



THE EROSION OF THE ERISA DEFENSE

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Paper presented at a WSTLA seminar

As the public has become increasingly concerned over the cost containment practices of managed care entities, such entities have become more vulnerable to liability. The scope of their immunity under ERISA has been more narrowly defined by the courts, and there is now pending legislation sponsored by both Democrats and Republicans in Congress to limit what protections managed care entities still have relating to health care decisions under ERISA, and even to transform the “ERISA defense” into the “ERISA cause of action”. The purpose of this paper is to give you some information as to how ERISA may relate to claims brought against managed care entities (what may be preempted and what may not be), and to give you some information as to how that law may be changing both by way of court decision and possible new federal statutory law.

Whether a claimant has been successful in an action against a managed care entity for tortious conduct has depended in part upon the nature of the claimant’s health care plan. Managed care entities, contracting with employee benefit plans to administer health care, have been successful to varying degrees, depending upon the jurisdiction, in avoiding liability for violations of state statutory and common law. In many of

those cases, courts have held that state law is preempted by the federal law, commonly referred to as ERISA, even though that law was not designed to provide an alternative code for compensating injured persons for such tortious conduct.

ERISA is the federal Employee Retirement Income Security Act of 1974, 29 U. S. C. s.1001 *et seq.* It comprehensively regulates the administration of employee pension and welfare plans which provide employee “medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident disability [or] death.” It does not regulate the substantive content of such plans. It does, however, contain a broad pre-emption provision declaring that the statute shall “supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan”. s.514(a) On the other hand, it contains an “insurance savings clause” at s 514 (b)(2)(A) which, with one exception, provides that nothing in ERISA “shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.” The one exception to the insurance savings clause is if the employer self insures.

A self insured employer may contract with a managed care entity to serve as its agent to administer its plan so long as the risk of loss is on the employer rather than on the insurance

company, and avoid regulation by state insurance laws. Managed care entities contracting with self insured employers under ERISA plans have consequently been able to avoid, to varying extents, liability under state law and state insurance regulations, by contending that they are just agents of the employer and protected under the ERISA preemption.

There are hundreds of court decisions, many of which are inconsistent, interpreting the scope of the ERISA pre-emption. Nevertheless, one can draw some generalities as to the types of claims against managed care entities serving as agents of employee pension and welfare plans which courts have usually found to be pre-empted by ERISA, and those which are usually found to avoid preemption.

The broad preemption language in ERISA has been successfully used by managed care entities to defend claims based upon laws which regulate the type of benefits or terms of the plan; which create reporting, disclosure, funding or vesting requirements; which provide rules for the calculation of the amount of benefits to be paid under the plan; and which provide remedies for misconduct growing out of the administration of the plan itself. National Elev. Indus., Inc v. Calhoun, 957 F.2d 1555 (10th Cir.), cert denied, 506 U.S. 953, 113 S.Ct. 406, 121 L.Ed 2d 331 (1992).

In this regard, claims for breach of contract, and liability for the managed care entity refusing to pay for certain equipment under the benefits plan have been deemed pre-empted by ERISA. Elsesser v. Hospital of Philadelphia College, 802 F.Supp. 1286 (E.D. Pa. 1992).

Also deemed pre-empted have been claims against managed care entities for denying certain benefits to participants. See, e.g. Corcoran v. United HealthCare, Inc., 965 F.2d 1321 (5th Cir. 1992); Kuhl v. Lincoln Health Plan of Kansas, 999 F.2d 298 (8th Cir. 1993).

When states adopted laws to protect against so-called drive-through deliveries, by requiring managed care entities to pay for specified minimum hospital stays for mothers and their newborns, those protections initially only extended to women who were not covered by an ERISA plan by reason of the pre-emption. Complaints over such uneven application led Congress to amend ERISA to require that all ERISA health plans offering child-birth benefits pay for hospital stays of at least 48 hours after a normal vaginal delivery and 96 hours after a cesarean section. (Newborns' and Mothers' Protection Act of 1996, Public law 104-204, September 26, 1996) While that legislation helped provide uniform protection to mothers of newborns, it underscored the preemptive application of ERISA as it applies to the provision of benefits.

In Dearmas v. Av-Med, Inc., 865 F. Supp. 816 (S.D. Fla. 1994), the Court held that a claim that the managed care entity's patient care coordinator acted negligently in evaluating a patient's condition and in requiring, approving and/or arranging transfer of the patient

to several hospitals "related to" administration of the ERISA plan and was thus pre-empted by ERISA.

