı ned under those plans.

reformation is impermissible under ERISA, (5) the Hospitals failed to exhaust claims for the mandatory pre-grievance process for all but 24 of the 564 "non-ERISA claims," (6) the Hospitals failed to comply with the time limit within which to file a grievance as set out in the contracts/plans and (7) all of the Hospitals' claims arising on or before November 30, 2008 are time barred by the statute of limitations for payment-correction claims by Hospitals.[6]

In opposition, the Hospitals seek partial summary judgment that declares they are deemed to have exhausted all administrative remedies available under the ERISA plans because the insurer failed to comply with ERISA regulations. According to the providers, ERISA regulations established the reasonable claims procedures that each plan must follow, including the manner and content of notification of benefit determination and for responding to appeals. The providers submit that the insurer's denial letters and notices of adverse benefit determinations did not provide the information required by ERISA and that accordingly, they should be deemed to have exhausted all administrative remedies and allowed to pursue their claims for benefits under ERISA.

Background

In 1974, Congress enacted ERISA (Employee Retirement Income Security Act) to encourage employers to set up pension and welfare plans and to help employees obtain health insurance, life insurance and other insurance/pension benefits.[7] BlueCross/Blue Shield contracts with employers, selling them health insurance benefit plans that will cover their employees. BlueCross/Blue Shield

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[6] 112 claims are contractually covered by agreements between the Hospitals and BlueCross/BlueShield and are not addressed by the Court

[7] ERISA, codified at 29 U S C A § 1001 et seq , was enacted to protect the interests of employee benefit plan participants and their beneficiaries by

> Requiring the disclosure of financial and other information concerning the plan to beneficiaries,
> Establishing standards of conduct for plan fiduciaries,
> Providing for appropriate remedies and access to the federal courts

contends that its health insurance plans are governed by the federal law, ERISA, which pre-empts all of the state law claims raised by the providers. It argues that the Hospitals' claims for the Network S patients[8] insured by BlueCross/BlueShield should be dismissed.

In the early to middle 1980's, courts held that federal law, not state law, would apply to litigation that related to employee welfare benefit plans governed by ERISA.[9] Since then, numerous state-court lawsuits "related to" ERISA were deemed pre-empted, and were subsequently tried in federal courts.

BlueCross/BlueShield argues that if the terms of its Network S plans (or other employee benefit plans) need to be examined in order to determine whether the Hospitals' claims are payable, then those Hospitals' claims "relate to" ERISA-covered plans and thus, ERISA pre-empts the state claims.[10] According to BlueCross/BlueShield, Count 1 and Count 3 in the Plaintiffs' Complaint, which seek additional reimbursements based on common law theories of breach of an implied contract, unjust enrichment and declaratory judgment, are therefore pre-empted by ERISA.

The Hospitals state that their claims are not pre-empted. They assert that federal law mandates that they provide emergency medical care and that state law provides that BlueCross/BlueShield is obligated to pay for the services. They submit that their claims are based on the statutes, not contract. Further, they assert that neither the federal nor state statutes established an

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8 In its brief, BlueCross stated that its motion for partial summary judgment addressed the 4,037 ERISA claims out of the approximately 4,700 claims at issue At oral argument, counsel for BlueCross/BlueShield stated that all claims at issue were covered under ERISA plans Therefore, it asserts, the Court did not need to reach a conclusion that the plans are ERISA plans and that the claimants (patients) are governed under those plans

9 29 U S C §1144(a) and (c)(1), *see Metropolitan Life Ins Co v Massachusetts,*471 U.S. 724 (1985), *overruled in part on other grounds by Ky Ass'n of Health Plans, v Miller*, 538 U S 329 (2003)

10 State law claims for payment to beneficiaries or their assignees under ERISA-governed employee benefit plans are generally preempted, unless the claims' effect on the plans is merely tenuous, remote, or peripheral Employee Retirement Income Security Act of 1974, §514(a), 29 U S C A §1144(a), *Productive MD, LLC v Aetna Health, Inc.*, 3:12-CV-00052, 2013 WL 4587859 at *26 (M D Tenn. Aug 28, 2013)

appropriate rate of payment for their services and thus, they submit two common law theories for reimbursement: (1) breach of an implied-in-law contract claim with damages based upon the reasonable value of the emergency services they provided and (2) a derivative claim based upon the Network S patients/enrollees' assignments of their benefits to the Hospitals. The Hospitals rely upon the Network S plan documents and the representations made to the patients/enrollees by BlueCross/Blue Shield as evidence of the reasonable value of their emergency services.

Summary Judgment

This case is governed by the summary judgment standards articulated by the Tennessee Supreme Court in *Hannan v Alltel*, 270 S.W.3d 1 (Tenn. 2008).[11] The moving party is entitled to succeed on its Motion only if it has either affirmatively negated an essential element of the non-moving party's claim or established that the non-moving party cannot prove an essential element of that claim at trial. *Id.* at 8-9. In determining whether an essential element of the non-moving party's claim has been negated, the Court must view the evidence in the light most favorable to the non-moving party. *Giggers v. Memphis Hous.* Auth., 277 S.W.3d 359, 364 (Tenn. 2009).

