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Report to Congressional Requesters

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EMPLOYER-BASED MANAGED CARE PLANS

ERISA's Effect on Remedies for Benefit Denials and Medical Malpractice

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The Honorable Alfonse M. D'Amato
United States Senate

The Honorable Gene Green
The Honorable Dale E. Kildee
The Honorable Nita M. Lowey
The Honorable George Miller
The Honorable Fortney (Pete) Stark
House of Representatives

The Congress enacted the Employee Retirement Income Security Act (ERISA) nearly a quarter of a century ago to protect employee pension and welfare benefits. Employers often provide health care coverage as an employee welfare benefit. While employers have voluntarily provided health care benefits for more than 50 years, a major change has occurred in the type of benefits they now offer. By 1995, nearly three-quarters of those who received coverage through private, employer-based plans were enrolled in some form of managed care rather than in traditional fee-for-service plans. Many believe that, given this change, the protections under ERISA for those who have disputes over health care benefits should be reexamined.

You expressed concern about how people enrolled in employer-based managed care plans are compensated when they are improperly denied health care benefits or when they experience negligent medical care—medical malpractice—and the role that ERISA plays. You asked us, therefore, to

- describe whether the transition from traditional employer-based fee-for-service health plans to managed care has changed the process of benefit determination,
- identify the remedies that ERISA provides to participants in employer-based managed care plans who are improperly denied benefits,
- determine whether ERISA affects the ability of participants to be compensated for injuries that result from either medical malpractice or improper benefit denials at employer-based managed care plans, and
- describe the consequences of changing ERISA's remedies.

To meet these objectives, we reviewed (1) ERISA and its accompanying regulations, (2) studies addressing ERISA as it relates to providing health

care, and (3) federal court decisions focusing on ERISA health benefit denials and medical malpractice in the context of employer-based managed care. We concentrated our review of federal court decisions on cases that were decided by federal appellate courts—cases with the broadest applicability. We also reviewed law review articles and health, business, and other articles we found in professional journals and other publications. Collectively, these articles discussed ERISA, its remedies, and the implications for employers, plan participants, managed care plans, and health care providers. The bibliography at the end of this report lists the studies and the articles. In addition, we interviewed representatives of selected employer, consumer, managed health care plan, and health care provider groups, and the Department of Labor (DOL). In our study, we describe ERISA's effect on the remedies available for improper benefit denials and medical malpractice claims. In doing so, we describe relevant features of employer-based managed care plans such as grievance and appeal procedures and utilization review. We performed our work between April 1997 and May 1998 in accordance with generally accepted government auditing standards.

Results in Brief

In contrast to traditional fee-for-service insurance, managed care plans attempt to ensure that enrollees receive services that are necessary, efficiently provided, and appropriately priced. Such a cost containment strategy can alter the process and timing of "benefit determination"—deciding whether a plan covers and hence will pay for a service for a participant. Since the late 1980s, employers have largely shifted to offering managed care plans that use such techniques as prospective utilization review (UR). As a result, benefit coverage decisions have increasingly shifted from being made after services are provided to before. Consequently, when services are determined not to be covered, plan participants who are unable to obtain financing may not be able to obtain the services their physicians recommend, or perhaps any service at all.

ERISA effectively limits the remedies available when employees of private-sector firms claim to have been harmed by plans' decisions to deny coverage of a particular service. Under ERISA, plans must have an appeal process for participants who are dissatisfied with a benefit denial. If participants are not successful in obtaining the denied benefit through this process, they can file a civil lawsuit. ERISA's exclusive remedy for improper benefit denials is to require the plan to provide the denied service and, at the court's discretion, pay attorney fees. ERISA does not provide for compensating participants who have sustained losses because of the

denial or a plan's failure to provide a plan benefit. Groups representing consumers believe that ERISA's limited remedy neither provides sufficient compensation for injuries that benefit denials contribute to nor effectively deters unjustified benefit denials. The groups believe that this may allow plans to limit access to care. Groups representing employers maintain that ERISA contains appropriate provisions to protect plan participants against improper benefit denials.

ERISA can affect participants' ability to be compensated for injuries sustained while in an employer-based health care plan. If injured through the negligence of health care professionals—medical malpractice—patients or their families may pursue compensation against these providers for monetary and nonmonetary losses and punitive damages under state tort laws. ERISA does not affect these cases. In contrast, ERISA's preemption of state laws that "relate to" employee health benefit plans enables managed care plans and UR firms (which are involved in administering employee health benefit plans) to avoid liability under state law for medical malpractice.

In deciding cases in which plan participants seek compensation for alleged injuries, the courts must first decide whether the dispute relates to benefit administration or medical care. Federal courts have been trying to decide how far ERISA preemption of state laws extends as it relates to consumers' negligence claims against an employer-based managed care arrangement. When federal appellate courts have concluded that a claim arose through a benefit determination, they have ruled that ERISA preempts the claim. When claims are filed against managed care plans because of the negligence of their health care providers, appellate courts have differed on whether ERISA preemption applies.

Compelling evidence is lacking on the likely effects of amending ERISA to provide either expanded remedies for losses due to disputed benefit denials or the ability to sue managed care plans for medical malpractice or other negligence under state tort laws. Predictions about the effects of amending ERISA differ markedly, depending on the perspectives of the group involved. Consumer groups and others assert that additional remedies could (1) improve health care quality by holding plans accountable for the consequences of their benefit coverage decisions and (2) provide participants with a course of remedies more comparable to state tort laws when injuries result. However, managed care plan and employer groups maintain instead that these additional provisions would result in increased costs or benefit reductions. Some suggest that

additional costs could result from defensive measures and increased service use to guard against potential disputes or liability. According to plan and employer groups, managed care plans that experienced higher costs from increased liability would be likely to pass these costs on to employers who, in turn, might increase employee cost-sharing or cut back on health care coverage. To date, data are not available to accurately estimate the extent to which the quality of health care would improve or the amount by which the costs of plans, employers, and employees might change if either ERISA's remedies or preemption of state laws were amended. However, many have suggested that an "upstream" approach—that is, one that seeks to address disputed benefit denials at an earlier stage and thus prevent court suits—may also warrant consideration during the debate on ERISA.

Background

ERISA was enacted to protect participants in employer-based pension and welfare benefit plans.[1] After several highly visible pension plan failures and abuses in the 1960s and early 1970s, the Congress enacted ERISA in 1974.[2] Although it was established primarily as a pension law, ERISA also regulates welfare benefits—including health care benefits—that participants and their beneficiaries receive through employers.[3,4]

ERISA lays out the framework within which employer-based health benefit plans must operate. ERISA requires plans to (1) designate a named fiduciary to administer a plan in the sole interest of the participants, (2) provide pertinent documents and plan-related information to participants, and (3) file annual reports with DOL—the federal agency responsible for overseeing ERISA's implementation.[5] However, ERISA's regulatory requirements for employer-based health care plans are not nearly as

[1]ERISA seeks to protect "the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. 1001(b).

[2]Public Law 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. 1001-1461 (1994)).

[3]An ERISA-regulated "welfare plan" includes any plan or program established by an employer for the purpose of providing medical care or benefits to its employees through the purchase of insurance or otherwise. 29 U.S.C. 1002(1).

[4]"Participants" as used throughout this report includes both plan participants and their beneficiaries.

[5]ERISA defines a fiduciary as anyone who exercises discretionary control or authority over the management of a plan or renders investment advice to a plan (29 U.S.C. 1002(21)(A)). ERISA established fiduciary standards to protect employee benefit plan participants from plan mismanagement.

comprehensive as are those for pension plans. ERISA's requirements do not focus solely on health care but apply to a variety of employer-based welfare benefit plans.[6] Also, ERISA provides no financial or solvency standards to which employer-based health benefit plans must adhere.

By enacting ERISA, the Congress created a federally administered regulatory scheme that applies, with some exceptions, to all employer-based pension and welfare benefit plans, including employer-based health plans.[7] The Congress included a section in ERISA that states that ERISA supersedes, or preempts, all state laws that "relate to" an employee benefit plan.[8] According to employer groups, this "preemption" provision helps eliminate problems for multistate employers who could face conflicting and burdensome state statutes and regulations when they provide health benefits in more than one state.

Because the states have traditionally been granted the power to regulate the business of insurance, the Congress "saved" insurance laws from ERISA's preemption provision. That is, ERISA cannot supersede a state insurance law. However, an employer-based health plan cannot be deemed to be a health insurer for the purposes of being regulated by state insurance laws under this "savings" clause.

Employers who choose to provide health care benefits can do so in different ways. An employer can self-fund the coverage—that is, assume the financial risk associated with health insurance. Because self-funded plans are not considered to be an insurance product, they are exempt from state insurance laws and are therefore regulated solely through ERISA. Alternatively, an employer can purchase a health insurance product directly from an established health insurer. State laws regulating health insurers are saved from preemption. Consequently, the states can regulate the insurance product that the ERISA plan purchases. For example, an insurance product purchased by an employer would have to cover all state-mandated health care benefits, but all those benefits would not have

[6]As described in ERISA, a welfare benefit plan generally provides for hospital, medical, surgical, sickness, accident, disability, death, unemployment, or certain other benefits.

[7]ERISA does not apply to health plans sponsored by governments and churches. 29 U.S.C. 1003(b)(1), (2).

[8]29 U.S.C. 1144(a). The question whether state laws "relate to" an employee benefit plan in specific circumstances has given rise to substantial litigation. In addition, ERISA's civil enforcement provision (29 U.S.C. 1132(a)) has been interpreted by the Supreme Court as providing for "complete preemption." Complete preemption means that a state-related cause of action can be moved directly to a federal jurisdiction because federal law so completely occupies the area that it would displace any state claims that may arise.

to be covered in a self-funded plan. Similarly, such a product would be subject to state law requirements for grievance and appeal procedures.

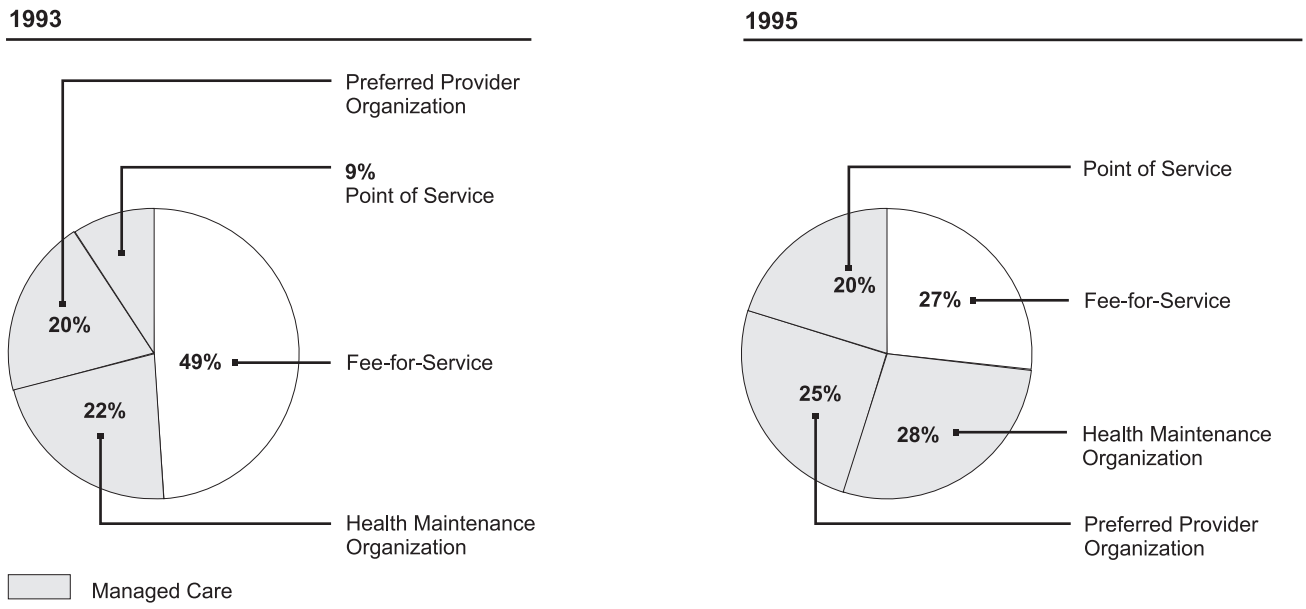
The distinction between self-funded and purchased health plans does not apply to the remedies available under ERISA for benefit claims disputes under employee benefit plans. With respect to these remedies, ERISA does not distinguish between the disputed benefit's being provided through an employer-purchased plan or a self-funded plan. As the Supreme Court has found, ERISA preempts state law claims for compensatory damages that result from benefit denials because the state laws governing such claims "relate to" employee benefit plans. Furthermore, under its preemption clause, ERISA may or may not supersede state tort laws that govern the kinds and amounts of compensation that may be available for health-care-related injuries.

