

SELF-FUNDED HEALTH PLAN LOOKS TO HOSPITAL FOR REIMBURSEMENT OF MILLION-DOLLAR ERROR

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An employee health plan paid \$1,500,000 for care provided to a newborn child who was never a plan participant and was never eligible for coverage. The 7th Circuit Court of Appeals determined that the plan could not seek repayment from the treating facilities under the Employee Retirement Income Security Act ("ERISA"). However, the Court of Appeals also ruled that the plan's breach-of-contract claim against the hospital and doctors can still be pursued under state law.

The Story

Scott Gurzynski was an employee of Kolbe & Kolbe Millwork Company, Of Wausau, Wisconsin. Kolbe offered health insurance through a self-funded plan (the "Plan"). In August of 2007, Scott applied to add his newborn child, K.G., to the Plan's coverage. Kolbe's Plan administrators made numerous efforts to contact Scott to obtain required information to help the Plan determine whether K.G. could be covered. Scott never supplied the required information. Scott finally informed Kolbe, in November, that K.G. did not live with Scott; she lived with her mother. Further, Scott stated that he was not claiming his daughter as a tax dependent. Therefore, K.G. was not eligible for coverage. However, Kolbe continued to ask Scott for further information so that it could determine whether K.G. was eligible for coverage.

With the coverage issue not yet resolved, K.G. received treatment at Children's Hospital of Wisconsin, from doctors at the Medical College of Wisconsin. During the course of at least 4 separate treatments, the Medical College costs totaled \$472,357.84, and the bill from Children's Hospital came to another \$1,199,538.58. The Kolbe Plan paid the invoices from the Medical College and Children's Hospital when submitted.

Ten months after the original coverage application, Kolbe issued a notice to Scott that coverage for K.G. was denied. Scott responded in a letter

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stating “I intend to contest that denial.” However, Scott never filed an appeal.

As part of the Plan’s operation, the Medical College and Children’s Hospital entered into service agreements with third-party network providers, who in turn arranged with the Kolbe Plan for the entities to provide “Covered Services” to Plan participants. These “Covered Services” were defined under the agreements as those medical services covered under the Plan, subject to any limitations on such coverage under the Plan.

Each time K.G. entered the hospital, Scott signed a financial agreement to assign all insurance benefits “to which the patient is entitled” to Children’s Hospital and to acknowledge that he was financially responsible to Children’s Hospital for noncovered charges.

The Kolbe Plan contained a “right to request overpayment” for Plan payments that were made in error or made to any “Covered Person or any party on a Covered Person’s behalf” where the amount is over the amount payable under the Plan’s terms. Finally, the Plan stated that it had the right to recover against “Covered Persons if the Plan has paid them or any other party on their behalf.”

Once it was determined that K.G was not covered under the Plan, Kolbe requested that Children’s Hospital and the Medical College return all payments. Both refused. The Plan sued both organizations in Federal District Court in Wisconsin under ERISA, to recover \$472,357.84 paid to the Medical college and \$1,199,538.58 paid to Children’s Hospital on behalf of K.G.

The 2009 District Court Decision

In Kolbe & Kolbe Health & Welfare Benefit Plan v. Medical College of Wisconsin, Inc., et al, 2009 U.S. Dist. Lexis 93067 (W.D. Wis. Oct. 6, 2009), the District Court dismissed Kolbe’s suit. First, the District Court ruled that Kolbe was asking for monetary compensation to the Plan; this remedy is not available under ERISA. As part of this determination, the District Court also noted that the Plan’s relationship under ERISA was between the Plan and Scott Gurzynski, not between the Plan and either treatment provider. Second, the District Court ruled that the Plan could not alternatively work around ERISA and sue under federal law for “restitution” -- to be restored to its original financial position -- outside of ERISA.

The District Court also decided that the Plan could not bring a state common law breach of contract action against Children’s and the Medical College (again, outside of ERISA), holding that as the contract question related to the ERISA Plan, ERISA trumped state law. Kolbe appealed the District Court decision.

The 2011 Court of Appeals Decision

In Kolbe & Kolbe Health & Welfare Benefit Plan v. Medical College of Wisconsin, Inc., et al, No. 09-CV-205, September 2, 2011¹, the 7th Circuit Court of Appeals first addressed the District Court's dismissal of the ERISA claim, and agreed that the Plan could not recover from the treating organizations, but for a different reason. As the Court of Appeals stated, the Plan "pled its [ERISA] claim out of court" and could not be repaid for K.G.'s care since K.G. was never in the Plan and so was not a "Covered Person." Second, the Court of Appeals also agreed that the Plan's claim for restitution outside of ERISA failed, for the same reason: there was no error payment on account of a "Covered Person" under the Plan: K.G. was not in the Plan.

However, the Court of Appeals reversed the District Court on the third issue, permitting the Plan to pursue its state law claims. The Court of Appeals reasoned that since K.G. was never enrolled in the ERISA plan, ERISA does not preempt the state law cause of action for breach of contract. The Court of Appeals commented at the end of its opinion that the state law claim will likely be heard in the appropriate state court, not federal court, since the ERISA claims that brought this matter to federal court have now been dismissed.

Pursuing the State Law Claims

The resolution of the contract claim will lie in the interpretation of the service agreements among the parties. Kolbe will argue again that Children's and the Medical College violated their service agreements by providing services to non-participants and then receiving payment from the Plan anyway; as a result, Kolbe will argue that it should be reimbursed for the payments it made.

The providers will likely point out that Kolbe had more than one opportunity to straighten this out before all of the \$1,500,000 was paid. Is it too late for the Plan to now say that there was a breach, since for ten months the Plan acted as if it agreed with the providers' actions? Children's Hospital and the Medical College prevailed on the federal ERISA claims because their services were not provided to a plan participant. The providers will need to exercise caution as the breach-of-contract matter unfolds, however, to avoid having the same reasoning turn against them in state court.

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¹For the full opinion, please see <http://law.justia.com/cases/federal/appellate-courts/ca7/10-2284/10-2284-2011-09-02-opinion-2011-09-02.html>.