However, summary judgments are proper in virtually any civil case that can be resolved on the basis of legal issues alone. *Fruge v. Doe*, 952 S.W.2d 408, 410 (Tenn. 1997); *Byrd v. Hall*, 847 S.W.2d 208, 210 (Tenn. 1993); *Pendleton v. Mills*, 73 S.W.3d 115, 121 (Tenn. Ct. App. 2001). They are not, however, appropriate when genuine disputes regarding material facts exist. Tenn. R. Civ. P. 56.04. Thus, a summary judgment should be granted when the undisputed facts, as well as the inferences reasonably drawn from the undisputed facts, support only one conclusion - that the party

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[11] The *Hannan* standard has been criticized in *Sykes v Chattanooga Hous Autho.*, 343 S.W.3d 18, 25 n 2 (Tenn 2011), but the holding in *Hannan* controls this case

seeking the summary judgment is entitled to a judgment as a matter of law. *Pero's Steak & Spaghetti House v. Lee*, 90 S.W.3d 614, 620 (Tenn. 2002); *Webber v. State Farm Mut Auto Ins Co.*, 49 S.W.3d 265, 269 (Tenn. 2001); *Clifford v. Crye-Leike Commercial, Inc.*, 213 S.W.3d 849, 852 (Tenn. Ct. App. 2006).

Applicable Statutes

The parties' arguments suggest a conflict between two federal statutes, ERISA and EMTALA (Emergency Medical Treatment and Active Labor Act[12]); the insurer contends that ERISA pre-empts this action, while the providers contend that EMTALA mandates emergency treatment and that its claims pursuant to EMTALA are not pre-empted by ERISA.

The relevant language in ERISA regarding pre-emption states that

> [e]xcept as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

29 U.S.C.A. § 1144(a)(hereinafter referred to as "section 1144(a)").

Another relevant portion of the ERISA statutes states that

> (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

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[12] The Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U S C A. §1395dd, was passed in 1986 and requires hospitals to provide care to anyone needing emergency healthcare treatment regardless of citizenship, legal status or ability to pay There are no reimbursement provisions. Participating hospitals may only transfer or discharge patients needing emergency treatment under their own informed consent, after stabilization, or when their condition requires transfer to a hospital better equipped to administer the treatment The statute defines "participating hospitals" as those that accept payment from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) under the Medicare program. *Id.* at §1395dd(e)(2) In practical terms, EMTALA applies to virtually all hospitals in the U S , with the exception of the Shriners Hospitals for Children, Indian Health Service hospitals, and Veterans Affairs hospitals EMTALA's provisions apply to all patients, and not just to Medicare patients

29 U.S.C.A. § 1144(b)(2)(A).

The relevant language in EMTALA regarding emergency medical treatment states:

> In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical scıeening examination within the capability of the hospital's emergency department, including ancillaıy services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

42 USC § 1395dd(a).

A Tennessee companion statute to the EMTALA provisions bars an insurer from denying coverage for emergency medical services, stating

> [a] health benefit plan shall not deny coverage for emergency services if the symptoms presented by an enrollee of a health benefit plan and recorded by the attending provider indicate that an emergency medical condition could exist, regardless of whether or not prior authorization was obtained to provide those services and regardless of whether or not the provider furnishing the services has a contractual agreement with the health benefit plan for the provision of the services to the enrollee.

Tenn. Code Ann §56-7-2355(b)(1) [Coverage of Emergency Services]("CES").

<u>ERISA and EMTALA</u>

EMTALA mandates that the Hospitals provide emergency medical treatment. 42 U.S.C.A. §1395dd. This Court need look no further than the wording of that statute to determine that the Hospitals must perform. This federal mandate does not turn on, nor affect, the eligibility of patients/enrollees under the contractual provisions of the Netwoık S plan, nor does it interfere with BlueCross/Blue Shields' administıation of its health care plans. EMTALA defines an emergency medical condition to mean

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in-

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(ii) serious impairment to bodily functions, or
(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions-

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

42 U.S.C.A. § 1395dd(e)(1).

Pursuant to 29 U.S.C.A. §1144(b)(2)(A) and (B), Tennessee retains the authority to regulate the insurer, BlueCross/Blue Shield, in situations involving the Hospitals' federal mandate to provide emergency services. BlueCross/BlueShield argues that one core purpose of ERISA was to provide uniformity in administration of employee benefit plans and to avoid subjecting plan administration to varying state legal standards. *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001). BlueCross/BlueShield states that the phrase "relate to" in section 1144 (a) is to be given broad, common-sense meaning, so that a state law "'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *New York Conf of BCBS Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (quoting *Shaw v Delta Air Lines*, 463 U.S. 85, 96-97 (1983)). BlueCross/BlueShield argues that the language in 29 U.S.C.A. § 1144(a) cited above displaced all state claims that "relate to" any employee benefit plan or that fall within ERISA's sphere, not just those that are inconsistent with ERISA's substantive provisions. *See Metropolitan Life Ins Co. v.*

Massachusetts, 471 U.S. 724 (1985), *overruled in part on other grounds by Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003). However, a Network S patient/enrollee who is in an emergency medical condition does not require that BlueCross/BlueShield make any administrative or eligibility decision in order for emergency services coverage to be warranted.

