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BEHAVIORAL HEALTH ISSUE BRIEF SERIES

Issue Brief #8

Coverage Decisions Versus the Quality of Care: An Analysis of Recent ERISA Judicial Decisions and Their Implications for Employer- Insured Individuals¹

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Introduction

The United States Congress is currently debating landmark legislation that would expand federal standards applicable to managed care products purchased by employer-sponsored health plans covered by the Employee Retirement Income Security Act (ERISA).² The single most contentious issue in this debate concerns whether state damages remedies should be available for persons who suffer injuries as a result of the treatment decisions made by managed care companies. Under current law, the answer to this question turns on whether a court views a plaintiff's case as one that involves a "claim for benefits" or as one that challenges the *quality of care*. In the former situation, ERISA preempts (i.e., overrides) all state law remedies; in the latter, federal courts have determined that ERISA does not preempt the claim and have remanded numerous cases to state court. Because an estimated 125 million persons are covered by ERISA health benefit plans,³ this unanticipated effect of the law on the rights of individuals has been enormous and profound.

Over the past several years, this "quality versus coverage" distinction has resulted in a diminution of the ERISA defense available to employee health benefit plans. Yet the distinction still leaves many types of actions classified as coverage decisions, thereby depriving individuals of damages remedies where they exist under state law. Several recent ERISA judicial decisions

¹ The Department of Health and Human Services has reviewed and approved policy-related information within this document, but has not verified the accuracy of data or analysis presented. The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Care Financing Administration (HCFA), or the U.S. Department of Health and Human Services.

² ERISA §501 et seq.; 29 U.S.C. §1001 et seq.

³ Peter Jacobson and Scott Pomfret, "ERISA Litigation and Physician Autonomy," 283 JAMA 921, 921 (2000).

involving persons injured by managed care treatment decisions suggest that courts may be on the verge of adopting yet a new framework for determining when an ERISA managed care case involves a claim for quality or a claim for coverage. If this latest line of cases is adopted, then in fact most ERISA health benefit claims involving the services of managed care companies may in fact be classifiable as quality claims, thus falling outside the sweep of ERISA preemption.

This Issue Brief, prepared for the Substance Abuse and Mental Health Services Administration, examines the evolution of this framework for analyzing health claims emanating from the conduct of ERISA-covered managed care arrangements and considers its implications for the provision of treatment for mental illness and addiction disorders. Both studies and anecdotal evidence suggest that managed care companies impose particularly rigorous controls over treatment for mental illness and addiction disorders.⁴ It is therefore perhaps not surprising that legal challenges to treatment decisions frequently involve individuals with these conditions. Consequently, to the extent that courts are in fact on the verge of re-conceptualizing their approach to analyzing managed care cases under ERISA, the implications for treatment of mental illness and addiction disorders may be especially significant.

This Issue Brief begins with an overview that examines the coverage- and quality-related theories of liability that courts have developed over the years in the case of insurers and institutional health care providers and reviews their application to the managed care industry. The Issue Brief next considers the effect of ERISA on the application of these theories to managed care products furnished through ERISA-sponsored employee benefit plans. Part three examines recent court decisions that may signal a basic shift in judicial theory in the area of quality versus coverage. We conclude with a discussion of what this shift means for individuals covered by ERISA plans, as well as for the health care system as a whole.

It should be noted at the outset that this area of the law is in an extreme state of flux and thus policy could shift once again, especially if legislation pending in Congress alters ERISA preemption or the legal framework for determining the coverage/quality distinction. Nonetheless, the question whether managed care companies can or should be liable for damages for death and injuries sustained as a result of negligent or wrongful treatment decisions on their part is one that appears to resonate deeply with Americans (including employers themselves, according to at least one study).⁵ Thus, it is likely that the “ERISA shield” against liability in managed care treatment cases will continue to erode.