Most workers and their families in the private sector receive their health insurance coverage through employers. According to DOL statistics, about 125 million people receive health insurance through about 2.5 million employer-based health care plans covered by ERISA. While the exact number of people who receive health care through self-funded employer-based plans is unknown, several studies have estimated that approximately 40 percent of insured people are enrolled in self-funded plans, plans that are free from state insurance regulation.

During the past decade, the number of people enrolled in employer-based managed health care plans has continued to increase. About 29 percent of those who received health insurance through an employer-based plan were enrolled in some type of managed care in 1988, according to KPMG Peat Marwick. Figure 1 shows that a far greater percentage of people who received health insurance through an employer in 1995 were enrolled in managed care plans than in fee-for-service, even compared with just 2 years earlier.[9] Furthermore, four times as many employers offered no fee-for-service option in 1997 as in 1988.

[9]The proportion of employees at medium- to large-sized companies enrolled in managed care plans was 81 percent in 1997 according to KPMG Peat Marwick.

Figure 1: Percent of People Receiving Health Insurance Through Employer-Based Plans by Type of Plan, 1993 and 1995



Source: Data for 1995 are a composite of the results of two national surveys conducted in the spring of 1995. One survey, conducted by KPMG Peat Marwick, surveyed firms with 200 or more workers. The other, conducted by Wayne State University, surveyed firms with 200 or fewer workers. Findings for 1995 were compared with those of a 1993 survey that used similar methods and questionnaires. These data were reported in a study by Gail A. Jensen and others, "The New Dominance of Managed Care: Insurance Trends in the 1990s," Health Affairs, Vol. 16, No. 1 (1997), p. 126.

Prospective Decisions About Whether a Policy Covers a Procedure Are a Feature of Managed Care

Paying for health care in the United States has become increasingly expensive. In the 1980s, employers in the private sector, who shoulder much of the health care costs, were becoming particularly attuned to the alarming speed at which these costs were rising. As cost growth continued at double-digit rates, employers began to search for more economical ways of providing health care benefits while maintaining or improving the quality of care. In their search, many employers began to turn away from traditional fee-for-service health care and look to managed care—which, among other things, selectively contracts with providers and manages the use of services. This transition to managed health care has made benefit determinations more critical for participants in employer-based plans.

Managed Health Care Plans Operate Differently From Fee-For-Service Plans

For many years, private-sector employers relied on traditional fee-for-service health insurance to provide their employees with health care benefits. Health insurance became increasingly expensive, partly because participants had virtually an unlimited choice of health care providers with few controls on service use or costs. Traditional fee-for-service insurers paid the bills for covered services and typically did not become involved in medical treatment decisions. These insurers played primarily a financial role and left medical decision-making to physicians and hospitals.[10] Under a traditional fee-for-service health insurance plan, (1) the attending physician usually decided when medical services were necessary, (2) the patient received the services, and (3) the insurer either paid or did not pay, depending on an independent retrospective review of the claim. Therefore, benefit disputes usually focused on whether the insurer would pay, not on whether services would be provided.

Generally, managed health care attempts to contain costs by addressing both the price and quantity of health care services. Managed care plans attempt to ensure that services provided to plan enrollees are necessary, delivered efficiently, and priced appropriately. Managed care covers a broad spectrum of health care delivery arrangements and financing. Types of managed care plans include health maintenance organizations (HMO), preferred provider organizations (PPO), and point of service (POS) plans.[11] HMOs—the oldest form of managed care—operate under several different models. For example, staff model HMOs employ health care providers directly and often serve only enrolled HMO patients at facilities owned by the HMOs. Independent practice association (IPA) model HMOs contract with providers who serve other patients as well as HMO enrollees in the providers' own offices.

Prospective UR Has Consequences for Benefit Determinations

Managed care plans may use different methods to control access to care, but prospective UR—used to determine in advance the medical necessity or appropriateness of more costly, nonroutine health care services—is distinctive. Prospective UR adds a layer of review to the decision-making

[10]See Wendy K. Mariner, "Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field," American Journal of Public Health, Vol. 86, No. 6 (1996), p. 864.

[11]HMOs provide or arrange for services to enrollees—for a fixed, prepaid amount of money—through a panel of providers. HMOs use primary care physicians as gatekeepers who manage the enrollees' use of services. PPOs contract with providers for discounted fees for services to plan members. Members have a financial incentive to use participating providers. POS plans give members a choice when services are needed as to how to receive services, whether through an HMO, a PPO, or a fee-for-service plan.

between attending physicians and their patients. In managing patient care, most managed care plans have adopted prospective UR procedures. Prospective UR determines whether the attending physician's proposed course of medical treatment and proposed service location are necessary based on clinical criteria.

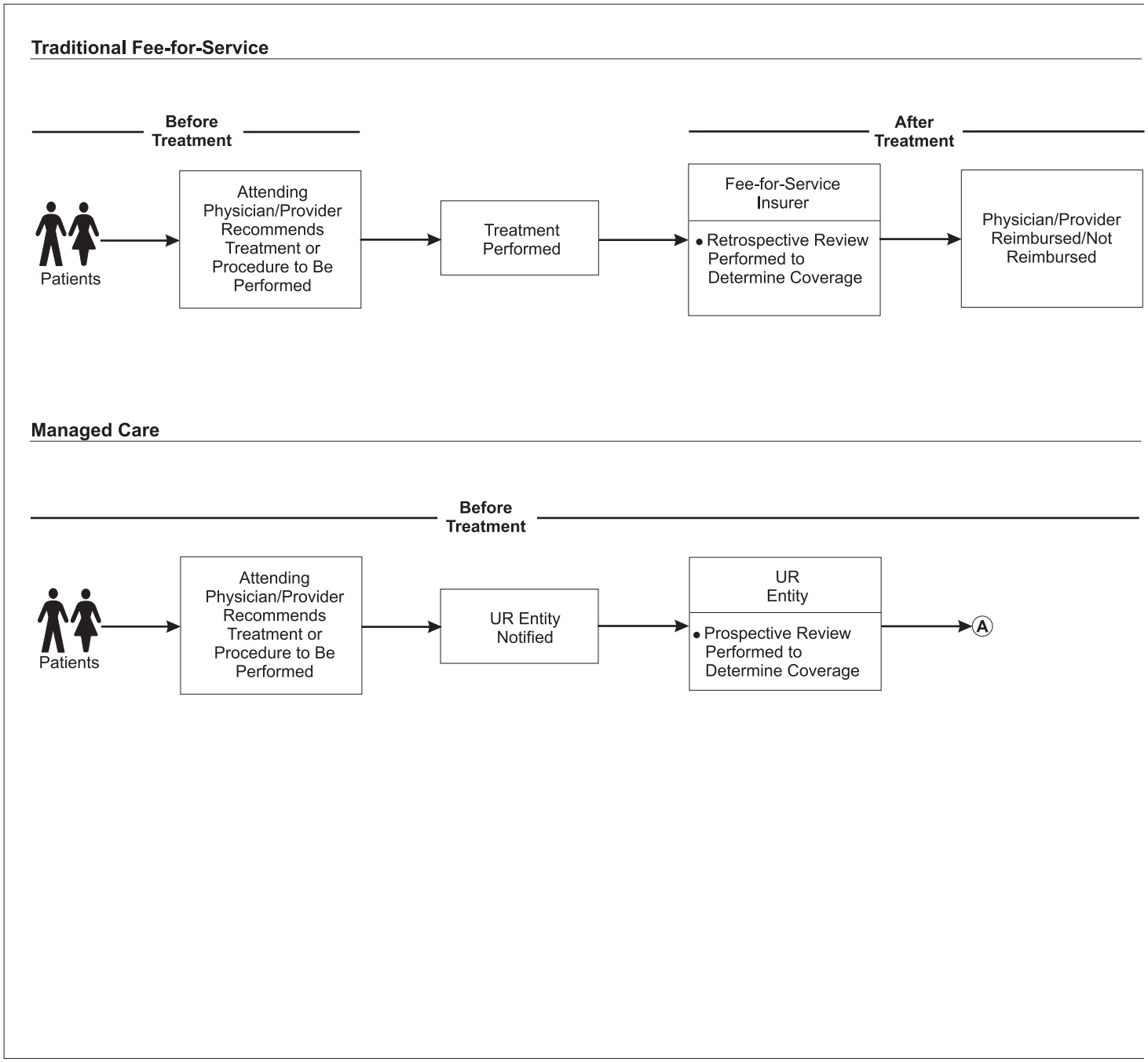
Managed care plans often assume the administrative function of making benefit determinations—that is, determining whether a specific treatment or procedure is covered by the employer's plan. Plans may assume this function when employers contract with HMOs and other types of managed care to provide health care services for ERISA participants or when the plans administer employer-based ERISA self-funded plans.