Whether a decision by a managed care entity to limit the choice of hospitals to which a patient may be transferred is deemed to be an administrative decision or a medical decision may depend upon the facts of the particular case. The issue is presently before the Pennsylvania Supreme Court in the case of Pappas v. Asbel, 450 Pa.Super. 162, 675 A.2d 711 (1996).

In May, 1991, Mr. Pappas reported neck and shoulder pain in the office of his doctor and was given an intramuscular pain killer. The next morning, he could not walk and was taken to a small local hospital. The ER physician determined that he had an epidural abscess impinging on his spinal cord, an emergency condition. The ER physician called a nearby hospital which was better equipped to handle such an emergency, but found out that the hospital did not participate with the patient's ERISA plan administrator, U.S. Healthcare (USHC). The ER physician then contacted USHC for authorization. After some time, USHC responded that it would not approve that hospital, but would approve three other hospital choices. The ER physician then contacted the alternate choices and finally got one to accept Mr. Pappas.

By the time Mr. Pappas was treated at that hospital, he had become a quadriplegic. Mr. Pappas sued his treating doctor and the small local hospital. Those defendants filed third-party claims against USHC, alleging that part of the delay was due to USHC's

"negligent" refusal to approve transfer to the first hospital since this was an emergency. The trial court dismissed the third-party claims on the ground that USHC's decision was a benefit administration decision governed by ERISA. The treating doctor and the first hospital settled with Pappas, and those defendants and their insurers then appealed the summary judgment for USHC to recover part of their costs. The intermediate appellate court reversed, and the case is now on appeal to the Pennsylvania Supreme Court.

The American Medical Association, the Pennsylvania Medical Society, and the Pennsylvania Trial Lawyers Association filed amicus briefs for the insurers against USHC. In its brief, the AMA contended that the insurers could

"argue to a jury that USHC failed to have in place the appropriate policies and protocols which either deferred to the emergency physician's clinical judgment or provided for the care of patients in emergency circumstances by non-participating health care facilities. USHC's failure constitutes negligence for which USHC must be held accountable to both the patient and the health care providers. Otherwise, ... USHC will continue to base its decisions solely on cost containment, diminishing the quality of care made available to the public with immunity from any liability for the injuries which result."

Even though claims relating to the administration of the plan are ordinarily pre-empted by ERISA, a claim may be brought under ERISA in Federal Court for breach of fiduciary duty. Although decisions have varied depending upon the jurisdiction, in one favorable case,

Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997), the Court of Appeals held that a widow had standing in Federal Court to sue a managed care entity, which had contracted to provide health care benefits for employees of her deceased husband's employer, on the grounds that the defendant had breached its fiduciary duty by failing to disclose a financial incentive scheme put in place to influence a treating doctor's referral practices when a patient needed specialized care.

Mr. Shea had been hospitalized overseas for severe chest pains, had an extensive family history of heart disease, and complained to his family doctor of chest pains, shortness of breath, muscle tingling and dizziness. Despite all the warning signs, his doctor said a referral to a cardiologist was unnecessary. Under the terms of the policy, Mr Shea could see a specialist only after getting a written referral from his primary care physician. What Mr. Shea was not told was that his primary care doctor was rewarded by the managed care entity for not making covered referrals to specialists, and that the doctor was docked a portion of his fees if he made too many referrals. A few months later, Mr. Shea died of heart failure.

The Court quoting from Eddy v. Colonial Life Ins. Co. of Am., 919 F.2d 747,750(D.C.Cir.1990), stated that: "The duty to disclose material information is the core of a fiduciary's responsibility, animating the common law of trusts long before the enactment of ERISA." The Court went on to say that "This kind of patient necessarily relies on the doctor's advice about treatment options, and the patient must know whether the advice is influenced by self serving

financial considerations created by the health insurance provider. ... Indeed, in this case the danger to the plan participant's well being was created by the fiduciary itself. If Mr. Shea had been aware of his doctor's financial stakes, he could have made a fully informed decision about whether to trust his doctor's recommendation that a cardiologist's examination was unnecessary."