⁴ See, e.g., “Behavioral Health Benefits in Employer-Sponsored Health Plans, 1997,” 18:2 Health Affairs 67-78 (Mar./Apr. 1999). In this regard it is also worth noting that in the fall of 1999, when United Health Care announced its intention to permit network physicians to make independent decisions regarding the medical necessity of care, it was careful to exempt from this new policy decisions involving treatment for mental illness. M. Freudenheim, “Big HMO to Give Decisions on Care Back to Doctors,” N.Y. Times, November 9, 1999 at A1.

⁵ Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits* (Menlo Park, CA, 1999). In this study, 61% of all small firms, the majority of firms in nearly all regions of the country, and the majority of nearly all firms by industry type favored consumer protections including the right to be able to sue health plans for malpractice. Exhibit 15.6, p. 156.

Part 1. Overview: The Liability of Managed Care Companies Under State Law

The modern managed care system represents a hybrid of health insurance and health care. In their contracts, managed care companies of all types and at all levels in the contracting process⁶ sell health care, rather than simple health coverage. Members of managed care plans, whether loosely organized or tightly managed,⁷ are either encouraged or required to obtain their health care from a network of providers whose selection, compensation, and (to a greater or lesser degree) treatment decision-making⁸ all are subject to the control of a corporate entity and its agents. In essence, therefore, managed care represents the sale of health care for a preset fee, with the purchaser, the managed care company, its provider network, and covered members all sharing in the financial risks created by the enterprise.

Because managed care is a hybrid corporate model, courts have applied several bodies of law in deciding managed care liability cases. The two principal bodies of law that have been applied are the law of insurance *coverage*, and the law of *health care quality*.

The law of health insurance coverage and the theory of bad faith breach of contract. An insurance policy constitutes a contract between the insurer and the insured. As with any contract-based action, a breach of contract by an insurer can result in recovery of foreseeable damages for injuries that flow from the breach. In the case of health care, these foreseeable damages could be the cost of the treatment that was sought as well as compensation for lost work time and other predictable damages (typically identified as part of the contract itself).

Because of the unequal bargaining relationship between the parties in the case of insurance agreements (very few Americans, whether insured directly or through an employer, actually sit down and negotiate the terms of their insurance agreement with a managed care company), courts have long recognized the high potential for unfair dealing. As a result, over the past half century American courts have applied the theory of “bad faith breach of contract”⁹ to create liability on the part of health and liability insurers for unfair coverage decisions. The theory of bad faith breach applies to situations in which an individual can demonstrate that “an insurer has failed to deal fairly and in good faith with its insured by refusing without proper cause to compensate its insured for a loss covered by the policy.”¹⁰ Using this theory, plaintiffs can recover not only compensatory damages but also damages for pain and suffering, punitive damages, and attorneys fees.¹¹

⁶ A single managed care company may be the prime contractor in one arrangement or a subcontractor in another. For example, a Blue Cross company may be a prime contractor for an employer in one case and may sell its network to a different prime contractor who administers a managed care product for another employer. *See, e.g., Corcoran v United HealthCare, Inc.*, 965 F. 2d 1321 (5th Cir. 1992), cert. den. 506 U.S. 1033 (1992).

⁷ A loosely organized entity might be a preferred provider organization, which builds a non-exclusive network of providers who agree to discount the cost of care for members and supervises their activities to only a limited degree. At the other extreme is a staff or group model HMO that employs or contracts with its participating physicians and other health providers on an exclusive basis and maintains strict controls over practice management and utilization of services.

⁸ Sara Rosenbaum et al., “An Evaluation of Agreements Between Managed Care Organizations and Community-Based Mental Illness and Addiction Disorder Treatment and Prevention Providers (Second Edition),” (School of Public Health and Health Services, The George Washington University Medical Center, Washington, DC (1999)).

⁹ *See, e.g., Gruenberg v Aetna Insurance Co.*, 510 P. 2d 1032 (Cal. 1973).

¹⁰ *Id.*

¹¹ Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, 1997; 1999-2000 Supplement), Ch. 2(B).