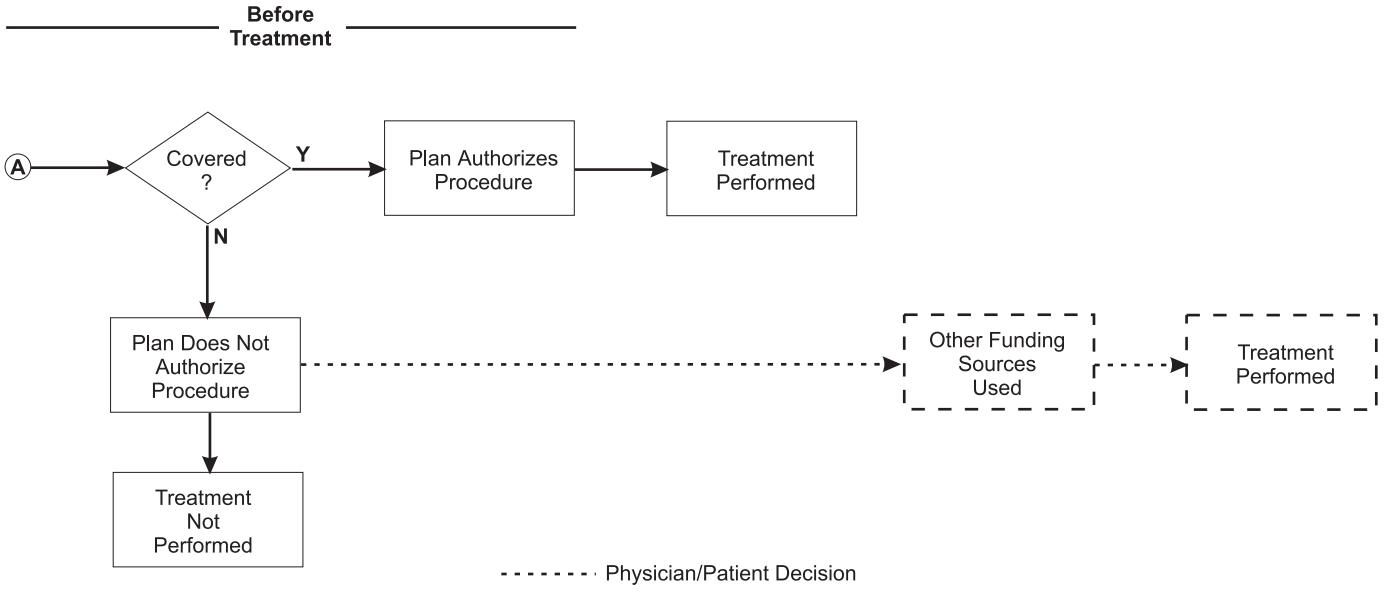
Prospective UR procedures vary among managed care plans. Plans differ in the services requiring prior authorization, the type of personnel making decisions, and the criteria used to determine medical necessity.[12] Plan-based medical personnel such as physicians or nurses may be involved at different stages of the process and may exercise independent clinical judgment rather than relying exclusively on plan-specified criteria. However, they exercise this judgment for the purpose of determining plan coverage for the service in question. Such decisions are made independently from the decisions made by a patient's attending physician. (The attending physician and plan officials may discuss the plan's benefit coverage decision.) Figure 2 shows that compared with traditional fee-for-service care, the coverage decisions at managed care plans for some services are often made through a prospective UR process—before the patient receives health care services.[13]

[12]Two common examples of prospective UR procedures are preadmission certification of hospital admissions and authorization for expensive diagnostic testing.

[13]Although the managed care industry asserts that plans do not reward providers for withholding "medically necessary" care, capitation payments and other economic incentives could also influence a health care provider's actions or recommended treatments. For example, because of economic incentives, a health care provider may choose not to provide a more costly service and therefore would not refer the request for a prospective UR coverage decision. In such a case, no benefit denial would occur and the service would not be provided. Moreover, no benefit denial dispute would arise because the patient may not be aware that a service was an option and not provided. Therefore, plans' ability to ensure that appropriate care is provided requires a mechanism to counterbalance the economic incentives of capitation.

Figure 2: Providing Health Care Through Traditional Fee-for-Service and Managed Care




Before Treatment
A
Covered ?
Y
N
Plan Authorizes Procedure
Treatment Performed
Plan Does Not Authorize Procedure
Other Funding Sources Used
Treatment Performed
Treatment Not Performed
Physician/Patient Decision

Ultimately, the health plan decides whether a particular service is covered based on the review conducted by its agents. A health plan's decision to deny coverage does not preclude the attending physician from providing treatment—if the patient can obtain other funding to pay for it. Nonetheless, it may be that for financial or other reasons, the patient may not obtain the recommended service. Consequently, benefit disputes involving managed care plans often focus on whether the plan should compensate the patient for any injuries or damages that may have occurred because the disputed service was not provided.

ERISA Provides the Exclusive Remedy for All Employer-Based Health Benefit Denials

Plan participants who believe they have been denied a plan benefit can seek to reverse the denial through the plan's claims appeal process. If participants are unsuccessful, they can sue the plan as a last resort. If participants are successful in court, the only remedy under ERISA allows them to receive the denied benefit and, at the court's discretion, attorney fees. Groups representing consumers are concerned that ERISA's remedy does not sufficiently deter inappropriate benefit denials and that it is difficult to pursue claims in court. Conversely, employer groups believe that ERISA already provides the appropriate mechanism for protecting plan participants.

ERISA's Benefit Denial and Appeal Process

ERISA requires that employer-based health benefit plans provide participants with information on covered benefits in a summary plan description (SPD). The SPD gives details on the plan and describes the rights, benefits, and responsibilities under the plan. Plans that meet federal standards for HMOs are permitted to omit certain information from their SPDs and are deemed to satisfy ERISA's requirements for resolving benefit disputes.[14]

ERISA requires plans to have a system for resolving benefit disputes. The minimum procedures that an employer-based health benefit plan must follow when denying a benefit and for resolving any dispute that arises from the denial are specified in ERISA and its implementing regulations,

[14]See 29 C.F.R. 2520.102-5, 2560.503-1; 42 U.S.C. 300e et seq.

which were published in 1977.[15] Generally, as shown in table 1, it can take up to 1 year to complete the benefit denial and resolution process: (1) plans have 90 days in which to deny a benefit, although they can request an extension of up to 90 days; (2) a participant has up to 60 days to appeal after the denial, or request a review of the decision; and (3) the plan must resolve the appeal promptly, within 60 days, although an additional 60 days can be requested under special circumstances.

Table 1: Claim Denial and Appeal Process Under ERISA

ERISA requirements	Time period
Benefit denials	Plans have 90 days to make denial
Initial denial must	
— be written	
— be understandable	
— state reason	
— refer to the plan provision	
— state how to resolve	
— identify how to appeal	
Plans can request extension under special circumstances	Plans can request up to 90 more days
Participant can request review of decision	Participant has 60 days to request review
Benefit appeals	Plans have 60 days to decide appeal
Plans can request extension under special circumstances	Plans can request up to 60 more days

Source: DOL regulations in 29 C.F.R. 2560.503-1—Claims procedure.

ERISA's requirements for handling benefit appeals are limited in some respects. For example, the regulations contain no provisions for expedited

[15]The relevant passages in ERISA and the regulations are in 29 U.S.C. 1133 and 29 C.F.R. 2560.503-1.

Almost all states require HMOs to establish consumer grievance procedures. Insured, state-regulated ERISA health benefit plans are subject to these state requirements. Legislation or regulation mandating external review has been enacted by 16 states. Data are from the National Conference of State Legislatures as shown in HMO Complaints and Appeals: Most Key Procedures in Place, but Others Valued by Consumers Largely Absent (GAO/HEHS-98-119, May 12, 1998). Also, according to representatives of the American Association of Health Plans—the principal trade association representing more than 1,000 HMOs, PPOs, and other network health plans—many health plans contracting with self-funded ERISA plans often find it expedient to follow state-mandated grievance procedures in place for their other lines of business.

appeals.[16] Furthermore, there is no provision for an independent review of the plan participant's appeal. The same entity that initially denied the benefit can make the appeal decision.[17] If not satisfied with the results of the appeal process, a plan participant has the final recourse of suing the plan.

ERISA Limits Remedies to Benefits Denied

ERISA provides that when a participant is not satisfied with the results obtained through a plan's appeal process, the only way to resolve the benefit denial is to sue the plan to obtain the benefit.[18] This remedy applies to participants in all employer-based health plans, except those sponsored by governments and churches—both those self-funded and those purchased from an insurer. While this type of civil suit can be filed initially in either a federal or state court, frequently the cases in state courts are removed to a federal court on a defendant's motion. If successful in court, however, the participant is entitled only to receive the denied benefit and, at the court's discretion, attorney fees. If a participant establishes in a lawsuit that a plan wrongfully denied a benefit, ERISA authorizes the court to order that the benefit be provided.[19] ERISA does not contain any provisions for compensating for damages that may occur because of the benefit denial such as lost wages, additional health care costs, or pain and suffering.[20] Nor does ERISA provide for any punitive damages.

Generally, when a benefit is refused or a claim is denied, a participant's ultimate recourse is to sue under ERISA. (The participant may be required

[16]DOL solicited public comments in the fall of 1997 on the need to change ERISA's procedures and in May 1998 was in the process of developing regulatory changes. Areas under consideration, among others, include (1) requiring that claims for urgent medical care be processed within a time period appropriate to the emergency but in no event more than 72 hours, (2) making clear that a statement of the right to appeal and a description of the appeal process must accompany the benefit denial, and (3) determining whether there is a need to establish uniform minimum standards for all ERISA plan claims procedures, including plans providing benefits through federally qualified HMOs. See Request for Information, 62 Fed. Reg. 47262 (1997).

[17]DOL says it lacks the authority to require independent review.

[18]29 U.S.C. 1132(a).

[19]In this and subsequent references to wrongful denial of benefits, we describe the remedy as an order to provide the denied benefit, because ERISA specifically provides for that. (It also permits lawsuits to clarify a participant's right to future benefits or to enforce his or her rights under the terms of the plan.) Often, however, providing the benefit is not an adequate remedy—for example, when the participant has already received the benefit at his or her own expense or has died. ERISA does not expressly authorize reimbursement for the cost of a denied benefit. However, when necessary to do justice, a court might order reimbursement under its so-called equity power, under which judges may craft appropriate remedies not provided for in the law.

[20]In Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987), the Supreme Court held that ERISA contains a civil enforcement scheme that was intended to provide an exclusive remedy. The Court found that state law claims for compensatory damages "related to" employee benefit plans and were therefore preempted by ERISA.

first to go through an administrative appeal process.) In such a case, the participant asserts that a service promised through the employer-based health care plan was not provided. Under ERISA, the plan's fiduciary is responsible for protecting the interests of the participants. ERISA states that fiduciaries have a duty to act "solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries. . . ." In this role, a fiduciary must be prudent and act according to the plan documents. Under ERISA, the failure to pay a valid claim may constitute a breach of a fiduciary's responsibilities. However, courts ordinarily uphold the fiduciary's decision unless the participant can show that the decision was "arbitrary and capricious."[21] Arbitrary and capricious behavior may include such activities as (1) using undisclosed medical criteria that are more restrictive than those used by other insurers, (2) basing a denial on an ambiguous provision of the benefit agreement, or (3) failing to comply with ERISA's notification and reconsideration procedures if that failure prevented a request of reconsideration of an adverse determination.[22]

Consumer Groups Believe Access to Health Care May Be Denied

Benefit coverage determinations have taken on a more critical role as employers have changed from traditional fee-for-service health care to managed care. Benefit denials can now more easily restrict access to care because benefit determinations are often made before services are provided, especially for nonroutine, high-cost services or treatments. This is a different situation from traditional fee-for-service coverage. A participant may not be financially able to obtain more costly services if the plan does not pay.

According to representatives of consumer groups, ERISA's remedy does not deter inappropriate benefit denials. ERISA provides no penalty when benefits are denied inappropriately. If found to be in the wrong, the employer-based plan must then only provide the benefit that had been denied.[23] In addition, consumer groups believe that saving money gives employer-based health plans an incentive to deny benefits.

[21]Where an administrator of an employee benefit plan has discretionary authority to determine eligibility for benefits or interpret plan terms, the courts can overturn the administrator's decision only if it is arbitrary, capricious, or an abuse of discretion. See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989).

[22]According to James L. Touse, "Medical Management and Legal Obligations to Members," The Managed Health Care Handbook (Gaithersburg, Md.: Aspen Publishers, Inc., 1993), p. 487.

[23]Such views are shared by some insurance regulators. Some insurance regulators interviewed for a 1996 study also "observed that insurers and HMOs sometimes refuse care or payment because they know they have nothing to lose by doing so." See Patricia Butler and Karl Polzer, Private-Sector Health Coverage: Variation in Consumer Protections Under ERISA and State Law, Special Report (Washington, D.C.: National Health Policy Forum, 1996), p. 49.