Claims based upon benefits administration by the managed care entity may also be brought under Section 502 of ERISA. Such claims, however, are limited to the cost of the benefit denied and plaintiff must demonstrate that the managed care entity acted in an arbitrary and capricious manner in limiting benefits in order to recover. See Firestone Tire & Rubber Co. v. Burch, 489 U.S. 101, 109-115 (1989). The United States Court for the Eastern District of Pennsylvania recently addressed ERISA preemption as it relates to the denial of benefits by a managed care entity in the case of Thomas-Wilson v. Keystone Health Plan East HMO, 1997 WL 27097 (J. McGlynn, Jan. 23, 1997). The court dismissed the plaintiff's state law claims for breach of contract, torts and punitive damages, holding that "Because the civil enforcement provision of ERISA Section 502(a) provides the exclusive remedy under which a party entitled to invoke ERISA may recover benefits, the state law causes of action, which include contract and tort claims, are pre-empted by ERISA."

The ERISA pre-emption has generally not been extended to claims concerned solely with the quality of the benefits provided, or of medical

negligence against a managed care entity for substandard care, particularly where such claims are based upon a theory of vicarious liability for the acts of physicians acting as ostensible agents of the managed care entity. Elsesser, Id; Chaghervand v. Healthcare Corporation of the Mid-Atlantic, Inc., , 909 F. Supp. 304 (D.Md. 1995); Pacificare of Oklahoma, Inc v. Burrage, 59 F.3d 151 (10th Cir. 1995); Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995); Prihoda v. Shpritz, 914 F.Supp. 113, 118 (D. Maryland 1996); Haas v. Group Health Plan, Inc., 875 F. Supp. 544 (S.D. Ill. 1994). Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995) cert denied, U.S. , 116 S.Ct. 564, 133 L.Ed 2d 489 (1995). (But see Nealy v. U.S. Healthcare HMO, 844 F. Supp. 966 (S.D.N.Y. 1994) in which the court held that claims, including those for medical negligence, against an HMO and its medical director "relate to" the administration of the plan and were therefore subject to pre-emption.)

In Dukes, Mr. Dukes was a member of an HMO though an employer-sponsored health care program. He underwent surgery on his ears and was given a prescription by his physician to have blood tests. The hospital refused to do the tests. Although the tests were eventually done, Mr. Dukes' condition had deteriorated in the meantime, and he subsequently died as a result of the delay. The Third Circuit held that this was not a claim to recover benefits due, but was a claim about the quality of a benefit received and was therefore not pre-empted by ERISA. The Court distinguished between the claims made by the plaintiff in Dukes from other cases finding complete preemption of claims relating solely to plan and

benefits administration. Upon remand and subsequent discovery in the Dukes case, the plaintiff voluntarily dismissed all claims against U.S. Healthcare.

Inconsistencies between the rights of patients covered under ERISA plans and those who are not, and inconsistencies in the application of the pre-emption language by the courts have led a number of federal lawmakers to consider offering amendments to ERISA.

Representative Charles Norwood (R-GA) recently offered a bill entitled The Patient Access to Responsible Care Act of 1997 which would, among other things, clarify that individuals are not prevented from bringing liability claims against the agents of self insured plans for wrongful death or personal injury suffered by the medical decision-making policies of the plan.

Representative Pete Stark (D- CA) has also just introduced a bill which would amend ERISA to make managed care entities liable under federal law for failure to provide any benefit, pursuant to a clinically or medically inappropriate decision, resulting from any cost containment technique, utilization review, or any other medical care delivery policy decision. It would apply strictly to managed care entities and not to other forms of health care financing, and strictly to cases where patients suffered personal injury as a result of the denial of benefits. The bill provides for punitive damages, and joint and several liability for managed care entities and health care providers. A companion bill was introduced in the Senate by Senator Alphonse D'Amato (R- NY).

In conclusion, there appears to be an increasing acceptance of the proposition among many in the judicial and legislative branches that managed care entities ought not to be shielded from liability for their own wrongdoing under an expansive interpretation of the ERISA preemption. This is undoubtedly due at least in part to an increasing awareness of the magnitude and ramifications of the health care revolution in America, which unfortunately is being driven too much by concerns about cost containment and too little by concerns over quality of care. We can only hope that the erosion of the ERISA defense will restore a greater sense of accountability among managed care entities serving as agents for employee benefit plans, and that this will in turn cause them to be more sensitive to the potential human costs of their actions and decisions. ERISA may then once again be regarded as a true benefit to employees, rather than as a barrier to equal rights with respect to medical care.