On its face, ERISA did not pre-empt other federal laws. 29 U.S.C.A. §1144(d). In 1983, the U.S. Supreme Court held that §514(d)[13] saved federal laws from pre-emption, stating that "ERISA's structure and legislative history, while not particularly illuminating with respect to § 514(d), cautioned against applying it too expansively." *Shaw v. Delta Air Lines, Inc* , 463 U.S. 85, 104. "Congress applied the principle of pre-emption 'in its broadest sense to foreclose any non-Federal regulation of employee benefit plans,' creating only very limited exceptions to pre-emption." *Id.* However, "§514(d) does not pre-empt federal law." *Id.* at 105. Since the ruling in *Shaw*, ERISA has not pre-empted claims made pursuant to EMTALA.[14]

ERISA and the Tennessee Statute

With regards to the state law claims, the U.S. Supreme Court has retreated from the broadest reading once given to the phrase "relate to" as contained in the ERISA statute. *Travelers*, 514 U.S. 656. In *Travelers,* the Supreme Court held that New York's statute requiring hospitals to collect surcharges from patients covered by a commercial insurer, but not from patients insured by a Blue Cross/Blue Shield plan, did not "relate to" employee benefit plans within the meaning of § 1144(a) and, thus, was not pre-empted. *Travelers*, 514 U.S. at 659–60. The Court reasoned that these

[13] The language used in Section 514 of the original ERISA statute passed in 1973 is essentially the same language contained in 29 U S C A §1144(d), as amended

[14] No case law has been presented to the Court by the parties, nor located by the Court, showing that ERISA has ever preempted claims arising under EMTALA.

economic incentives did not operate to bind plan administrators to a particular choice and had only an indirect economic effect on the choices made by ERISA plans. *Id.* The Court explained that the state law did not conflict with Congress's goal of providing a uniform administration of employee benefit plans because it did not attempt to regulate the content or administration of ERISA plans. *Id.* at 656. Justice Souter opined that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.'" *Id.* at 655 (quoting HENRY JAMES, RODERICK HUDSON XLI (NEW YORK ED., WORLD'S CLASSICS 1980)).

The *Travelers* Court, recognizing that the limiting phrase "insofar as they ... relate to," contained in §514,[15] did not provide much help in delineating the limitations of ERISA preemption, decided that it must look "beyond the unhelpful text" of §514 and "look instead to the objectives of the ERISA statute" to assure that the phrase "relate to" is correctly interpreted. *Id.* at p. 655.

> Accordingly, *Travelers* developed new tests narrowing the scope of ERISA preemption of state laws. [The Court] concluded that ERISA preempts only those state laws having a connection with or reference to employee benefit plans that affect the nature of the plans and the objectives of ERISA. [The Court] noted that the objective of Congress in passing ERISA was to insure national uniformity in the administration of the employee benefit plans it covers. Accordingly, *Travelers* sought to avoid preemption of state laws having only a "tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability." By narrowing the scope of ERISA preemption to state laws that interfere with national uniformity in the administration of the employee benefit plans, *Travelers* sought to enforce the legislative purpose of ERISA without unnecessarily infringing on matters subject to traditional state regulation.

Benitez v N. Coast Women's Care Med Grp., Inc., 106 Cal. App. 4th 978, 985-86, 131 Cal. Rptr. 2d 364, 370 (Cal. Ct. App. 2003)(citations omitted).

The U.S. Supreme Court further declared in *Pegram v Herdrich*, 530 U.S. 211, 212, (2000),

that the scope of ERISA state law preemption is not determined by whether the conduct of a person employed to provide services under a plan has adversely affected a plan beneficiary's interests, but instead by whether the conduct was an eligibility/administrative decision regulated by ERISA.

Thus, ERISA will not preempt the Hospitals' state law claims if those claims based on services rendered do not affect eligibility or administrative decisions or otherwise interfere with the nature of the plans and the objectives of ERISA. In addition, Tenn. Code Ann §56-7-2355(b)(1) may be protected from preemption under ERISA if the statute is deemed to regulate insurance, banking, or securities. In such cases, ERISA pre-emption does not apply. 29 U.S.C.A. §1144 (b)(2)(A).

Reimbursement

The Hospitals contend that BlueCross/BlueShield failed to reimburse them fully for the fair market value of their services. The Hospitals' request for reimbursement raises a number of questions. First, are the Hospitals' claims for reimbursement pursuant to Tenn. Code Ann. §56-7-2355 pre-empted by ERISA? Second, what legal support exists for the Hospitals to seek reimbursement from BlueCross/BlueShield for emergency services provided to Network S patients/enrollees? Third, who is obligated to pay for reimbursement, the patient or BlueCross/BlueShield? Fourth, how is the proper amount and method of reimbursement determined? Fifth, what, if any, obligation does BlueCross/BlueShield have to make any supplemental reimbursements?

The first question arises because BlueCross/BlueShield contends that regardless of the Hospitals' implied-in-law contract claim or their derivative claim, all of the Hospitals' claims are pre-empted by ERISA. Despite the legislative intent expressed in the state statute addressing

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[15] See footnote 13

emergency health coverage, BlueCross/BlueShield does not acknowledge an obligation to pay the Hospitals the benefits conferred in its plans. Alternatively, it states that it has fully paid the Hospitals for any emergency care rendered to Network S patients/enrollees.