Plan participants may face other problems pertaining to benefit denials, according to consumer group representatives. For example, participants may not be aware of or understand the information contained in the SPDs that explains the benefit appeal process or ERISA's remedy. A recent study found that according to state regulators, most plan participants neither read nor understood plan documents.[24]

Furthermore, it may be difficult for a plan participant to pursue a benefit denial in court because the participant may not be able to find or afford legal representation. Attorneys often accept cases on a contingency fee basis—they receive a percentage of the final settlement or award made by the court. However, the ultimate success in winning an ERISA case is receiving the denied benefit and, at the court's discretion, reasonable attorney fees. There is no chance for a large monetary award based on damages. Therefore, attorneys have little financial incentive to take these cases.

Employer Groups and Managed Care Industry Believe Participants Are Adequately Protected

According to groups that represent employers, the Congress sought to strike a balance in the remedy it provided for benefit denials when it enacted ERISA. Representatives of employer groups believe that the Congress chose to include a remedy that was not overly burdensome on employers because they provide health care benefits voluntarily. These groups believe that ERISA's remedy must consider the employers who voluntarily provide health care coverage and the plan participants who expect to receive services they believe are covered by the plan. Furthermore, the ERISA Industry Committee—which represents major private employers regarding public policy and related matters affecting employee benefit plans—believes that despite employers' shift since 1974 from predominantly fee-for-service health benefit plans to mostly managed care plans, ERISA continues to provide an adequate framework for protecting plan participants. According to this employer group, ERISA protects participants by requiring that plan fiduciaries act in their sole interest and that denied claims receive fair hearings.

Employers have no incentive to deny benefits that are rightly due to plan participants, according to several employer groups. Employer groups say that employers provide health benefits to keep their employees healthy so

[24]See Karl Polzer and Patricia A. Butler, "Employee Health Plan Protections Under ERISA," Health Affairs, Vol. 16, No. 5 (1997), p. 95. This study does not address a related hypothesis: plan participants may have little incentive to learn about appeals and related procedures until faced with a benefit denial. However, systematic data on such plan participants and their ability to get timely information are not available.

that the employees can be productive. In addition, representatives of the American Association of Health Plans believe that significant counterbalances prevent inappropriate benefit denials. According to the association, health plans are also concerned about making improper benefit denials. For example, health plans could face a loss of business and reputation and could risk incurring unfavorable publicity. Furthermore, representatives of employer groups said that plan fiduciaries can be assessed penalties if they are found to make arbitrary and capricious benefit determinations. For example, they said that ERISA provides the authority to ban individuals or entities from acting as plan fiduciaries, effectively putting them out of business. In principle this sanction is available, but in practice it is rarely invoked.

ERISA May Limit Participants' Ability to Sue Managed Care Plans for Damages Under State Law

ERISA's preemption clause generally prevents plan participants from holding managed care plans directly liable under state laws for the damages that result from their negligent acts or omissions, and it complicates plan participants' ability to hold managed care plans indirectly liable for the negligence—medical malpractice—of their providers. This situation has caused much debate. Federal courts are addressing the scope of ERISA preemption as it relates to negligence in an employer-based managed care arrangement.

State Law, Not ERISA, Allows Suits for Direct Negligence Against Providers and Organizations

Physicians and other health care providers can be held directly liable for their own negligent acts—generally called medical malpractice. Medical malpractice is defined as acts of omission or commission, usually based on negligence, that result in injuries. Plan participants may attempt to hold health care providers directly liable for injury by filing medical malpractice claims seeking compensation for monetary and nonmonetary losses.[25] In addition to monetary and nonmonetary losses, plaintiffs can seek to obtain punitive damages.

Medical malpractice claims are generally governed by state tort law.[26] State tort laws may differ with respect to the kinds and amounts of compensation that are available. A determination of liability for medical malpractice is based upon four elements: (1) the existence of a duty of care to the patient, (2) an applicable standard of care and its violation,

[25]Monetary losses include medical bills, rehabilitation costs, and lost income. Nonmonetary losses include pain, suffering, and anguish.

[26]A tort is a wrongful act or omission (not based on a contract) that causes injury to another person. Tort law provides a framework for compensating medical malpractice damages.

(3) a compensable injury to the patient resulting from that breach, and (4) a causal connection between the violation of the standard of care and the harm complained of.[27] The medical malpractice liability system is generally thought to have three primary goals: (1) provide compensation to people who are injured through negligent medical care, (2) create an incentive for physicians to provide careful treatment, and (3) provide accountability in dispute resolution.[28]

In addition, health care organizations, including hospitals and managed care plans, can be held directly liable for their own negligent acts or omissions. That is, a managed care plan can be held directly liable for its own failure to fulfill a duty owed to its patients in non-ERISA-based plans and can be sued for damages under state laws. For example, a negligence claim brought against a managed care plan can be based on a benefit denial or some other aspect of employee benefit plan administration, including UR and preauthorization of services, alleging that the actions of the plan constitute direct negligence.

Organizations Can Be Held Indirectly Liable for Providers' Negligence Under State Law

An injured person's right to sue a managed care plan—for example, an HMO—under state law for the medical malpractice of its health care providers is evolving in much the same way that the right to sue a hospital for the negligence of its providers evolved. Initially, hospitals were viewed as only providing a place where patients could receive services from independent health care providers.[29] However, courts eventually began to address whether hospitals could be held "vicariously" or indirectly liable for the actions of health care providers—who were either employees or independent contractors—in addition to being held directly liable for their own actions.[30]

Plan participants are increasingly attempting to hold HMOs to be vicariously liable when health-care-related injuries occur. For example, an employer can be held indirectly responsible for the actions of its

[27]Henry Campbell Black, Black's Law Dictionary, 6th ed. (St. Paul, Minn.: West Publishing Co., 1990), p. 959.

[28]Daniel Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" The Quarterly Journal of Economics, Vol. 111, Issue 2 (1996), p. 353.

Randall R. Bovbjerg, "Medical Malpractice on Trial: Quality of Care Is the Important Standard," Law and Contemporary Problems, Vol. 49, No. 2 (1986), pp. 321-48.

[29]See Lisa Panah, "Common Law Tort Liability of Health Maintenance Organizations," Journal of Health and Hospital Law, Vol. 29, No. 3 (1996), pp. 146-59 and 192.

[30]The case starting the trend to holding hospitals responsible for the actions of physicians was Bing v. Thunig, 143 N.E.2d 3, 163 N.Y.S.2d 3, 8 (N.Y. 1957).

employees under the legal theory of "respondeat superior."[31] This theory of law applies most clearly to staff model HMOs in which health care providers are directly employed by the HMO.[32] A staff model HMO's employed health care providers are typically physicians, nurses, and others, including those who make UR decisions. Consequently, plan participants' attorneys can try to hold staff model HMOs liable for the negligent actions of their health care providers.[33]

Most HMOs, however, treat physicians as independent contractors rather than retaining them as direct, salaried employees. When an HMO contracts with physician associations to provide health care services—the IPA model—the HMO also may be held liable for negligent medical care if the plan participant perceives the HMO to be providing the health care. This is the "ostensible agency" theory of law. Courts must determine whether the HMO represented the physician to be its employee and whether the patient looked to the HMO, rather than the physician, as the health care provider.[34] If the patient has no choice when selecting a treating physician, the patient could more reasonably look to the HMO as a provider.[35]

ERISA Preemption Role Is Not Always Clear

ERISA's preemption clause complicates the ability of employer-based health care plan participants to sue managed care plans when injuries occur. In fact, ERISA has become a major source of confusion as to whether a plan participant may recover damages from a managed care organization for the negligence of its health care providers.[36] Because ERISA preempts state laws that "relate to" employee benefit plans, managed care plans have argued that ERISA preempts the ability to sue them under state tort laws

[31]Respondeat superior or "vicarious liability" is the doctrine of tort law that an employer is liable for the negligent acts of an employee acting within the scope of his or her employment.

[32]Plaintiffs must demonstrate a "master-servant" relationship between the HMO and the provider. Courts look for such factors as how the HMO chooses, hires, controls, and compensates providers and whether the HMO owns the facilities.

[33]The plaintiff must prove that the provider performed negligently, there was a direct employment relationship between the HMO and the provider, and the provider was acting within the scope of employment.

[34]When determining whether the HMO presents the physician as its employee, the courts look at the HMO's representations to the patient. When determining whether the patient looks to the HMO for care, the courts consider the degree of control the plan exerts over the patient's selection of physicians and whether the physician's malpractice arose out of the performance of an inherent function of the plan.

[35]See L. Frank Coan, Jr., "You Can't Get There From Here—Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs," Georgia Law Review, Vol. 30, No. 4 (1996), pp. 1023-60.

[36]See F. Christopher Wethly, "Vicarious Liability Malpractice Claims Against Managed Care Organizations Escaping ERISA's Grasp," Boston College Law Review, Vol. 37, No. 4 (1996), pp. 813-60.

either directly for their own negligence or indirectly for the negligence of health care providers. When sued by an ERISA plan participant in a state court, the managed care plan can seek to move the case to federal court because of ERISA and, even in state court, can assert ERISA preemption as a defense. As ERISA provides more limited remedies than state tort laws—only the benefit denied and no compensatory or punitive damages—there are incentives for managed care organizations to claim the ERISA preemption.

Managed care entities increasingly perform several functions simultaneously for employer-based plans—UR, plan administration, arranging or providing medical treatment—and consequently the distinction between administering a plan and providing health care may be less clear. Federal courts have found that the UR entity may make medical decisions in the context of making a benefit determination under an employer's ERISA plan.[37]

DOL has intervened as amicus curiae—"friend of the court"—in eight lawsuits addressing ERISA's preemption of state tort laws.[38] In these cases, DOL argued that ERISA does not preempt negligence or medical malpractice claims against HMOs when the plan participant is part of an employer-based health plan.

[37]A well-publicized UR example in which ERISA was held to preempt a malpractice claim against a UR entity is found in the lawsuit filed by Florence Corcoran (Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992), cert. denied, 506 U.S. 1033). Because of a high-risk pregnancy, Mrs. Corcoran's attending physician determined that she needed to be hospitalized for close monitoring. Because of a requirement of participation in her employer's health plan, Mrs. Corcoran's physician sought precertification for the hospital admission. The firm performing UR for the employer's plan determined that hospitalization was not medically necessary and would not be covered. Instead, a period of part-time home nursing care was authorized for Mrs. Corcoran. Subsequently, during a period while a nurse was not on duty, the fetus became distressed and died. In this case, the court found that the UR firm made medical decisions and gave medical advice but did so in the context of making a determination about the availability of benefits under the health plan. The court also noted that prospective UR decisions influence treatment choices to a far greater degree than retrospective review, saying that "a beneficiary, faced with the knowledge of specifically what the plan will and will not pay for, will choose the treatment option recommended by the plan in order to avoid risking total or partial disallowance of benefits." However, in the Corcoran case, the plan's SPD stated that all decisions regarding medical care were up to plan participants and their physicians.

[38]The eight cases were (1) Dukes v. U.S. Healthcare, (2) Visconti v. U.S. Healthcare, (3) Rice v. Panchal, (4) Ravenel v. Kaiser Foundation Health Plan of Texas, (5) Robbins v. HIP of New Jersey, (6) Bledsoe v. Brown, (7) Shea v. Esensten, and (8) Nascimento v. Harvard Community Health Plan.

Federal Courts Allow ERISA Preemption for Benefit Determination Decisions

Federal appellate courts have concluded that when the action of a managed care plan involves benefit administration, ERISA preempts damage claims under state law, even though the plan's action may have been a wrongful denial of benefits. Whether a plan action is benefit administration or a medical decision is not always clear; the distinction often depends on the facts of each case. Courts have generally concluded that benefit determinations by plans—for example, that a particular medical service is not covered—fall in the category of benefit administration. Once the action of the plan is characterized as benefit administration, ERISA preempts state causes of action.