In certain jurisdictions managed care entities, specifically HMOs, are not considered to be insurers and thus cannot be held liable for bad faith breach of contract. However, in recent years courts have begun to apply the common law tort of bad faith to managed care organizations for the wrongful denial of coverage. In *McEvoy v Group Health Cooperative of Eau Claire*,¹² the Wisconsin Supreme Court concluded that an HMO could be found liable for injuries caused by its injurious out-of-network benefit decisions. *McEvoy* involved a decision by a health plan medical director to terminate treatment for anorexia nervosa that was being furnished by an out-of-network specialty center in favor of in-network, less intensive treatment. The termination order was given even though the patient had not finished the course of treatment and had not achieved the recovery milestones identified under established treatment protocols, and even though the patient's treating physician opposed the termination. The plaintiff, who weighed 95 pounds at the time of discharge, relapsed almost immediately; when she was finally readmitted she weighed only 74 pounds. At that point the family paid for treatment.

Noting that the common law tort of bad faith had existed under Wisconsin law for 20 years, the court observed that HMOs are "hybrid entities" that when acting as insurers, create a "power imbalance similar to that between a classical insurer and policyholder." Since HMOs in fact hold licenses to sell insurance and are subject to many of the same regulations that govern traditional (i.e., indemnity) insurers, the court concluded that the liability theories applicable to other forms of insurance should apply here.

The *McEvoy* court also noted the public policy rationale for extending this theory of liability to HMOs:

Through contractual arrangements with physicians and patients, HMOs are able to exert significant influence on, if not outright control over, the costs of treatment regimens * * *. The fears attendant with such arrangements, however, revolve around the economic model of health care financiers focusing on reducing aggregate costs while failing to recognize and to protect adequately the medical needs of individual subscribers. This fear is particularly acute in the present high-cost medical economy where an adverse benefits ruling means not just that the financial will not provide payment, but also that the medical care itself is effectively denied.¹³

In distinguishing between in-network and out-of-network decisions, the court noted that in-network decisions by HMO physicians could be pursued as classic malpractice actions, while in making an out-of-network decision, the HMO was acting purely as an insurer and thus should be covered by insurance liability theory. Other courts appear to follow the *McEvoy* lead.¹⁴

Theories of medical quality liability: vicarious and corporate liability. As noted by the *McEvoy* court, managed care organizations also can be viewed as corporate entities that provide health care. In this regard, they are analogous from a legal point of view to hospitals, whose liability for the quality of the health care they furnish has been a tenet of medical malpractice theory for the past 40 years.¹⁵

Two separate theories of liability – vicarious liability and corporate negligence – can exist in the case of corporate health care providers. Both may be present in the same case.

¹² 570 N.W. 2d 397 (Wis. 1997).

¹³ *Id.* at 403.

¹⁴ See, e.g., *Long v Great West Life and Annuity Insurance Co.*, 957 P. 2d 823 (Wyo. 1998) (insurer may be liable under bad faith breach theory for unreasonable denials of prior authorization for necessary care).

¹⁵ *Law and the American Health Care System*, op. cit., Ch. 3(E).

Vicarious liability. Under the theory of vicarious liability, a provider may be held liable for the acts of its agents. In the case of hospitals, these agents may be physicians with staff privileges, nurses, and other health providers who work in the facility. In the case of managed care organizations, the agents are the network physicians, hospitals and other providers. The fact that the relationship between the company and the health professional is non-exclusive and contractual as opposed to an exclusive contractual or employment relationship does not defeat an agency claim. For example, in *Jackson v Power*,¹⁶ one of the leading cases on hospital liability law, a hospital was held vicariously liable for the negligence of its independent contractor emergency room physician. The Alaska Supreme Court found that under state licensure law and national accreditation standards, the hospital had a non-delegable duty to furnish emergency care and thus could be held liable for the quality of its contractor's care.

A key in hospital agency theory may be whether the patient picks the health provider, with vicarious liability limited to situations (such as emergency room physicians, anesthesiologists, or radiologists) where the hospital effectively supplies the service without choice.¹⁷ However, other courts have held that hospitals can be liable whenever they supply the service, regardless of the actual level of patient choice.¹⁸ Vicarious liability on the part of hospitals turns on the degree of control they maintain over the work of individual health professionals; even where they maintain no actual control, hospitals can be liable under "apparent" or "ostensible" agency theory where the relationship created gives the appearance of control.