In order to conduct health care insurance business in Tennessee, BlueCross/BlueShield must comply with the numerous regulatory provisions in Tenn. Code Ann. §56-7-2300, et seq. Title 56, Part 23 is entitled "Mandated Insurer or Plan Coverage." Examples of regulatory provisions for group health plans issued by an entity subject to Tennessee insurance law can be found in Tenn. Code Ann. §§56-7-2301(d), 2302, 2312, 2317, 2347, 2348 and 2353, in addition to 2355, Tennessee's Coverage for Emergency Services ("CES") statute. The Tennessee statute, CES, does not direct payment, but rather, prohibits BlueCross/BlueShield from not paying, i.e., denying coverage for emergency services ("CES"). When BlueCross/BlueShield transacts insurance business in Tennessee, BlueCross/BlueShield shall not deny benefits[16] to providers of emergency health care services. While the statute does not determine the eligibility of enrollees/patients for emergency health care under the contractual provisions of the insurer's plans, the insurer may not deny coverage for any patient/enrollee with whom it has contractually agreed to provide such coverage. When a state law "does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the [law] has some economic impact on the plan does not require that the [law] be invalidated." *Hospice of Metro Denver, Inc. v. Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752, 754 (10th Cir. 1991)(quoting *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2nd Cir. 1984), cert. denied, 472 U.S. 1008 (1985)). Thus, it is this specific statute that imposes a condition upon health care insurance companies seeking to do business in Tennessee. It makes payment to the

Hospitals understood by implication. An implied payment is part and parcel of the implied-in-law contract claim.

In *De Buono v NYSA-ILA Med & Clinical Servs Fund,* 520 U.S. 806 (1997), Justice Stevens reversed the Second Circuit, stating that the imposition of New York's Health Facility Assessment ("HFA"), a tax on the gross receipts for patients' services, was one of myriad state laws of general applicability that impose some burdens on the administration of ERISA plans, but nevertheless did not relate to them within the statute's meaning. According to Justice Stevens, the HFA's tax was not the type of state law that Congress intended ERISA to supersede. The syllabus to the case crisply sets forth the Court's reasoning, stating that

> [i]n *Travelers,* the Court unequivocally concluded that the "relates to" language was not intended to modify the starting presumption that Congress does not intend to supplant state law. In evaluating whether the normal presumption against pre-emption has been overcome in a particular case, this Court must look to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive... Following that approach, here, the HFA clearly operates in a field that has been traditionally occupied by the States: the regulation of health and safety matters. Nothing in the HFA's operation convinces this Court that it is the type of state law that Congress intended ERISA to supersede. It is one of myriad state laws of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not relate to them within the statute's meaning.

De Buono, 520 U.S. at 807 (internal citations omitted).[17]

Similar to New York's law in *De Buono*, Tenn. Code Ann §56-7-2355(b)(1) regulates

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[16] Benefits under health care plans are not paid by the insurer to the insured, or the employer, but rather, are paid to providers of health care services

[17] In *De Buono*, the Supreme Court discussed the supposed difference between direct and indirect impact, upon which the Second Circuit relied in distinguishing this case from *Travelers* The Court stated that the distinction could not withstand scrutiny. The syllabus to the case explained the Court's reasoning as follows.

> While the Fund has arranged to provide medical benefits for its beneficiaries directly, had it chosen to purchase the services at independently run hospitals, those hospitals would have passed their HFA costs onto the Fund through their rates. Although the tax would be "indirect," its impact on the Fund's decisions would be in all relevant respects identical to the "direct" impact felt here

520 U S at 807

insurance coverage for emergency services, an area that ERISA was not intended to supersede. The economic impact of the statute does not deplete the Network S plan's assets, as BlueCross/BlueShield acknowledges that its plans' coverage for emergency services is the same, whether the enrollee/patient was treated by a provider that was in-network or was out-of-network;[18] the financial impact of the reimbursement was anticipated by BlueCross/BlueShield when it contracted with various Network S employers. Tennessee's statute applies uniformly to all health care plans, does not violate the Congressional intent contained in ERISA and is not preempted by the federal statute.

As to the second question, the basis for reimbursement, and the third question, who shall pay, the patient or BlueCross/ BlueShield, these questions are best answered by statutory construction, the most basic rule of which is

> to ascertain and give effect to the intention and purpose of the legislature. However, the court must ascertain the intent without unduly restricting or expanding the statute's coverage beyond its intended scope. The legislative intent and purpose are to be ascertained primarily from the natural and ordinary meaning of the statutory language, without a forced or subtle interpretation that would limit or extend the statute's application.

Zimmerman v. City of Memphis, 67 S.W.3d 798, 802 (Tenn. Ct. App. 2001)(internal quotations and citations omitted).

Tenn. Code Ann §56-7-2355(b)(1) provides that "[a] health benefit plan shall not deny coverage." Accordingly, under the plain language of the statute, Tennessee has mandated that if a patient has health care coverage and requires emergency services, the insurers who issue the health care plans may not deny coverage to the Hospitals that provided those emergency services, regardless

of any contractual relationship or any pre-approval for emergency services required by the health care plan.