The federal courts are divided on the effect of ERISA when the managed care plan acts not merely as a benefit administrator but as a provider of medical care. Some courts have held that ERISA does not preempt malpractice suits against managed care plans under state law when the complaint is based on medical advice or care by the plan provided through an employee or an agent of the plan. Other courts have held that ERISA preempts suits against managed care plans under state law based on malpractice by plan employees or agents.[39] The appendix summarizes some of the decisions on ERISA by the federal courts addressing these issues.

Competing Concerns of Several Groups Complicate Debate on ERISA's Role

When ERISA's preemption of state tort law applies, plan participants/consumers, employers, and managed care plans are affected differently. As a result, each of these groups has its own distinct reaction to the role that ERISA's preemption clause plays in the ability to file claims for medical malpractice and benefit denials under state law.

Consumer groups object to ERISA's preemption clause because it denies plan participants the ability to pursue damage claims against plans for benefit decisions under state law. As federal court cases have shown, ERISA plan participants have been left without any legal right to sue for damages

[39]The ERISA Industry Committee pointed out that a recent law review article maintains that managed care organizations such as HMOs, PPOs, and integrated delivery systems should be held legally responsible for the negligence of physicians treating their subscribers or enrollees. This is known as enterprise liability. The article states that "it does not appear that ERISA will block state courts in imposing enterprise liability on M[anaged]C[are]O[rganization]s." However, the author acknowledges that courts have not yet adopted such an approach and are unlikely to do so soon. See Clark C. Havighurst, "Making Health Plans Accountable for the Quality of Care," Georgia Law Review, Vol. 31 (1997), pp. 587-647.

when injuries occur as a result of such benefit coverage decisions.[40] There are no data to show how often participants are left without the right to sue for damages. Moreover, the high cost of treatments may effectively keep plan participants from paying for care themselves that employer-based plans determine to be medically unnecessary or not covered. In addition, ERISA's remedy for injuries occurring because of benefit denials is insufficient, according to consumer advocates. They believe that providing more remedies would also improve the quality of health care that consumers would get by holding managed care plans accountable for unfair denials, limitations, or reductions in care.

Employers provide health care benefits voluntarily to help attract and retain workers, especially in a competitive environment, and to help keep trained employees healthy and productive. Many employees consider these benefits to be important. When employers choose to provide health care benefits, employer groups believe that ERISA's preemption gives them the ability to design innovative health plans that can be consistent across state borders. Employer groups say that if plan fiduciaries were subject to compensatory or punitive damages, employers would be less likely to provide health benefits because of the higher costs associated with them.

When managed care plans administer employer-based health care benefits, they believe that they are protected from state law remedies by ERISA's preemption clause. They view making benefit determinations—including whether a particular service is medically necessary—as administrative functions associated with benefit plans covered by ERISA. They believe that subjecting such decisions to state law remedies would raise costs as participants/consumers and trial lawyers seek damages from plans because of their perceived "deep pockets." According to the American Association of Health Plans, the very methods that have made health plans successful at arranging for affordable, high-quality health care would be undermined. Also, the association maintains that the need to defend against tort claims for denial of benefits would cause health plans to take defensive measures. For example, the association notes that plans may

[40]While the Corcoran court found for ERISA preemption, the court acknowledged that it "eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable, there is theoretically less deterrence of substandard medical decisionmaking. Moreover, . . . bad medical judgments will end up being cost-free. . . . ERISA plans, in turn, will have one less incentive to seek out the companies that can deliver both high quality services and reasonable prices." (965 F.2d 1321, 1338, 5th Cir. 1992). In addition, a federal court in another federal circuit found that while ERISA preempted the specific claim filed, "ERISA has evolved into a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits," (Diane Andrews-Clark v. Travelers Insurance Co., 984 F. Supp. 49, 53 (1997)).

authorize coverage for more services, whether or not they are medically necessary, to avoid possible litigation. However, the scope of defensive measures may be limited. One survey showed that the final benefit denial rate was no more than 3 percent, although higher denial rates may be associated with certain services or specialties.[41]

No Consensus Exists Regarding Changes to ERISA

In effect for more than two decades, the remedies ERISA provides are facing increased scrutiny. While they were considered to be sufficiently fair when enacted by the Congress in 1974, much has changed since then. Now, as more federal court cases challenge ERISA preemption, many members of the Congress believe that the time has come to revisit either ERISA's civil enforcement scheme—its remedies section—or its preemption clause. In addition to the legislative proposals that have been introduced, alternative solutions may merit further exploration. Nonetheless, any changes made to ERISA will evoke positive reactions by some of those who are affected and negative reactions by others.

Congressional Proposals to Change ERISA

In the first session of the 105th Congress, two different types of amendments to ERISA were introduced to address the question of compensating plan participants who are injured as a result of improper medical decisions made by managed care entities. Generally, these proposals would either (1) provide for compensation in ERISA's civil enforcement section or (2) change ERISA's preemption clause so that it does not supersede state tort laws. The two proposal types differ with respect to how injured plan participants would be able to seek relief. Under the first type, ERISA itself would provide more remedies for alleged injuries. Under the second, ERISA would make it easier for participants to pursue state-provided remedies when seeking compensation from managed care plans.

Alternatives to Amending ERISA's Civil Enforcement or Preemption Sections

The courts are the arena within which participants pursue remedies when injuries occur under employer-based managed care plans, but more could be done to try to avoid litigation. Several studies and groups have

[41]According to a 1995 survey of physicians, first-round denials of coverage for physician-recommended services were less than 6 percent. However, many of these initial denials were ultimately approved, so the final denial rate was no more than 3 percent. (Although the majority of physicians had no coverage denials for the forms of care studied, denial rates exceeded 20 percent for some physicians.) The overall denial rate was highest for mental health, substance abuse, and referral to a specialist of choice. See Dahlia K. Remler and others, "What Do Managed Care Plans Do to Affect Care? Results From a Survey of Physicians," Inquiry, Vol. 34 (fall 1997), pp. 196-204. This study did not, however, attempt to account for the possible deterrence of denials on the physicians' recommendations regarding services.

supported this preventive or "upstream" strategy. Rather than amending ERISA to provide for the ability to pursue increased remedies for damages that result from medical decisions made by managed care entities, more attention could be placed on resolving disputes earlier.

The National Association of Insurance Commissioners took the position that ERISA should be changed to ensure more government oversight and authority over ERISA health plans' claim and coverage determinations. Also, according to the association, ERISA needs to provide participants with more meaningful internal and external appeal mechanisms in addition to the appeals to courts that are permitted. It also suggested that ERISA could be revised to require each ERISA health plan to provide independent alternative dispute resolution mechanisms to mediate or adjudicate disputes with participants that cannot be resolved through internal review.[42] The association believed that ERISA should be amended to give participants in ERISA health plans access to state tort law remedies, subject to reasonable limits, only if its other suggested changes were not implemented.

A recent study on managed care plan liability stated that having a procedure through which participants could appeal a managed care plan's benefit denials to an outside reviewer could resolve disputes before harm occurred and could prevent the need for lawsuits later on.[43] Analysts sponsored by the National Institute for Health Care Management reported that an ideal system for resolving benefit disputes should "Recognize the inevitability of conflict between emotionally vulnerable patients and any economically rational health system by anticipating common disputes, tempering expectations with clear rules and implementing timely, efficient dispute resolution mechanisms."[44] Also, several groups we spoke with representing consumers, health care plans, and employers told us that more emphasis needs to be placed on strengthening the grievance and appeal procedure within managed care plans.

[42]Consumer groups generally oppose the use of any mechanism that is binding on participants and takes away the opportunity to appeal a decision to the courts. Access to federal courts is guaranteed under ERISA and consumer groups do not want that right weakened in exchange for a "better" appeal procedure.

[43]See Patricia A. Butler, Managed Care Plan Liability: An Analysis of Texas and Missouri Legislation (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, 1997), p. 22.

[44]See Linda A. Bergthold and William M. Sage, Medical Necessity, Experimental Treatment and Coverage Determinations: Lessons From National Health Care Reform, (Washington, D.C.: National Institute for Health Care Management, 1994), p. 4.

Furthermore, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry stated that a timely appeal process can help reduce the incidence of injury. As a result, the commission recommended that the internal and external appeal process be enhanced. The Commission recommended the establishment of external review systems that would be limited to reviewing (1) decisions relating to services that are "experimental" or "investigational," (2) decisions in which a service is determined not to be medically necessary and the cost exceeds a "significant threshold," and (3) decisions in which the denial, based on medical necessity, could jeopardize the life or health of a patient.[45]

DOL Supports Stronger Remedies to Enhance a Preventive Compliance Strategy

While DOL supports the need to strengthen ERISA's claim resolution procedure, it also believes that stronger remedies are needed. According to DOL, stronger remedies are needed at the end of the process to ensure compliance with the process "upstream." That is, DOL believes that it could develop a regulation to implement a better claim resolution procedure for plan participants but could not ensure compliance if there was no cost imposed for failure to comply. Consumer groups also concur with DOL's concern that current ERISA remedies do not adequately protect plan participants or deter plans from noncompliance.

Challenges in Balancing Concerns When Considering Changes to ERISA

Any effort to amend ERISA or make other changes would likely involve tradeoffs among the divergent interests of consumers, managed care plans, and employers. For example, if the Congress amended either ERISA's preemption clause or remedies section as discussed previously, plan participants would have access to a broader array of remedies for adverse outcomes under employer-based managed care plans. Patients commonly expect that the medical care they receive is of reasonable quality. ERISA's preemption of the liability of health plans may remove a powerful incentive to provide high-quality service.[46] An amendment to make it easier to hold managed care plans liable for injuries could cause plans to take more actions to avoid injuries, and the number of adverse outcomes could decrease. Furthermore, the denial of benefits can, if it affects the course of treatment, cause physical injury, which in turn may result in the

[45]Quality First: Better Health Care for All Americans, Final Report to the President of the United States, The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry (Washington, D.C.: 1998), pp. 155-61.

[46]See Jack K. Kilcullen, "Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability," American Journal of Law & Medicine, Vol. 22, No. 1 (1996), pp. 7-50.

loss of income or one's job. Such losses cannot be recovered by reimbursing the patient for the cost of the denied benefit.[47] Amending ERISA could change this.

If more participants were able to pursue benefit disputes, however, the courts could potentially have to handle more cases. The limited data available indicate that in recent years more medical malpractice claims are being filed. The number could increase if ERISA were amended. But an adverse outcome does not necessarily mean that a claim will be filed. The findings of a study conducted at New York hospitals and reported in The New England Journal of Medicine in 1991 showed that the number of negligent adverse outcomes was eight times the number of tort claims filed.[48] Thus, as shown by this study, many individuals who are injured by medical negligence may not file a claim. Some contend that even when patients bring malpractice suits, the current liability system for resolving such claims is inefficient and ineffective. Many agree that in the current system, claims take a long time to be resolved, legal costs are high, and settlements and awards are unpredictable. Further, there is concern about whether the system deters the negligent practice of medicine.

In contrast, according to managed care and employer groups, health care costs could increase if ERISA were amended to provide compensation in its civil enforcement section or to change its preemption clause so that it does not supersede state tort laws. Some have expressed concern that the increases would be significant. According to the Corporate Health Care Coalition, expanding ERISA's remedies to encourage more litigation without improving the quality of decision-making would greatly increase plan liabilities and have a "chilling effect" on the use of managed care techniques.[49] As a result, health plans might find it more difficult to deny even inappropriate claims. However, data to accurately estimate the likely extent of such potential increases are lacking.[50]

[47]See Wendy K. Mariner, "Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field," p. 868.

[48]A. Russell Localio and others, "Relation Between Malpractice Claims and Adverse Events Due to Negligence," The New England Journal of Medicine, Vol. 325, No. 4 (1991), pp. 245-51.

