

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

JONATHAN WIRTH, individually : CIVIL ACTION
and on behalf of all others :
similarly situated :
 :
 :
v. :
 :
 :
AETNA U.S. HEALTHCARE : NO. 03-5406

MEMORANDUM

Bartle, J. February , 2004

The issue presented concerns the propriety of the defendant's removal to this court of an action alleging illegal practices under Pennsylvania's Motor Vehicle Financial Responsibility Law ("MVFRL") where defendant relies on the doctrine of complete preemption under the Employee Retirement Income Security Act ("ERISA") as the basis for removal.

I.

Plaintiff Jonathan Wirth, a citizen of Pennsylvania, originally brought this purported class action against Aetna U.S. Healthcare ("Aetna") in the Court of Common Pleas of Bucks County. Aetna, whose correct legal name is Aetna Health, Inc., is a health maintenance organization and a Pennsylvania corporation. At all times relevant to this case, Wirth was covered by a healthcare agreement issued by Aetna to his father's employer. He claims that he and his fellow class members have suffered personal injuries in motor vehicle accidents that took place in the Commonwealth and have obtained, or are in the

process of obtaining, recoveries against third party tortfeasors. According to Wirth, Aetna has asserted liens against these tort recoveries for the medical benefits it has provided and is doing so pursuant to the indemnification and subrogation clauses in its healthcare agreements.¹ Plaintiff asserts that the liens are prohibited by § 1720 of Pennsylvania's MVFRL, a statute which among other things governs the insurance requirements for motor vehicle owners in the Commonwealth. Section 1720 reads as follows:

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits paid or payable by a program, group contract or other arrangement whether primary

1. Wirth's Class Action Complaint filed in state court describes the class as follows:

All persons insured under an Aetna healthcare Policy, who were involved in a motor vehicle accident in the Commonwealth of Pennsylvania, and Aetna asserted a Lien during the Class Period against the insured's tort recovery.

The Class Period begins four (4) years prior to the filing of this action and continues to the date of judgment unless extended or reduced by the Court.

Excluded from the Class are Aetna's employees, its officers and directors, plaintiff's counsel and the Judge of the Court to which this case is assigned.

Compl. at 4.

or excess under section 1719 (relating to coordination of benefits).

75 Pa. Cons. Stat. Ann. § 1720. In addition to seeking damages under § 1720 of the MVFRL, plaintiff asserts claims on behalf of the class for breach of contract, unjust enrichment, and bad faith insurance practices under 42 Pa. Cons. Stat. Ann. § 8371. The plaintiff also requests declaratory and injunctive relief. The complaint on its face does not plead a federal claim for relief.

Aetna timely removed the action to this court, pursuant to 28 U.S.C. § 1441(a), on the ground that the plaintiff's claims are completely preempted by ERISA, 29 U.S.C. §§ 1001 et seq. Plaintiff has now moved to remand and seeks attorney's fees and costs pursuant to 28 U.S.C. § 1447(c). Aetna, as the removing party, bears the burden of proving subject matter jurisdiction. Dukes v. U.S. Healthcare, 57 F.3d 350, 359 (3d Cir. 1995).

II.

Section 502(a)(1)(B) of ERISA states that "[a] civil action may be brought by a participant or beneficiary ... to recover benefits due 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. § 1132(a)(1)(B). A "plan" under ERISA includes an "employee benefit plan," that is, one "... established or maintained by an employer ... for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or

otherwise ... medical, surgical, in hospital care or benefits
...." 29 U.S.C. § 1002(1) and (3).

ERISA contains sections that deal expressly with
preemption. These provisions are known as the "preemption
clause," the "savings clause," and the "deemer clause." The
"preemption clause" provides:

Except as provided in subsection (b) of this
section [the saving clause], 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 ...

ERISA § 514(a), as set forth in 29 U.S.C. § 1144(a). The
"savings clause" reads:

Except as provided in subparagraph (B) [the
deemer clause], 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.

ERISA § 514(b)(2)(A), as set forth in 29 U.S.C. § 1144(b)(2)(A).