In *West v Shelby County Healthcare Corp.,* W2012-00044-COA-R3-CV, 2013 WL 500777 (Tenn. Ct. App. Feb. 11, 2013) at *12, the appellate court reviewed the obligation of the patient to pay for medical services and held that a hospital ordinarily is entitled to be compensated for its services, by either an express or implied contract, and if no contract exists, there is generally an implied agreement that the patient will pay the reasonable value of the services rendered. The Court further held that as soon as the Memphis hospital began to treat the patient, a debt came into being, i.e., "a specific sum of money became due" by virtue of the medical services rendered. *Id.* The appellate court opined that

> the maxim that services rendered give rise to a debt is as old and universal as the maxim that a lien presupposes a debt. As a general matter, the rule applies with equal force in the medical context.

Id. Hence, the court expressed approval of the concept that health care providers and their patients typically stand in a creditor-debtor relationship. *Id* However, unlike the facts in *Shelby County Healthcare*, Tennessee's CES (Coverage for Emergency Services) statute provides the hospital with a statutorily-created basis for compensation independent of pursuing the patient. Tenn. Code Ann §56-7-2355(b)(1). Nothing in the CES statute requires that the Hospital pursue payment from the patient/enrollee before seeking the benefits from the health benefit plan. If the Legislature had not intended for the insurers to compensate the Hospitals, the language regarding contractual relationship would have been wholly unnecessary. Both the patient/enrollee and the employer are already covered by the contractual terms and conditions of BlueCross/BlueShield's health care plans. The

[18] In the present case, the Hospitals filed documents showing that BlueCross/BlueShield contracted with employers to provide

statutory provision addresses health care providers, that is, the Hospitals. The Legislature's intent was to provide that the insurance benefits would not be denied to the health care providers.

Given the statutory waiver of any advance notice in an emergency situation and given the statutory waiver of any contractual relationship between the health care plan and the Hospital, one may reasonably conclude that the legislature intended to create a contract implied-in-law that BlueCross/BlueShield shall not deny compensation to the Hospitals for rendering emergency medical services to BlueCross/BlueShield's enrollees. Hence, the basis for reimbursement and who shall pay are found within the state statute's wording.

As to the fourth question, the amount of compensation for emergency services is not before the Court at this time. The only question before the Court is whether the Hospitals' claim for reimbursement arising under state law requires the application of the pre-emption doctrine. The Court has already determined that the claim is not pre-empted, but if calculation of the reimbursements relates to the terms of the health care plan, the matter may be pre-empted by federal law. The answer to the fifth question, what obligation, if any, does BlueCross/BlueShield have to make any supplemental reimbursements, necessarily involves the same analysis. BlueCross/BlueShield contends that it has fully paid the providers for any emergency care rendered by the Hospitals. The Hospitals argue that BlueCross/BlueShield failed to pay, underpaid or refused to pay them a reasonable amount for their services, using a variety of reasons to justify its actions. The Hospitals contend that their claims for implied contract/unjust enrichment and declaratory judgment are not based on a breach of any obligations imposed upon BlueCross/BlueShield by its own health care contracts, but rather, based upon the statutory obligation imposed upon the insurer to pay for

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enrollees with the same benefits for emergency services, regardless of whether the provider was in-network or was out-of-network

emergency services. *See Hospice of Metro Denver, Inc. v. Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752, 754 (10th Cir. 1991).

Recovery based on an unjust enrichment claim and recovery based on an implied-in-law contract claim have similar common law foundations.[19] The Hospitals state that they have a claim for unjust enrichment if they show that a benefit was conferred on BlueCross/BlueShield, that BlueCross/BlueShield appreciated the benefit and that it accepted the benefit under circumstances that would make it inequitable for BlueCross/BlueShield to retain the benefits without paying the value for the benefit. *River Park Hospital, Inc v. BlueCross/BlueShield of Tennessee, Inc.*, 173 S.W 3d 43, 58 (Tenn. Ct. App. 2002). The Hospitals assert that they were statutorily compelled to confer a benefit on BlueCross/BlueShield by providing emergency medical services to Network S patients/enrollees. They assert that BlueCross/BlueShield benefited because it was required to provide coverage for such services to those patient/enrollees when it undertook to conduct insurance business in Tennessee, and it received premiums from its members in exchange for making a contractual obligation with them to provide the benefits. If BlueCross/BlueShield is allowed to fulfill its contractual obligations to enrollees without paying the health care provider, argue the Hospitals, it would be unjustly enriched. These parties are similarly situated to the parties in *River Park,* cited above, in which the Tennessee appellate court observed "both parties were required to deal with one another; neither had any choice." *Id.* at 59 In that case, the court held that the hospital which provided emergency services was entitled to a "reasonable rate of reimbursement." *Id.* at 60.