[49]G. Lawrence Atkins and Kristin Bass, ERISA Preemption: The Key to Market Innovation in Health Care (Washington, D.C.: Corporate Health Care Coalition, 1995), p. 43.

[50]Several studies have attempted to estimate the potential costs associated with amending ERISA to extend malpractice liability to managed care plans. The estimates of these studies vary widely. However, the Congressional Budget Office is developing a paper to capture the cost implications of a broad range of proposed managed-care-related changes, including consumer protection and ERISA remedy issues. It expects this paper to be completed by the summer of 1998.

If managed care plans can be sued under state tort law, plan representatives say that they will pass the costs associated with these suits on to employers—the payers of health care. Employers say that faced with such cost increases, they might in response (1) reduce health care benefits, perhaps by excluding from coverage particular treatments and procedures; (2) provide a "defined contribution," or a fixed amount earmarked for such costs, to employees' health care costs; (3) shift more of the cost to employees by making them pay a higher percentage of the premiums; or (4) eliminate health care benefits completely.[51] Consequently, plan participants could end up with expanded remedies for adverse outcomes but potentially fewer or more expensive health care benefits.

Employer groups also suggest that the increased ability of plan participants to sue managed care plans and UR firms would lead to what ERISA preemption was intended to prevent. That is, benefit determination decisions would be considered treatment decisions (which would elicit the full array of malpractice remedies), and plans operating in multiple states would be subject to various laws. In addition, employers are concerned that they would be more likely to be sued for damages resulting from benefit denials or medical negligence because of their perceived "deep pockets." To date, however, no employers have been held liable for such damages.

Observations

When the Congress enacted ERISA in 1974, it would have been nearly impossible to predict the state of the U.S. health care delivery system in the late 1990s. Managed care has grown rapidly only within the past decade. Benefit coverage decisions now are more often made in advance of treatment, which creates a new kind of potential legal liability not faced by traditional fee-for-service health insurers—and not envisioned a quarter of a century ago.

ERISA's remedies section and preemption clause and their effect on compensation for injured plan participants have posed challenging questions for the courts. Recent case law displays a trend toward expanding liability beyond health care providers to include managed

[51]A 1995 study shows that employer-based health care coverage may be declining. Between 1988 and 1993, the percentage of the nonelderly population with employer-based coverage dropped from 67.0 percent to 61.1 percent. While several factors may have contributed to this decline, the study reported that some employers may be less willing to offer coverage because of its cost, and some employees may decline coverage because employers are requiring them to pay a higher premium. See John Holahan, Colin Winterbottom, and Shruti Rajan, "A Shifting Picture of Health Insurance Coverage," Health Affairs, Vol. 14, No. 4 (1995), pp. 254 and 255.

health care organizations. Generally, an HMO will be held liable when it directly provides medical services, when the provider is acting as its agent, or when it leads a beneficiary to reasonably believe that the provider is its agent. However, plan participants can be left without a remedy for injuries when they occur because of benefit denials. As managed care enrollment continues to grow, HMO exposure to liability will undoubtedly increase.

Proposed changes to ERISA's remedies section or its preemption clause seek to provide for fair and appropriate remedies for participants in managed care plans. However, analysts' efforts to assess the merits of such changes have been far from definitive, in part because the contending parties' interests and views differ sharply and in part because strong evidence on the effects of amending ERISA on cost and quality is absent. That is, there is no research on how or how much plans', employers', and consumers' costs would change if ERISA were amended. To date, much of the debate surrounding ERISA's current remedies has focused on a proposed "downstream" approach—which seeks to change the remedies available through the courts. Many have suggested that an "upstream" approach—which seeks to prevent court suits and protracted litigation—may warrant consideration as well.

Agency Comments and Our Response

DOL reviewed a draft of this report and provided technical comments, which we incorporated as appropriate. We also furnished a draft of this report for review to the American Association of Health Plans, Association of Private Pension and Welfare Plans, the ERISA Industry Committee, two ERISA experts—one of whom specifically represented the consumer viewpoint—and one expert in medical malpractice.

In commenting on the draft, the American Association of Health Plans focused on several areas that it believed needed to be clarified and revised. These included (1) distinguishing better between benefit coverage determinations and treatment decisions and clarifying the roles of physicians and plans in those decisions; (2) clarifying the discussion of plans' direct liability and vicarious liability for physicians' medical malpractice; and (3) providing additional information on state requirements for managed care plans' grievance and appeal processes, the incidence of service denials, and existing "counterbalances" to plans' inappropriate denial of benefits. The association also suggested the need both to discuss more fully the concern of some about proposed expansions of state tort law damages for health care liability and to make more prominent the discussion of "upstream" solutions such as improved

grievance and appeal procedures for participants. The final report contains revisions to reflect these clarifications and additions.

In its comments, the ERISA Industry Committee emphasized that ERISA is an adaptable and flexible law that is as relevant now as when it was enacted in 1974. Furthermore, the committee believed that the nature of benefit determinations has not fundamentally changed because of the transition from fee-for-service to managed health care. The committee stated that because in most cases health plans are making payment decisions and not treatment decisions, participants are not prohibited from obtaining treatment at their own expense and health care providers can still treat participants. Therefore, the committee believed that the draft report overstated the significance of changes in the health care delivery system as they relate to the legal issues associated with ERISA's appeal procedures and remedies. While we acknowledged the committee's position on the role that ERISA's standards play in the current health care environment, we believe the evidence suggests that prospective benefit coverage decisions can, in fact, affect participants' ability to obtain needed treatments, especially if other financial resources are not available.

The ERISA Industry Committee suggested, as did the American Association of Health Plans, that we distinguish better between benefit coverage determinations and treatment decisions, as well as elaborating on concerns about the effectiveness of the tort system as a remedy. The committee also commented that the report could better reflect the role of an employer-sponsored health benefit plan's fiduciary in safeguarding participants' interests and the potential that increased liability could cause benefit plan administrators to take defensive and other measures, with resulting increased costs and decreased coverage. We revised the final report to reflect these clarifications and perspectives.

In response to additional comments from these and other reviewers, we clarified certain distinctions and made technical changes as appropriate. We did not receive comments from the Association of Private Pension and Welfare Plans.

As we arranged with your offices, unless you announce the report's contents earlier, we plan no further distribution of it until 30 days after the date of this letter. We will then send copies to the Secretary of Labor. We will make copies available to others on request. If you or your staff have any questions, please call me at (202) 512-7114. This report was prepared

initially under the direction of the late Michael Gutowski; his role was later assumed by Jonathan Ratner. Major contributors to this report include Joseph Petko, Roger Thomas, Susan Poling, and Barry Bedrick.

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Abbreviations

DOL	Department of Labor
ERISA	Employee Retirement Income Security Act
HMO	health maintenance organization
IPA	independent practice association
POS	point of service
PPO	preferred provider organization
SPD	summary plan description
UR	utilization review

Federal Court Cases Addressing ERISA, Preemption, Benefit Denials, and Medical Malpractice

The preemption clause of the Employee Retirement Income Security Act of 1974 (ERISA) provides that ERISA supersedes any and all state laws "insofar as they . . . relate to any employee benefit plan" covered by the act. In many instances, the courts have concluded that ERISA preempts participant claims against managed care providers. Although plan participants may have limited remedies under ERISA, the remedies under state law that would typically be more generous, such as compensatory, punitive, or extracontractual damages, are barred by ERISA preemption. As managed care has become more widespread, plan participants or beneficiaries have sought to sue ERISA plans, employers, and organizations conducting utilization review (UR) under state law for malpractice, wrongful death, or benefit denials because of their actions or determinations under the plans. The plans, employers, and UR providers have argued that under the preemption clause, these state remedies are not available. (They have also argued that suits of this kind filed in state court must be removed to federal court.) In this appendix, we discuss these issues and describe some of the cases. In preparing this appendix, we reviewed federal case law and law review articles.[52]

The federal courts have found that ERISA may or may not preempt state law governing negligence or malpractice in suits against a managed care plan by a plan participant, depending on the circumstances of the case. It seems clear that if a court concludes that a claim is based on the wrongful denial of a benefit offered by the health plan, ERISA will preempt any claim for relief under state law. Under ERISA, the only remedy available to plan participants may be a court order requiring that the benefit be provided; ERISA preempts remedies authorized under state law such as compensatory, punitive, or extracontractual damages for malpractice. Some federal courts have permitted malpractice suits under state law against managed care plans to go forward where the provider is considered to be an agent of the plan or where the plan directly provides medical services.

Managed Care Arrangements

A managed care arrangement usually involves cost containment or some other control of the use of medical services. Several types of managed care arrangements are commonly used. A health maintenance organization

[52]Especially helpful were the following law review articles: Ellen A. Fredel, "ERISA and Managed Care: What the Courts Are Saying," Benefits Law Journal, Vol. 8, No. 3 (1995), pp. 105-18, and Gabriel J. Minc, "ERISA Preemption of Medical Negligence Claims Against Managed Care Providers: the Search for an Effective Theory and an Appropriate Remedy," Journal of Health and Hospital Law, Vol. 29, No. 2 (1996), pp. 97-106.

(HMO) provides medical services to members for a flat or fixed fee.[53] HMO subscribers or members are usually required to use an HMO-employed or HMO-contracted physician in order to qualify for coverage. A preferred provider organization (PPO) typically arranges for independent physicians, specialists, servicing hospitals, and other providers to provide medical care to subscribing members based on a fixed, usually discounted, fee.[54]

Both PPOs and HMOs typically use UR in some form. Under UR, the organization or a third party under contract with it evaluates proposed procedures or treatments to determine on the basis of clinical criteria whether they are medically necessary.[55]

Many employers who provide health care benefits through group plans regulated under ERISA have turned to managed care to control health care costs. As managed care has emerged as a principal cost-control measure, ERISA's federal preemption has affected the ability of participants to seek compensatory or punitive damages from managed care plans, based on a plan's role in providing medical care.

Critics of ERISA preemption believe that it is fundamentally unfair that ERISA supersedes state control over medical malpractice or negligent care cases. They also object to the limited remedies available under ERISA for the denial of a claim, which contrasts with state extracontractual, punitive, or compensatory damages for the same denial outside ERISA: When a UR organization determines that a particular treatment is not medically necessary, it is arguably making a medical decision. Yet ERISA leaves plan participants without a remedy for negligence or medical malpractice by a UR organization.

ERISA Preemption

ERISA was enacted to protect the interests of employees and their beneficiaries through comprehensive federal requirements and protections for employee pension and welfare benefit plans.[56] It sets standards for pension plans, including standards for vesting, accrual, and funding, and provides fiduciary standards for both pension and welfare benefit plans.

[53]Fredel, "ERISA and Managed Care," p. 105.

[54]Fredel, "ERISA and Managed Care," p. 105.

[55]Fredel, "ERISA and Managed Care," p. 105.

[56]Employee Retirement Income Security Act of 1974, H.R. Rep. No. 93-533 (93rd Cong., 1974), reprinted in U.S. Code Congressional and Administrative News, 4639-4670 (1974).

ERISA's federal preemption provision is intended to avoid conflicting state rules on the administration of these federally regulated plans.[57]

The ERISA preemption provision—section 514(a) of ERISA—says that with certain exceptions, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA.[58] If a plan participant or beneficiary claims to have been the victim of negligence or medical malpractice,[59] or wrongful denial of benefits by the plan, and injury or other damage resulted, then preemption is significant: Although state law typically authorizes punitive, compensatory, or extracontractual damages, such as for emotional distress, loss of consortium,[60] or injury,[61] ERISA does not.