In the case of managed care, the basic theories of vicarious liability (i.e., non-delegable duty, actual agency, and apparent agency) all become relevant. This is because by virtue of their own sales contracts, national accreditation standards, and various state and federal laws, managed care companies appear to maintain relationships with their networks that parallel the type of relationship that gives rise to a claim of vicarious liability.

In recent years, courts have applied vicarious liability theory to managed care arrangements. For example, in *Boyd v Albert Einstein Medical Center*,¹⁹ a Pennsylvania state court examined the master contract between the HMO and its purchasers, which stated that the HMO operated a "comprehensive prepaid program of health care* * *." The HMO contracted with an independent practice association (IPA) for its physician services; the IPA in turn selected its members, exercised control over their continued membership in the practice, and paid them from common funds. The court found that this evidence could support a claim of vicarious liability against the HMO, given its operation as a direct service provider rather than an indemnity insurer. At the same time, other courts have found similar relationships to lack the level of actual or apparent control necessary to establish vicarious liability.²⁰

Corporate negligence. The other theory of liability that governs hospitals and that has been held to apply to managed care organizations with seemingly increasing frequency is the theory of

¹⁶ 743 P. 2d. 1376 (Alaska 1987).

¹⁷ See, e.g., *Mehlman v Powell*, 378 A. 2d 1121 (Md. 1977); *Hannola v City of Lakewood*, 426 N.E. 2d 1187 (Ohio App. 1980), and other cases cited in *Law and the American Health Care System*, op. cit., Ch. 3(E).

¹⁸ *Law and the American Health Care System*, op. cit., Ch. 3(E).

¹⁹ 547 A. 2d 1229 (Pa. Super. 1988).

²⁰ See, e.g., *Chase v Independent Practice Association, Inc.*, 583 N.E. 2d 251 (Mass. App. 1991).

corporate negligence. In the landmark case of *Darling v Charleston Community Memorial Hospital*,²¹ the Illinois Supreme Court held that hospitals, as health care corporations, have a duty, grounded in licensure law and accreditation standards, to ensure that the services they furnish meet the standard of care. Doing so means the use of reasonable care in selecting and overseeing medical and other health professional staff, and reasonable oversight of the quality of care furnished by the staff. In a separate liability case, the Pennsylvania Supreme Court noted that the corporate theory of liability would not

be triggered every time something goes wrong in a hospital which harms a patient. * * * To establish corporate negligence a plaintiff must show * * * that the hospital itself is breaching a duty and is somehow substandard. This requires that the hospital knew or should have known about the breach of duty that is harming its patients. Just as regular negligence is measured by a reasonable person standard, a hospital's corporate negligence will be measured against what a reasonable hospital under similar circumstances should have done.²²

The notion that corporate health care providers have a direct obligation to patients to select competent staff and oversee the quality of their practice has gained increasing stature with courts considering the liability of managed care companies for substandard quality health care furnished by or through their corporate structures.²³

Recent legislative developments: liability for wrongful coverage determinations. In recent years several states have extended the theory of liability for negligent or wrongful coverage decisions by enacting laws that give individuals a direct right to sue an insurer for injuries sustained as a result of negligent or wrongful coverage determinations. An extension of sorts of the bad faith breach of contract theory, a negligent coverage statute permits a plaintiff to directly pursue a managed care company in its capacity of *coverage decision-maker*, without regard to whether one also can characterize the case as a *quality of care* case. Under such a statute, the negligence can be part of the coverage decision itself, rather than the actual fact of treatment, a critical distinction in the case of hybrid entities such as managed care companies.²⁴

In sum, under current law, plaintiffs in liability actions against managed care companies have two basic types of claims relevant to this Issue Brief: claims of liability that involve companies in their capacity as *insurers* and *coverage decision-makers*; and claims against companies in their capacity as *treatment providers*. One set of facts conceivably could give rise to both types of claims. Other theories of liability against managed care companies include theories based on fraud and violations

²¹ 211 N.E. 2d 253 (Ill. 1965).