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[19] As noted above, the terms "unjust enrichment" and "contract implied in law" are used virtually interchangeably *River Park Hosp , Inc v BlueCross BlueShield of Tennessee, Inc* , 173 S W 3d 43, 59 (Tenn Ct. App 2002)(citing *Paschall's, Inc v Dozier*, 219 Tenn 45, 407 S W.2d 150, 154 (1966))

BlueCross/Blue Shield argues that there would be no relationship[20] between the Hospitals and BlueCross/BlueShield regarding claims for plan benefits but for the fact that the patient/enrollees were participants in Netwoık S plans, and as such, claims by beneficiaries and their assignees for payment pursuant to such plans are generally preempted by federal law. *Productive MD, LLC v. Aetna Health,* Inc. 857 F. Supp.2d 690, 694 (M.D. Tenn. 2012). In *Productive Life*, the district court stated that

> [t]o further ERISA's purposes, ERISA includes expansive pıeemption provisions that are intended to ensure that employee benefit plan *regulation would be exclusıvely a federal concern*. . . The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme [in § 502] would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Id. (internal citations omitted)(emphasis added). The district court further opined that

> Ultimately, "[i]t is not the label placed on a state law claim that determines whether it is preempted, but whether in essence such a claim is for the recovery of an ERISA plan benefit.

Id.

As set out above, Congress enacted EMTALA many years after ERISA and imposed a federal obligation upon the nation's hospitals and health care providers to render emergency services. Contrary to the language in *Productive MD, LLC*, ERISA did not intend to ensure that regulation of employee benefits plans would be exclusively a federal concern. ERISA specifically left the regulation of insurance companies to the states. 29 U.S.C.A. §1144(b)(2)(A). As explained above, Congress intended that ERISA would preempt state laws that affect eligibility or administrative decisions or that interfered with the natuıe of the plans and the objectives of ERISA. It did not,

[20] As already set forth, coveıage ıs based upon the statute, not upon a contıactual relatıonshıp between the Hospıtals and

however, intend to interfere with any state's regulation of the insurance business. A law that "regulates insurance," so as to escape ERISA preemption under ERISA's savings clause, must be specifically directed at the insurance industry. *Fershtadt v. Verizon Communications Inc.*, 550 F. Supp. 2d 447 (S.D. N.Y. 2008); 5 Law and Prac. of Ins. Coverage Litig. § 57:24

Tennessee's General Assembly enacted a statute aimed specifically at the health care insurance industry, which requires that any health care benefit plan not deny coverage for emergency services regardless of pre-approval or contractual obligations required by a plan. As previously stated, the statute does not address health care plan administration or eligibility.

Implied-In-Law Contract Claim

Whether this lawsuit is pre-empted by ERISA may also depend upon the cause of action asserted. Contracts implied-in-law "are a class of obligations which are imposed or created by law without the assent of the party bound, on the grounds that they are dictated by reason and justice." *Metro Gov't of Nashville & Davidson Cnty. v. Cigna Healthcare of Tennessee, Inc.*, 195 S.W.3d 28, 32-33 (Tenn. Ct. App. 2005)(quoting *Weatherly v. American Agric. Chem. Co.*, 65 S.W.2d 592, 598 (1933)).

> It is well established that want of privity between parties is no obstacle to recovery under quasi contract. The apparent reason is that such contracts are not based upon the intention of the parties but are obligations created by law. They are founded on the principle that a party receiving a benefit desired by him, under circumstances rendering it inequitable to retain it without making compensation, must do so.

Paschall's, Inc. v. Dozier, 407 S.W.2d 150, 154 (1966)(internal citations omitted).

The common law theory of implied-in-law contract provides recovery based upon *quantum meruit*. A party may recover damages in equity if there exists a contract implied-in-law. *See Cigna*

BlueCross/ BlueShield.

Healthcare, 195 S.W.3d at 32 (citing *Paschall's,* 407 S.W.2d at 153). According to BlueCross/BlueShield, to recover under *quantum meruit*, the Hospitals must prove that they provided BlueCross/BlueShield with valuable services. *Forrest Constr. Co , LLC. V. Laughlin*, 337 S.W.3d 211, 227 (Tenn. Ct. App 2009). As noted in *West v. Shelby County Healthcare Corp,* the reasonable value of the services rendered is key to compensation when the agreement is implied. *West*, 2013 WL 500777,*12. Tenn. R. Evid. 701(b) allows a witness to testify to the value of the witness's own property or services *State v Tappan,* W2006-00168-CCA-R3CD, 2007 WL 1556657 (Tenn. Crim. App. May 29, 2007)(citing *Reaves v State,* 523 S.W.2d 218, 220 (Tenn. Crim. App.1975)).

Proper reimbursement does not require interpretation of the health care plans' terms and conditions to determine the amount, although reference to the plan may be an indicator of what BlueCross/BlueShield contemplated would be a fair market or reasonable rate of compensation for emergency services. In this case, all of the BlueCross/BlueShield plans at issue cover services related to emergency medical conditions. Further, in all of its health care plans, BlueCross/ BlueShield allows full-billed charges and pays in-network benefits for all out-of-network "emergency care services."

For the reasons stated previously, the Hospitals' implied-in-law contract cause of action,[21] is not pre-empted by ERISA. To assert their claim for reimbursement, they do not have to refer to the health care plans; they do need to refer to the Tennessee statute to establish the basis for their claim

[21] BlueCross/BlueShield contends that the Hospitals must prove that their services conferred a benefit on BlueCross/BlueShield to be entitled to any recovery Implicit in the statutory language is that the insurer receives the benefit of conducting insurance business in Tennessee and must abide by the condition imposed by the State as a contract term

and refer to the common law to meet their burden of proof as to the value of their services.[22]

Derivative Claim

The Hospitals' derivative claim, however, is based upon the Network S patients/enrollees' assignments of their benefits under the health care plan. The assignments necessitate that the Hospitals abide by the terms and conditions imposed by the health benefit plan upon the enrollee/patient. In order to secure those benefits, the Court would have to refer to the health care plan to enforce its terms and thus, the derivative claim is pre-empted by ERISA. *Productive MD, LLC.*, 857 F. Supp.2d at 694.