The federal courts are increasingly being called upon to define more precisely the scope of ERISA preemption. Courts of appeals for the various federal circuits have interpreted the preemption provision differently. Conflicts among the circuits can be resolved by a definitive ruling by the Supreme Court or by legislation.

The courts have also identified a second kind of preemption that may apply to ERISA claims; in addition to preemption under section 514(a) of ERISA, which determines whether state law applies, ERISA claims are subject to so-called complete preemption under section 502.[62] Section 502 provides that state and federal courts have concurrent jurisdiction over

[57]According to Seema R. Shah, "Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to PacifiCare of Oklahoma v. Burrage," Minnesota Law Review, Vol. 80, No. 6 (1996), pp. 1545 and 1554, n. 45, the "rationale behind uniformity [preemption] was to avoid the administrative burdens that compliance with different federal and state laws would impose upon employers. Members of Congress were concerned employers would shift the cost of the administrative burdens to employees and their beneficiaries by lowering benefit levels. To avoid this problem, 'Congress intended preemption to afford employers [and employee benefit plans] the advantages of a uniform set of administrative procedures governed by a single set of regulations.'"

[58]29 U.S.C. 1144(a). As discussed below, ERISA litigation may also involve "complete preemption." Complete preemption has to do with whether a case filed in state court must be removed to federal court at the defendant's request, not with whether state law is preempted by ERISA. It is the latter that is commonly referred to as ERISA preemption.

[59]Shah, "Loosening ERISA's Preemptive Grip," p. 1545, n. 7.

[60]Compensable loss of consortium occurs when a tort damages the relationship between a husband and wife. It encompasses not only the material assistance of the injured spouse but such intangible benefits as companionship, cooperation, and affection. As discussed below, it has in recent years been extended to relations between parents and children. See Henry Campbell Black, Black's Law Dictionary, 6th ed. (St. Paul, Minn.: West Publishing Co., 1990), p. 309.

[61]Laura H. Harshbarger, "Note: ERISA Preemption Meets the Age of Managed Care: Toward a Comprehensive Social Policy," Syracuse Law Review, Vol. 47 (1996), pp. 191-224.

[62]Harshbarger, "Note: ERISA Preemption Meets the Age of Managed Care," p. 194, n. 15.

claims "to recover benefits due to [a participant or beneficiary] 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 . . . ."[63] Complete preemption under section 502 is a jurisdictional concept; if the defendant successfully argues that complete preemption applies, the case is removed to federal court.

In general, if a plaintiff chooses to file an action in state court, the defendant cannot force the removal of the action to federal court unless the plaintiff's complaint specifically raises issues of federal law. Suits filed in state court alleging malpractice or breach of contract in violation of state law would therefore ordinarily not be subject to removal on the defendant's motion. Presumably, in ERISA cases, defendants seek removal to federal court because they believe their federal defense—that section 514 preempts state law—will receive a more sympathetic hearing there than in state court. However, merely raising a federal issue as a defense does not ordinarily justify removal.[64]

Complete preemption is an exception to the general rule that removal is required only when the plaintiff's complaint raises a federal issue. The Supreme Court decided in Metropolitan Life Ins. Co. v. Taylor that a defendant may have a case removed from state to federal court even though the plaintiff's complaint does not raise federal issues if federal legislation has "so completely pre-empt[ed] a particular area that any civil complaint raising this select group of claims is necessarily federal in character."[65]

Complete preemption applies to ERISA claims under section 502. In Metropolitan Life, the plaintiff's complaint was based on common law contract and tort claims under state law only. However, the court found that any complaint brought against a plan under section 502, regardless of whether it is based on state causes of action, will be viewed as arising under federal law.[66]

Whether the case is heard in state or federal court, complete preemption does not resolve the issue of section 514 preemption. The plaintiff may still

[63]29 U.S.C. 1132(a)(1)(B), (e)(1) (1994).

[64]This is the so-called well-pleaded complaint rule. Other conditions may have to be met as well; for example, the federal court has original jurisdiction over the cause of action. See Franchise Tax Bd. v. Construction Laborers Vacation Trust, 463 U.S. 1, 9-12 (1983).

[65]481 U.S. 58, 63-64 (1987).

[66]Metropolitan Life, 66.

argue that his or her claim is not one that "relates to any employee benefit plan" and therefore that section 514 does not preempt his or her state cause of action.[67]

Deciphering the meaning and outer limits of "relates to" has been contentious and difficult.[68] One federal appellate court described the law in this area as "a veritable Sargasso Sea of obfuscation."[69] The Supreme Court in Shaw v. Delta Air Lines Inc. provided a basic definition: a state law "relates to" an employee benefit plan, within the meaning of the preemption clause of ERISA, if the law has "a connection with or reference to such a plan."[70] The Court noted that it is not enough that a state law affects employee benefit plans; the effect may occur "in too tenuous, remote or peripheral a manner" to warrant concluding that the law "relates to" the plan for purposes of the preemption clause.[71]

The Supreme Court refined its interpretation of what it means for a state law to "relate to" an employee benefit plan in New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.[72] In that case, the Court concluded that ERISA did not preempt a state law that mandated surcharges on the hospital bills of patients insured by commercial insurers (and certain HMOs) but not on the bills of patients insured by Blue Cross and Blue Shield. The Court concluded that these laws were not "related to" ERISA plans, even though the surcharges would have an indirect economic effect on ERISA plans: "if '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.'"[73]

[67]Metropolitan Life, 66.

[68]Minc, "ERISA Preemption of Medical Negligence Claims," p. 97.

[69]Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 717-719 (2d Cir. 1993), rev'd, 514 U.S. 645 (1995). This characterization by the Court of Appeals of the difficulties of interpreting ERISA was in effect confirmed when the Supreme Court overturned its decision.

[70]463 U.S. 85, 96-97 (1983); see also District of Columbia v. Greater Washington Board of Trade, 506 U.S. 125 (1992). In Shaw, the court found that a state law forbidding employee benefit plans from discriminating on the basis of pregnancy and a state law requiring employers to pay sick-leave benefits to employees unable to work because of pregnancy both "relate to" employee benefit plans within the meaning of the preemption clause of ERISA. Shaw, 96.

[71]Shaw, 100, n. 21; Greater Washington Board of Trade, 130.

[72]514 U.S. 645 (1995).

[73]514 U.S. 645, 655.

The Court in Travelers relied on the fact that the surcharge under the state statute applied whether or not the health services were furnished through an ERISA-covered plan. The Court noted that

"while Congress's extension of pre-emption to all 'state laws relating to benefit plans' was meant to sweep more broadly than 'state laws dealing with the subject matters covered by ERISA, reporting, disclosure, fiduciary responsibility, and the like,' . . . nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern . . . ."[74]

In Travelers, the Supreme Court made clear that state laws that have only an indirect influence on ERISA plans are not preempted. State laws that indirectly affect "the relative costs of various health insurance packages in a given State," or that do not preclude plan administrators from adopting uniform administrative practice or uniform interstate benefit packages, do not implicate those "conflicting directives" from which the Congress meant to insulate ERISA plans and are therefore not preempted.[75]

A more recent Supreme Court decision, De Buono, N.Y. Commissioner of Health v. NYSA-ILA Medical and Clinical Services Fund, illustrates this distinction.[76] At issue was a New York law that imposed a tax on gross receipts for patient services at hospitals, residential health care facilities, and diagnostic and treatment centers to defray the cost of the state's Medicaid program. The administrator of an ERISA plan for longshore workers alleged that it was a state law that "relates to" a health plan within the meaning of ERISA. The Supreme Court stated that "a consideration of the actual operation of the state statute leads us to the conclusion that the [tax] 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 meaning of the governing statute. The HFA [Health Facility Assessment—a gross receipts tax] is a tax on hospitals."[77] The Supreme Court concluded that any state tax, or other law, that increases the cost of providing benefits to covered employees will have

[74]514 U.S. 654, 661.

[75]514 U.S. 654, 656-661.

[76]Barbara A. De Buono, New York Commissioner of Health et al. v. NYSA-ILA Medical and Clinical Services Fund, 117 S. Ct. 1747 (1997).

[77]De Buono, 1752.

some effect on the administration of ERISA plans, but that does not mean that every such state law is preempted by ERISA.[78]

Remedies Under ERISA

ERISA's enforcement provisions prescribe the causes of action and remedies available under this federal law. Managed care organizations involved in medical malpractice lawsuits have asserted that ERISA preempts these state law claims. A managed care arrangement that successfully asserts such a defense may effectively avoid state tort remedies of extracontractual, compensatory, punitive, or exemplary damages.[79]

ERISA provides that a participant or beneficiary may bring a civil action "to recover benefits due to him under the terms of the 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."[80] Only the benefits to which a plan participant or patient is contractually entitled under the terms of the plan are available under ERISA.[81] Thus, if a benefit is denied, the remedy is to obtain the benefit.[82] Under ERISA, no civil action can be brought for malpractice, emotional distress, wrongful death, or negligence.

[78]De Buono, 1753. However, the Court further noted in the relevant footnote that "as we acknowledged in Travelers, there might be a state law whose economic effects, intentionally or otherwise, were so acute as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers and such a state law 'might indeed be preempted under section 514.' That is not the case here."

[79]Minc, "ERISA Preemption of Medical Negligence Claims," p. 98.

[80]Section 502(a)(1)(B); 29 U.S.C. 1132(a)(1)(B).

[81]Minc, "ERISA Preemption of Medical Negligence Claims," p. 98.

[82]In this and subsequent references to wrongful denial of benefits, we describe the remedy as an order to provide the denied benefit, because ERISA specifically provides for that. (It also permits suits to clarify a participant's right to future benefits or to enforce his or her right under the terms of the plan.) Often, however, providing the benefit will not be an adequate remedy, as for example when the participant has already received the benefit at his or her own expense or has died. ERISA does not expressly authorize reimbursement for the cost of a denied benefit. However, a court might base an order for reimbursement on the so-called equity power, under which judges may craft appropriate remedies not provided for in the law when necessary to do justice.

Case Review

Denial of Benefits Cases Under UR

A review of the cases that can be categorized as a denial of a benefit as a result of a UR decision indicates that ERISA preempts state law claims for negligence, wrongful death, medical malpractice, and the like.

Corcoran v. United Healthcare, Inc. illustrates the difficult issues relating to jurisdiction, remedies, and public policy faced by a court applying ERISA preemption in the managed care context.[83] Because of the plaintiff's high-risk pregnancy, her physician asked that the expectant mother be hospitalized for close monitoring. Under the plaintiff's employer's health plan, precertification and UR were necessary for the hospital admission and the length of the hospital stay. The firm performing UR for the employer's plan determined that hospitalization was not necessary, but authorized up to 10 hours a day of home nursing care. When a nurse was not on duty, the fetus went into distress and died.

The parents filed a wrongful death action in state court, alleging, in part, that Mrs. Corcoran's unborn child had died as a result of the negligence and denial of hospital care by both the health plan and the UR firm. The defendants removed the action to federal court and moved for summary judgment. They characterized the plaintiffs' wrongful death action as, in reality, an action for mishandling a claim by firms retained merely to administer benefits under an ERISA-covered plan. Their relationship to the plaintiffs, they contended, was wholly defined by the terms of the employer plan; as a result, plaintiffs' claims "related to" an ERISA plan and were therefore preempted. Plaintiffs answered that preemption would "contravene the purposes of ERISA by leaving them without a remedy."[84]

The Court of Appeals for the Fifth Circuit upheld the district court's judgment that ERISA preempted the state tort claims against the health plan and the UR firm. The court noted that "it is by now well established that the 'deliberately expansive' language of this [ERISA preemption] clause . . . is a signal that it is to be construed extremely broadly. . . ."[85] The court concluded that state laws "relate to" employee benefit plans not only with respect to the specific subjects dealt with in ERISA, such as reporting,

[83]965 F.2d 1321 (5th Cir. 1992), cert. denied, 506 U.S. 1033 (1992). Minc, "ERISA Preemption of Medical Negligence Claims," p. 100.