²² *Edwards v Brandywine Hospital*, 652 A. 2d 1382, 1386 (Pa. Super. 1995).

²³ See, e.g., *Shannon v McNulty*, 718 A.2d 828 (Pa. Super. 1998) (in which the court, directly applying hospital theory, upheld corporate and vicarious negligence claims in connection with obstetrical related malpractice case) and *Petrovitch v Share Health Plan of Illinois, Inc.*, 719 N.E.2d 756 (Ill. 1999) (holding that the plaintiff presented sufficient evidence to entitle her to a trial on whether Share Health Plan is vicariously liable under the doctrines of both apparent and implied authority).

²⁴ The best known of these statutes is Texas Civ. Prac. & Reim §88.01 et seq., which establishes a duty on the part of a health insurer or HMO or other managed care entity to exercise ordinary care when making health care treatment decisions and provides for liability for damages for harm to an insured that is proximately caused by the failure to exercise ordinary care.

of other consumer protection statutes,²⁵ theories of public accommodation,²⁶ theories of due process in the case of publicly purchased managed care plans.²⁷

Part 2. The Effect of ERISA on Managed Care Liability

An Overview of ERISA and ERISA preemption. ERISA was enacted in 1974 to protect the integrity of employee pensions following a series of scandals related to employer and union fraud and mismanagement of billions of dollars in private pension payments.²⁸ ERISA applies to all employers except state and local governments and churches and church-related agencies (unless they choose to be covered by ERISA), and covers all benefits furnished through “employee benefit plans” sponsored by employers.²⁹

ERISA is a complex piece of legislation that establishes a substantial number of content standards in the case of employer pension plans but relatively few in the case of group health plans. ERISA provides a series of procedural protections for individuals whose claims for benefits are denied, including the right to a “full and fair hearing” from the employer plan and access to the courts to enforce their current and future rights under the plan. Because ERISA is grounded in the law of trusts,³⁰ individuals who are denied benefits promised by the plan may sue to recover their benefits and may also recover certain types of “extra-contractual” damages against the plan, such as injunctive relief.³¹ However, consistent with the law of trusts (which emphasizes protection of the trust corpus for all trust beneficiaries and thus protects the corpus from the possibility of large rewards other than the benefit owed in the case of any individual beneficiary), ERISA does not allow recovery for money damages. ERISA “fiduciaries” (i.e., the employer or entity entrusted with the administration of the plan) have as their highest duty the protection of trust assets and their use exclusively for the benefit of plan participants.

The fact that ERISA does not provide for damages as a remedy is not unduly significant in and of itself. Indeed, relatively few federal laws provide for the recovery of damages, since this type of remedy is viewed as the purview of state law and the judge-made common law on which much state law is grounded. However, ERISA has been construed by the United States Supreme Court as preempting virtually any state law that “relates to” an employee benefit plan, even in cases in which there is no specific provision of ERISA that is in conflict with the particular state law at issue.

This extraordinary level of preemption is known as “field preemption”, meaning that in the case of ERISA, the federal statute is judged to preempt the entire field of state law relevant to benefit plan administration, whether or not the state law comes into actual conflict with a provision of ERISA. Field preemption is highly unusual. Consistent with a federal legislative scheme (which if anything has been construed in recent years to limit the powers of Congress in areas of law reserved

²⁵ See, e.g., *Napoletano v Cigna Healthcare of Connecticut, Inc.*, 680 A.2d 127 (Conn. 1996).

²⁶ *Woolfolk v Duncan*, 872 F. Supp. 1381 (E.D. Pa. 1995).