Finally, there is the "deemer clause":

Neither an employee benefit plan ... nor any
trust established under such a plan, shall be
deemed to be an insurance company or other
insurer, bank, trust company, or investment
company or to be engaged in the business of
insurance or banking for the purposes of any
law of any State purporting to regulate
insurance companies, insurance contracts,
banks, trust companies, or investment
companies.

ERISA § 514(b)(2)(B), as set forth in 29 U.S.C. § 1144(b)(2)(B).

As the Supreme Court has observed, these three clauses
"are not a model of legislative drafting," but "[t]heir operation
is nevertheless discernible." FMC Corp. v. Holliday, 498 U.S.

52, 58 (1990). In FMC, the Supreme Court described the interaction of these various clauses as follows:

The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA. The savings clause returns to the States the power to enforce those state laws that "regulate insurance," except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws "purporting to regulate" insurance companies or insurance contracts.

Id. It is against this statutory background that we must decide the issue of removal.

As we have noted, the complaint alleges exclusively state law causes of action. Under the well-pleaded complaint rule, an action may be removed to this court based on federal question jurisdiction only if the federal claim appears on the face of the complaint. The fact that the defendant may have a defense under federal law is ordinarily not sufficient to allow removal. See Franchise Tax Bd. v. Constr. Laborers Vacation Trust, 463 U.S. 1, 10 (1983); Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266, 271 (3d Cir. 2001). However, the complete preemption doctrine is an exception to the well-pleaded complaint rule. Ry. Labor Executives Ass'n v. Pittsburgh & Lake Erie R.R. Co., 858 F.2d 936, 939 (3d Cir. 1998). Complete preemption exists when Congress has so thoroughly addressed an area of law that any claim brought within its scope is removable to the

federal court. Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 63-64 (1987). A claim that has been completely preempted is removable regardless of whether a federal claim appears from a reading of the complaint. Id. The Supreme Court has determined that claims falling within the scope of § 502(a)(1)(B) of ERISA are subject to complete preemption. Metro. Life, 481 U.S. at 66; Pryzbowski, 245 F.3d at 271.

In arguing that removal was improper, plaintiff suggests that his claim under § 1720 of the MVFRL is not within the terms of § 502(a)(1)(B) because it is not actually one for "benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). Plaintiff reasons that his claim directly relates to the amount of his tort recovery and is only "distantly related" to the health care benefits previously granted by Aetna. We disagree.

While plaintiff may be correct that his claims arose as a result of his tort recovery, there is an inextricable connection between Aetna's lien and the amount he is due under his healthcare agreement. The lien, if collected, not only reduces the net amount of his recovery from the tortfeasor but also has the effect of reducing the net amount of the benefit obtained from Aetna under the healthcare agreement.² We conclude

2. Jonathan Wirth's healthcare agreement with Aetna provides in relevant part:

If HMO provides health care benefits under this Certificate to a Member for injuries or
(continued...)

that plaintiff's claims directly relate to the net amount of the benefits due to him under his Aetna healthcare agreement. Consequently, they fall within § 502(a)(1)(B) of ERISA and are completely preempted. See Singh v. Prudential Health Care Plan, 335 F.3d 278, 291 (4th Cir. 2003).

In Pryzbowski, 245 F.3d at 273, our Court of Appeals described the test for complete preemption by ERISA:

2.(...continued)

illness for which a third party is or may be responsible, then HMO retains the right to repayment of the full cost of all benefits provided by HMO on behalf of the Member that are associated with the injury or illness

....

The Member specifically acknowledges HMO's right of subrogation. When HMO provides health care benefits for injuries or illnesses for which a third party is or may be responsible, HMO shall be subrogated to the Member's rights of recovery against any third party to the extent of the full cost of all benefits provided by HMO, to the fullest extent permitted by law....

The Member also specifically acknowledges HMO's right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when HMO has provided health care benefits for injuries or illness for which a third party is [sic] and the Member and/or the Member's representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this Certificate, HMO is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Member to the extent of the full cost of all benefits provided by HMO.

(bolding omitted; underlining added for emphasis).

Regardless of the language used, the ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action.

Here the claims are more nearly akin to administration of or eligibility for benefits than to the quality of health care.