Declaratory Judgment

The Hospitals seek a judgment declaring that BlueCross/BlueShield's handling of out-of-network emergency claims is arbitrary and capricious and in contravention of its policies and procedures, its plan documents and ERISA regulations. They contend that ERISA regulations set forth reasonable claims procedures that every plan must follow, including the manner and content of notification of benefit determination (29 C.F.R. §2560.503-1(g)) and for responding to appeals. (29 C.F.R. §2560.503-1(h)). According to the Hospitals, the undisputed facts show that the notices of adverse benefit determination and denial letters for the claims at issue do not provide the information required by ERISA regulations. In addition, the Hospitals ask that the Court declare whether they are entitled to receive full-billed charges. They contend that the Tennessee Declaratory Judgment Act grants courts the power to declare rights, status, and other legal relations, as well as the power to

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[22] Under a provision of a California statute requiring health care service plans to reimburse non-contracting providers for emergency medical services, and under the State's regulations, emergency room physicians who did not participate in a health care service plan had standing to bring an action against the plan, under unfair competition law (UCL) and common law quantum meruit, for the plan's reimbursements that were allegedly below cost and the value of providers' service *Bell v Blue Cross of California*, 131 Cal App 4th 211(2005)

construe or determine the validity of any written instrument, statute, ordinance, contract, or franchise, provided that the case is within the court's jurisdiction. Tenn. Code Ann. §29-14-103. They argue that the court has jurisdiction over the state claims pursuant to a number of statutes: Tenn. Code Ann. §§ 16-11-102, 16-11-103, 20-2-222 and 20-2-223. Finally, the Hospitals submit that the court has concurrent jurisdiction under 29 U.S.C. §1132(e)(1) which states that

> [s]tate courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

29 U.S.C.A. § 1132(e)(1).

The reference to paragraph (a)(1)(B) declares

> (a) Persons empowered to bring a civil action
>
> A civil action may be brought—
>
> (1) by a participant or beneficiary
>
> (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;

29 U.S.C.A. § 1132(a)(1)(B).

The Hospitals contend that these statutory provisions allow the Court to grant them the declaratory judgment relief they seek. This Court respectfully disagrees.

BlueCross/BlueShield correctly argues that under their health care plans, the Hospitals are neither participants nor beneficiaries[23] and accordingly have no independent standing to pursue a

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[23] This court is not unmindful that the state statute implies that the Hospitals may be third-party beneficiaries of its wording, but disagrees with the analysis of BlueCross/BlueShield as to the statute's intent As stated previously, if the Legislature had not intended for the Hospitals to be compensated, the language regarding contractual relationship would have been wholly unnecessary Both the patient/enrollee and the employer are covered by the contractual terms and conditions of BlueCross/BlueShield's health care plans The statutory provision states that "A health benefit plan shall not deny coverage for emergency services. . regardless of whether or not the provider furnishing the services has a contractual agreement with the health benefit plan for the provision of the services to the

cause of action under 29 U.S.C. §1132(a). If the Hospitals pursue their claim based upon the assignment of benefits from patient/enrollees, they would have to pursue the claims appeal procedure and the internal dispute resolution procedure for participants whose claims are disputed. *Productive MD,* 857 F.Supp.2d at 696; *see also Weiner v Klais and Co, Inc* 108 F.3d 86, 90 (6th Cir. 1997)(citing 29 U.S.C. § 1133(2)). It is the assignment that triggers the Hospitals' standing under 29 U.S.C. §1132(a); the Hospitals have no independent status that empowers them to bring a derivative action. *See Hermann Hosp v. MEBA Med & Benefits Plan,* 845 F.2d 1286 (5th Cir. 1988) *overruled on other grounds by Access Mediquip, L L.C. v UnitedHealthcare Ins.* Co., 698 F.3d 229 (5th Cir. 2012); *see also Cagle v Bruner*, 112 F.3d 1510, 1515 (11th Cir. 1997). Accordingly, the Hospitals have no standing under 29 U.S.C.§1132(a)(1)(B) to pursue claims assigned by the patients/enrollees. *Select Specialty Hosp. v Nat'l City Bank Health & Welfare Plan,* 1:07-CV-349, 2008 WL 268901, at *3 (W.D. Mich. Jan. 25, 2008).

BlueCross/BlueShield also makes a compelling and succinct argument that the Hospitals' allegations of purported technical violations of ERISA regulations regarding notices, claims, and appeals for purposes of their motion for partial summary judgment are inapposite to the Hospitals' position that ERISA does not pre-empt their claims. The sword cuts both ways. If the Hospitals contend that BlueCross/BlueShield's plans violate ERISA regulations, then ERISA pre-empts any cause of action that may arise by virtue of that violation. ERISA requires that such a violation, if any, be resolved in federal court. Accordingly, the Hospitals' motion for partial summary judgment seeking a declaratory judgment regarding BlueCross/BlueShield's violation of ERISA regulations is

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enrollee " The Legislature's intent was to provide that the insurance benefits would not be denied to the health care providers

not well taken and is denied.[24]

To the extent that the Hospitals seek full-billed charges, the Court has concluded that while the derivative claim based upon enrollees' assignments is subject to ERISA pre-emption, the Hospitals are entitled to seek compensation for the reasonable value of their services based upon the implied-in-law contract claim, an action not pre-empted by ERISA. However, the reasonable value of their services requires a factual determination in keeping with common law principles and will be addressed at an appropriate time.