²⁷ See, e.g., *Grijalva v Shalala*, 152 F.3d 1115 (9th Cir. 1998), vacated and remanded 119 U.S. 1573 (1999) (Medicare); *J.K. v Dillenberg*, 836 F. Supp. 694 (Medicaid); and *Daniels v Wadley*, 926 F. Supp. 1305 (D. Tenn. 1996) (Medicaid).

²⁸ John Langbein and Bruce Wolk, “Pension and Employee Benefit Law” (2d ed. 1995).

²⁹ 29 U.S.C. §1003.

³⁰ *Firestone Tire and Rubber v Bruch*, 489 U.S. 101 (1989).

³¹ 29 U.S.C. §1132(g).

to the states³²), most Congressional legislation with preemptive effect is drafted (and subsequently construed by the courts) to provide only for “conflict preemption”. Under the theory of conflict preemption, state law is preempted only where it actually conflicts with a specific provision in the federal statute.

In the case of ERISA, the United States Supreme Court has determined that the need for national uniformity in the *administration of employee benefit plans* is so great that the law must be construed as one that establishes field preemption. As a result, any state law that “relates to” an employee benefit plan is preempted.³³ The term “relate to” has been construed as meaning having a “connection with” or “reference to” the benefit plan; in recent years the Court has narrowed the range of laws that fall within either the “connection with” or “reference to” category to exempt laws whose relationship to the administration of employee benefit plans is simply too “tenuous and remote” or “indirect” to be considered as laws that relate to a plan.³⁴ In recent years the Court has moved away from a highly “textual” (i.e., literal) reading of the law’s preemption provisions and toward a contextual interpretation of the statute as a means of limiting its preemptive effects. Nonetheless, the reach of the preemption standard is still considerable.

Although ERISA preempts state laws that relate to ERISA-covered employee benefit plans, it also provides that state laws that regulate banking and insurance are “saved” from preemption.³⁵ This provision would appear to save many state laws that regulate the insurance industry, including state statutes creating liability for negligent treatment decisions, as well as the common law theory of bad faith breach of contract. However, the Supreme Court has further determined that not every law that regulates *the insurance industry* is a law that *regulates insurance*. The Court has held that in an ERISA case, it is a question of federal law whether a state law in fact is one that regulates insurance and thus is saved.³⁶ Generally, in order to be a law that “regulates insurance,” the state law at issue (whether statutory or judge-made common law) must meet a three-pronged test (although the Court has loosened this standard a bit during the past year³⁷). First, it must regulate the relationship between the insurer and the insured. Second, it must involve the spreading of risk. Third, it must be specific to the insurance industry. Thus, many laws that apply to insurers nonetheless may not be “saved” from preemption.³⁸

The application of preemption theory to state laws creating liability for damages against insurers. The full meaning of ERISA preemption in the case of individual rights was seen in the landmark Supreme Court decision of *Pilot Life v Dedeaux*.³⁹ The *Pilot Life* case involved an action for bad faith breach of contract by a man who had been denied his disability benefits under an ERISA-covered disability

³² See, e.g., *Kimel v Florida Bd. Of Regents*, 120 S. Ct. 631 (2000) and cases cited therein.

³³ ERISA §514(a); 29 U.S.C. §1144(a); *Shaw v Delta Airlines*, 463 U.S. 85 (1983).

³⁴ *New York State Conference of Blue Cross & Blue Shield Plans v Travelers Insurance Co.*, 514 U.S. 645 (1995) and *Donovan v Dillingham*, 688 F.2d 1367 (11th Cir. 1982).

³⁵ ERISA §514(a)(2); 29 U.S.C. §1144(a)(2).

³⁶ *Metropolitan Life Insurance Co. v Massachusetts*, 471 U.S. 721 (1985).

³⁷ See *Unum Life Insurance Co. of America v Ward*, 119 S. Ct. 1380 (1999), in which the Supreme Court upheld California’s “notice prejudice” law that prohibits insurers from denying claims that were not filed in a timely fashion unless they could prove that the lack of timely notice was in some way prejudicial. The law was upheld even though the “risk-spreading” prong of the three-pronged test could not literally be said to have been met.