Our determination that plaintiff's claim is one for benefits is consistent with other federal courts confronted with the same issue. For example, in a case similar to the one at bar, the Court of Appeals for the Fourth Circuit recently held that:

[Plaintiff's] claim to recover the portion of her benefit that was diminished by her payment to Prudential under the unlawful subrogation term of the plan is no less a claim for recovery of a plan benefit under [ERISA] § 502(a) than if she were seeking recovery of a plan benefit that was denied in the first instance ERISA's complete dominion over a plan participant's claim to recover a benefit due under a lawful application of plan terms is not affected by the fortuity of *when* a plan term was misapplied to diminish the benefit.

Singh, 335 F.3d at 291 (emphasis in original). See also Arana v. Ochsner Health Plan, 338 F.3d 433, 438 (5th Cir. 2003)(en banc); Carducci v. Aetna U.S. Healthcare, 204 F. Supp. 2d 796 (D.N.J. 2002); Franks v. Prudential Health Care Plan, Inc., 164 F. Supp. 2d 865, 873 (W.D. Tex. 2001); Riemer v. Columbia Medical Plan, Inc., No. Civ. L-96-2544, 1997 WL 33126252, at *1 (D. Md. Mar. 28, 1997).

In sum, plaintiff is seeking benefits from a plan enforceable under § 502(a)(1)(B) of ERISA.

III.

Plaintiff further argues that the savings clause of § 514(b)(2)(A) of ERISA trumps complete preemption and thus requires remand, even assuming that his claims are or would otherwise be encompassed by § 502(a)(1)(B). As noted above, § 514(b)(2)(A) provides that "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." The Supreme Court has held that § 1720 of the MVFRL falls within the terms of § 514(b)(2)(A), since it "regulates insurance" for motor vehicle owners in Pennsylvania. FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990). Aetna, however, contends that even if the plaintiff's state law claims are preserved by § 514(b)(2)(A), this does not defeat complete preemption. According to Aetna, once complete preemption is demonstrated, the action is removable. Under this analysis, the federal court will retain jurisdiction and apply state law if the circumstances outlined in the savings clause of § 514(b)(2)(A) are satisfied. See Lazorko v. Pennsylvania Hosp., 237 F.3d 242, 248 (3d Cir. 2000).

The Court of Appeals for this circuit has not had the occasion directly to address the issue before us. However, two very recent Supreme Court decisions support the principle that § 514(b)(2)(A) does not override complete preemption under § 502(a)(1)(B). In a 1999 ruling, the Court affirmed the

determination of the Court of Appeals that a California state law regulated insurance and therefore fell under ERISA's savings clause. Nonetheless, it did not question federal subject matter jurisdiction over the claim. UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358, 365-77 (1999). Likewise, more recently, the Supreme Court determined that the Illinois HMO Act regulated insurance but affirmed the decision of the Court of Appeals below which had exercised subject matter jurisdiction pursuant to § 502(a)(1)(B) of ERISA. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 363-87 (2002). See Arana v. Ochsner Health Plan, 338 F.3d 433, 439-40 (5th Cir. 2003); Carducci, supra, 204 F. Supp. 2d at 798 n.2. Thus, federal jurisdiction exists as a result of complete preemption if plaintiff's claims are encompassed within the terms of § 502(a)(1)(B) even though it may turn out that the savings clause of § 514(b)(2)(A) will require the application of state insurance law.

IV.

In summary, we hold that the defendant's removal of this purported class action to federal court was proper. The gravamen of plaintiff's complaint seeks "to recover benefits due ... under the terms of his plan." ERISA § 502(a)(1)(B). This claim and the others dependent on it are completely preempted by ERISA and we have subject matter jurisdiction over them. That we may ultimately apply § 1720 of Pennsylvania's MVFRL because of the savings clause of § 514(b)(2)(A) of ERISA does not affect our jurisdiction.

The motion of the plaintiff to remand this action to the Court of Common Pleas of Bucks County and his motion for attorney's fees and costs will be denied.

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ORDER

AND NOW, this day of February, 2004, for the reasons set forth in the accompanying Memorandum, it is hereby ORDERED that motion of plaintiff Jonathan Wirth for remand to the Court of Common Pleas of Bucks County, Pennsylvania and for attorney's fees and costs is DENIED.

BY THE COURT:

J.