Conclusion

The Court concludes that as a matter of law, partial summary judgment on some of the parties' requests is appropriate, and on others, inappropriate. BlueCross/BlueShield is granted partial summary judgment dismissing the Hospitals' derivative claims based upon the assignments of patient/enrollees' rights to benefits because that cause of action is pre-empted by ERISA.

However, to the extent that BlueCross/BlueShield seeks partial summary judgment dismissing the Hospitals' claim based upon implied-in-law contract, that cause of action is not pre-empted by ERISA for the reasons stated above and partial summary judgment is denied in that regard.

BlueCross/BlueShield is granted partial summary judgment as to the Hospitals' claim for declaratory judgment because the Hospitals lack standing to assert a claim under 29 U.S.C. §1132, *et seq* as explained herein.

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[24] BlueCross/BlueShield is correct that the Hospitals always bear the burden of proving entitlement to benefits under an ERISA plan *Reid v Metropolitan Life Ins Co*, 944 F Supp 2d 1279, 1304 (N D Ga 2013) As set out above, to the extent that the Hospitals claim entitlement based on a derivative claim, that claim is pre-empted by ERISA and the requisite proof of entitlement would be presented in federal court However, to the extent that the Hospitals claim entitlement based on an implied-in-law contract, while the burden of proof to entitlement remains on the Hospital, the claim is statutory and not based on an ERISA plan The Hospitals have no duty to exhaust an ERISA plan's administrative remedies if they are not proceeding under the ERISA plan, instead, their claim is

BlueCross/BlueShield is denied partial summary judgment based on the Hospitals' alleged failure to exhaust mandatory administrative remedies under the ERISA plans. While this Court agrees that any decisions regarding ERISA benefit claims, assignments, appeals procedures, flawed or otherwise, are pre-empted by ERISA and should be resolved in federal court, that is not the situation presented to the Court. The Hospitals' claim based upon an implied-in-law contract does not require reference to BlueCross/BlueShield's procedures for administrative appeals, assignments or benefit claims and is not pre-empted by ERISA. Partial summary judgment on this is, therefore, inappropriate.

BlueCross/BlueShield is denied partial summary judgment on its assertion that all claims for which the Hospitals received any payment from them on or before November 30, 2008 are time-barred under Tenn. Code Ann. §56-7-100(b). In analyzing the issues, the court focused on the ERISA pre-emption doctrine and concluded that this argument is unrelated to ERISA. However, these claims involve material facts which, when combined with the controlling law, preclude summary judgment.

BlueCross/BlueShield is denied partial summary judgment regarding the Hospitals' claim for quantum-meruit to the extent that it applies to the Hospitals' implied-in-law contract claim; to the extent that the claim for quantum-meruit applies to the Hospitals' derivative claims, partial summary judgment is granted, the derivative claim being preempted by ERISA.

BlueCross/BlueShield is denied partial summary judgment regarding all but 24 of the 564 "non-ERISA" claims [claims relating to employee-sponsored health plans not governed by ERISA because they are church-related or governmental] as the Hospitals' claim of implied-in-law contract

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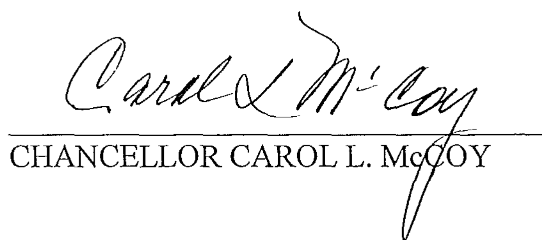
based in statute and their recovery is based upon common law theories of quantum meruit/unjust enrichment

does not require compliance with any mandatory pre-litigation grievance processes set for in any plan. BlueCross/BlueShield's request for partial summary judgment regarding the overall claims population necessitates resolution of material fact disputes and is denied.

The Court concludes that the Hospitals' action for breach of an implied-in-law contract with BlueCross/BlueShield is not pre-empted by ERISA. Under common law theories and the state statute, the Hospitals are entitled to recover from BlueCross/BlueShield the reasonable value of the emergency services rendered to BlueCross/BlueShield's patients/enrollees in Network S. The emergency services provided, the amount of compensation that is reasonable and the amount already reimbursed involve disputed material fact and necessitate a full hearing.

The Hospitals are denied partial summary judgment seeking a declaratory judgment that they are deemed to have exhausted all administrative remedies available and that BlueCross/BlueShield's Network S appeal process is unreasonable, arbitrary or capricious. Resolution of this issue requires reference to BlueCross/BlueShield's ERISA plans and is preempted by federal law.

All other matters raised by either party seeking partial summary judgment are respectfully denied. IT IS SO ORDERED.



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