³⁸ See cases cited in *Law and the American Health Care System*, op. cit., Ch. 2(C).

³⁹ 481 U.S. 41 (1987).

pension plan. The plaintiff's case was based on the Mississippi common law claim of bad faith breach of contract; the plaintiff argued that the law was saved as a law that regulated insurance.

Writing for the Court, Justice Sandra Day O'Connor, a noted advocate of states' rights, held that the common law tort of bad faith breach of contract "related to" ERISA plans and was therefore preempted, and further that the law was not saved as a law that regulated insurance. This latter holding was based on the Court's conclusion that, as a general tenet of the common law applicable to many types of contractual arrangements, the Mississippi common law failed to meet any element of the three-pronged test.

Justice O'Connor stressed that ERISA's civil enforcement provisions, which provide for the recovery of benefits owed but essentially no more, are so integral to the delicate political and substantive balance achieved by the law that to permit injured individuals to recover damages would fundamentally undermine the law's entire scheme.

The civil enforcement scheme of ERISA * * * is one of the essential tools for accomplishing the stated purpose of ERISA. * * * Under the civil enforcement provisions, a plan participant or beneficiary may sue to recover benefits due under the plan, or to clarify rights to future benefits. Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against an administrator's improper refusal to pay benefits. A participant or beneficiary may also bring a cause of action for breach of fiduciary duty and under this cause of action may seek removal of the fiduciary. * * * The policy choice reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Thus, with the *Pilot Life* decision, the Court removed the right of over 125 million Americans to recover damages against insurers offering ERISA-sponsored products for bad coverage decisions. Nothing in the history surrounding enactment of ERISA indicated that Congress ever contemplated such a far-reaching result, but the argument in favor of the decision (i.e., the overwhelming need to protect pension plans from depletion in the face of huge damages actions) was perceived as sufficiently compelling to scotch all possibility for a reversal of the decision. The decision not only removes the bad faith breach of contract claim from the armament of remedies available to injured parties but in all likelihood renders inapplicable state laws that permit damages for negligent coverage decisions.⁴⁰

The extension of Pilot Life to managed care cases. The first major test of the effect of the *Pilot Life* decision on claims against managed care companies brought by beneficiaries enrolled in ERISA-sponsored health plans came in *Corcoran v United Healthcare, Inc.*⁴¹ The facts of the *Corcoran* case were "undisputed" according to the court. The case involved a woman with a high-risk pregnancy and experiencing pre-term labor who, despite the standards of care that apply to such cases, was denied

⁴⁰ In *Corporate Health v Texas Department of Insurance*, 12 F. Supp. 597 (S.D. Tx. 1998), a federal court considered the application of the Texas liability law (discussed *supra*) to negligent treatment decisions by ERISA plans, but did not squarely reach its application to coverage determinations (since the case involved a facial challenge to the statute, the court was deciding whether under any circumstances the statute could survive a preemption challenge). Although after *Pilot Life* it is really not an open question whether such a law could in fact reach ERISA plans, the court in *Corporate Health* found the statute not preempted as applied to insurers and managed care plans merely acting as service providers to ERISA plans.

⁴¹ 965 F. 2d 1321 (5th Cir. 1992), cert. den. 506 U.S. 1033 (1992).

round-the-clock hospital care over her physician's objections by the defendant. United, as the utilization review company, instead prescribed part-time home nursing benefits. During the evening hours when the nurse was off duty, the woman went into full labor and lost the baby.

The family sued United Healthcare for wrongful death and negligence under Louisiana law. The defendants moved to dismiss the claim as preempted. According to the defendants, the claim was in essence one to recover benefits owed; as a result, ERISA preempted the Louisiana law allowing damages for negligent coverage decisions and provided the only avenue by which the family could seek redress for its alleged injuries. United argued that it simply made a benefit determination, not a medical decision.