[84]Corcoran, 1324 and 1325.

[85]Corcoran, 1328.

disclosure, and fiduciary obligations, but also, in a much broader sense, whenever the state laws have "a connection with or reference to" an employee benefit plan.[86]

The UR firm argued that it did not make medical decisions or provide medical advice; all it did was determine whether Mrs. Corcoran qualified for the benefits provided by the plan by applying previously established eligibility criteria. The court disagreed but held that while the UR firm made medical decisions and gave medical advice, it did so in the context of making determinations about the availability of benefits under the health plan. In the court's view, this was enough of a relationship to an employee benefit plan to require ERISA preemption.[87]

In Tolton v. American Biodyne, Inc. the Court of Appeals for the Sixth Circuit used the same analysis to conclude that ERISA preempted state causes of action based on UR.[88] In that case, the covered employee, Mr. Tolton, was drug-dependent and suicidal. His employer's managed care health plan included a UR requirement. On several occasions, Mr. Tolton met with or talked to a psychologist who performed UR and, on that basis, denied him inpatient care. After attempting to obtain treatment from a variety of health care providers on a number of occasions, Mr. Tolton committed suicide.

Mr. Tolton's estate brought an action in state court against the employer's health plan, the plan administrator, and each of the health care providers who had treated him, including the psychologist who had performed UR. The claims included wrongful death and medical malpractice. On the motion of the plan, the case was removed to federal court based upon ERISA preemption. Summary judgment was subsequently granted, in part on this same basis.[89]

On appeal, the Sixth Circuit Court of Appeals affirmed the lower court's holding that ERISA preempted the wrongful death and medical malpractice claims. The court further noted that "the result ERISA compels us to reach means that the [plaintiffs] have no remedy, state or federal, for what may have been a serious mistake."[90] The court also found that any cause of

[86]Corcoran, 1329, citing Shaw, 96-97.

[87]Corcoran, 1331 and 1333.

[88]48 F.3d 937 (6th Cir. 1995).

[89]Tolton, 937 and 941.

[90]Tolton, 943, citing Corcoran, 1338.

action based on the psychologist's UR decision and the denial of Mr. Tolton's claim was also preempted.

Similar facts resulted in the same outcome in a district court decision in the First Circuit, while also generating a strongly worded opinion by a judge who believed that the result was an injustice and that the Congress should amend the law. The beneficiary was denied 30-day inpatient care by a UR provider. After the beneficiary committed suicide, plaintiff brought claims for breach of contract, medical malpractice, wrongful death, loss of parental and spousal consortium, intentional and negligent infliction of emotional distress, and specific violations of the Massachusetts consumer protection laws. ERISA was found to preempt these claims, but the court commented that "ERISA has evolved into a shield of immunity that protects health insurers, UR providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits."[91]

Other federal appellate courts have followed the approach taken in Corcoran and Tolton. The Eighth Circuit Court of Appeals found in Kuhl v. Lincoln National Health Plan of Kansas City, Inc., that failure of the managed care entity to preapprove heart surgery constituted a denial of benefits and thus that the state cause of action was preempted by ERISA.[92] The failure to preapprove, in the court's view, did not constitute the provision of medical advice.[93] The same result was reached in the Ninth Circuit in Spain v. Aetna Life Insurance Co.[94]

Agency and Quality of Benefit Cases

Some courts have avoided ERISA preemption on the theory that the defendant managed care entity was "vicariously" liable for the medical malpractice of a provider acting as its agent. Under an agency theory, the HMO, the "principal," is responsible for the conduct of the doctor providing services because, as its "agent," he or she is acting on its behalf.[95] The principal may be liable as a result of the acts of the agent either vicariously or directly. Vicarious liability means, in effect, that the wrongful acts of the

[91]Diane Andrews-Clarke v. Travelers Insurance Co., 984 F. Supp. 49, 53 (1997).

[92]999 F.2d 298 (8th Cir. 1993), cert. denied, 510 U.S. 1045 (1994).

[93]Kuhl, 302.

[94]11 F.3d 129 (9th Cir. 1993), cert. denied, 511 U.S. 1052 (1994).

[95]"Agency" has been defined as a fiduciary relationship that results from the manifestation of consent by one person to another that the other shall act on his or her behalf and be subject to his or her control. Restatement (Second) of Agency § 1.

agent are attributed to the principal who did nothing wrong. Direct liability means that while the agent's wrongful act caused the harm, the principal also acted negligently or wrongfully—for example, in selecting or retaining its agents or monitoring their activities.[96]

In Pacificare of Oklahoma, Inc. v. Burrage, the basis of the claims against the HMO was malpractice.[97] The case was removed in part from state court, where it had originally been filed. But the federal district court did not agree that preemption applied and permitted the state court to hear the plaintiff's claims that (1) the HMO primary care physician was the agent of the HMO and (2) the HMO was liable, both vicariously and directly, for the physician's actions.[98]

The Tenth Circuit sustained the decision of the district court that ERISA did not preempt these claims against the HMO.[99] While noting that there was no simple formulation, the court identified four categories of state laws that might "relate to" a plan, as that term is used in ERISA:

"(1) laws that regulate the type of benefits or terms of ERISA plans; (2) laws that create reporting, disclosure, funding or vesting requirements for ERISA plans; (3) laws that provide rules for the calculation of the amounts of benefits to be paid under ERISA plans; and (4) laws and common law rules that provide remedies for misconduct growing out of the administration of the ERISA plan."[100]

The court of appeals found that the malpractice claim against the HMO did not sufficiently "relate to" an ERISA plan to warrant preemption because it did not involve the administration, quality, or level of benefits. The court noted that ERISA would not preempt a malpractice claim against the physician and therefore should not preempt a vicarious liability claim against the HMO if the HMO held the doctor out as its agent.[101] When, as in this instance, an HMO plan directly provides medical services rather than ensuring payment, vicarious liability for negligence or malpractice by an

[96]American Law of Torts, pp. 531-32 (1983).

[97]59 F.3d 151 (10th Cir. 1995), affd. 923 F. Supp. 1448 (1995).

[98]Pacificare, 152.

[99]Pacificare, 153.

[100]Pacificare, 154.

[101]Pacificare, 155.

agent of the HMO is not preempted. The court therefore directed that the case be returned to state court.[102]

In Dukes v. U.S. Healthcare System, Inc., the court addressed several theories of negligence or medical malpractice involving an HMO.[103] Mr. Dukes' primary care physician ordered a blood test by a hospital that for unknown reasons was not performed and that allegedly would have disclosed extremely high blood sugar. Mr. Dukes died after additional medical treatment. His wife sued the physicians, hospitals, and HMO, U.S. Healthcare System, in state court.

In seeking removal of the case to federal district court, the HMO argued that (1) Mr. Dukes had obtained medical care as a benefit from a welfare benefit plan governed by ERISA, (2) removal was required by the "complete preemption" theory, and (3) the plaintiff's claims were preempted by section 514(a) of ERISA.[104] The district court dismissed plaintiff's claims against the HMO on the basis of ERISA preemption. "[A]ny ostensible agency claim," the district court concluded, "must be made on the basis of what the benefit plan provides and is therefore 'related' to it." The court also held that "the treatment received must be measured against the benefit plan and is therefore also 'related' to it."[105]

The Third Circuit Court of Appeals reversed the district court and remanded the malpractice claims to the state court.[106] The appellate court concluded that complete preemption did not apply because the plaintiff's claims focused only on the quality of benefits received; the plaintiff was not alleging that benefits were withheld nor seeking either to enforce rights under the terms of the plan or to have the right to future benefits clarified.[107]

[102]Pacificare, 151. According to the plaintiff's attorney, this case did not go to trial in state court because the parties settled. The settlement agreement contained a nondisclosure provision, so no further information is available.

[103]57 F.3d 350 (3d Cir. 1995), cert. denied, 516 U.S. 1009 (1995).

[104]Metropolitan Life, discussed above. See also Dukes, 351.

[105]Dukes, 353 (quoting the district court opinion in Dukes v. U.S. Healthcare System, Inc., 848 F. Supp. 39, 42 [E.D. Pa. 1994]).

[106]Dukes, 352. The plaintiff's attorney told us that at the state court level, the plaintiff agreed to drop U.S. Healthcare (the HMO) from the suit. In the state trial, the plaintiff won a $3 million judgment against one of the doctors. Subsequently, U.S. Healthcare sued the plaintiff's attorney in federal court for "malicious prosecution," contending that his suit against it was without merit or support.

[107]Dukes, 356-367.

The court found a significant distinction between this case and Corcoran, the case discussed previously in which ERISA was held to preempt a malpractice claim based on the UR provider's determination—contrary to the opinion of the plaintiff's physician—that the plaintiff did not need hospitalization during her pregnancy. This court said that the UR provider in Corcoran, "unlike the HMOs here, did not provide, arrange for, or supervise the doctors who provided the actual medical treatment for plan participants."[108]

Another recent appellate decision, this one from the Seventh Circuit, concluded that ERISA does not preempt a claim that the administrator of an employee health benefits plan is liable under state law for medical malpractice by a physician who is an agent of the plan. The plaintiff in Rice v. Panchal was treated by a preferred provider furnished by his health plan.[109] He brought suit in state court against the doctor for malpractice and against the health plan on an agency theory: The health plan, the plaintiff claimed, was responsible for the medical malpractice by its preferred provider. On a motion by the health plan, the case was removed to federal district court under the doctrine of complete preemption.[110]

The Seventh Circuit Court of Appeals found in Panchal that there was no complete preemption of the claim against the health plan.[111] The court acknowledged that complete preemption would be required if the plaintiff's state law claim could not be resolved without an interpretation of the contract—the ERISA plan—governed by federal law. In Panchal, the court said that resolving the question of whether the health plan is liable for the medical malpractice of the provider under state agency law does not require construing the ERISA plan; the issues, in this view, were whether the doctor was in fact an agent, whether he was authorized to act for the principal, and whether the injury would not have occurred but for the victim's reliance on the agency. Answering these questions does not involve the interpretation of the ERISA plan.[112] (In the state proceeding, the plan would be free to raise ERISA preemption under section 514 as a defense.)

[108]Dukes, 360.

[109]65 F.3d 637 (7th Cir. 1995).

[110]Panchal, 639 and 640.

[111]Panchal, 645.

[112]Panchal, 645.

ERISA has generally been found to preempt medical negligence claims where a managed care provider has acted merely as a payer for claims with respect to a health plan.[113] In Butler v. Wu, the plaintiff brought a medical negligence claim against a physician and an HMO.[114] The physician was neither an agent nor an employee of the HMO; he provided services to HMO members as an independent contractor. The HMO did not provide medical treatment itself.

The district court granted the HMO's motion to dismiss the case against the HMO, based on ERISA preemption of state law claims.[115] The court held that ERISA preempts state-law negligence claims against HMOs "where, as in this case, the HMO is fulfilling a role closer to that of a traditional insurer than that of a direct provider of health care services."[116] The court, examining the evolution of the health care industry, noted that the distinction between arranging and paying for health care services and providing such services directly may not always be so clear, and it reserved judgment concerning whether preemption would apply if it found that an HMO was directly providing medical care.

[113]Minc, "ERISA Preemption of Medical Negligence Claims," p. 99.

[114]853 F. Supp. 125 (D. N.J. 1994).

[115]Butler, 129.

[116]Butler, 130.

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