The United States Court of Appeals for the Fifth Circuit agreed. Citing *Pilot Life*, the court determined the case involved a claim for benefits and held that the plaintiff's only remedies could be found in ERISA itself, and that Louisiana law was preempted. Holding that United made "medical decisions incident to benefit determinations," the court acknowledged the important difference between traditional insurance decisions in retrospective denial cases and the impact of such decisions in an era of managed care:

United argues that the decision it makes in *** the prospective context is no different than the decision an insurer makes in the traditional retrospective context. The question in each case is what the medical plan will pay for, based on a review of [the beneficiary's] clinical information and nationally accepted guidelines for the treatment of ** the condition. *** A prospective decision is, however, different in its impact on the beneficiary than a retrospective decision. In both systems, the beneficiary theoretically knows in advance what treatments the plan will pay for, because coverage is spelled out in the plan documents. But in the retrospective system, a beneficiary who embarks on the course of treatment recommended by his or her physician has only a potential risk of disallowance or all or a part of the cost of that treatment and then only after treatment has been rendered. In contrast, in a prospective system a beneficiary may be squarely presented in advance of treatment with a statement that the insurer will not pay for the proposed course of treatment and the beneficiary has the potential of recovering the cost of that treatment only if he or she can prevail in a challenge to the insurer's decision. A beneficiary in the later system would be far less inclined to undertake the course of treatment that the insurer has at least preliminarily rejected. By its very nature a system or prospective decisionmaking influences the beneficiary's choice of treatment options to a far greater degree ***. Indeed, the perception among insurers that prospective determinations result in lower health care costs is premised on the likelihood 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 ***. When United makes a medical decision *** it is making a medical recommendation which – because of the financial ramifications – is more likely to be followed. ***

The acknowledged absence of a remedy under ERISA's civil enforcement scheme for medical malpractice committed in connection with a plan benefit determination does not alter our conclusion. While we are not unmindful of the fact that our interpretation of the preemption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans the lack of an ERISA remedy does not affect a preemption analysis. *** Congress could not have predicted the interjection into the ERISA "system" of the medical utilization review process, but it enacted a pre-emption clause so broad and a statute so comprehensive that it would be incompatible with the language, structure and purpose of the statute to allow tort suits against entities so integrally connected with a plan.⁴²

⁴² *Corcoran*, 965 F. 2d at 1333-34.

Other courts followed the lead of the *Corcoran* court and held that ERISA preempted claims against managed care companies when performing prospective utilization review decisions, because such claims were in reality claims for benefits and thus subject to the exclusive remedies allowed in ERISA. In one particularly compelling case that yielded a written protest from the trial judge, the negligent coverage decisions made by a health plan was alleged to have led to the suicide of a man who was allegedly discharged prematurely from inpatient care for alcoholism and mental illness.⁴³ Numerous other decisions rejecting damages actions against managed care companies that, in administering ERISA plans made negligent or wrongful treatment decisions in the course of utilization review, rapidly mounted across the country.⁴⁴

The Dukes case and the quality/coverage distinction. In 1995, three years after the *Corcoran* ruling, the United States Court of Appeals for the Third Circuit issued a decision that established a crucial limitation on the application of ERISA preemption theory to claims involving medical injuries. *Dukes v U.S. Healthcare, Inc.*⁴⁵ involved claims for both vicarious and corporate negligence brought against the health care company and its participating hospitals and physicians. In the case the decedent failed to receive from both his physician and a participating hospital timely care that would have identified extremely high levels of blood sugar that led to his death. The widow filed a malpractice action against the plan and its network hospitals and facilities. The defendants “removed” the case to federal court under federal procedural rules and the trial court dismissed the claims as in essence claims for benefits subject to the limited remedies of ERISA.

The Third Circuit reversed, holding that claims alleging medical malpractice by health care providers involve challenges to the *quality of care*, rather than *claims for benefits*. Because quality of care cases do not involve claims for benefits, they do not “arise under” ERISA and thus are not preempted:

Nothing in the [complaint] indicates that plaintiffs are complaining about their ERISA welfare plans’ failure to provide benefits due under the plan * * *. [T]he plaintiffs * * * complain about the low quality of the medical treatment they actually received and argue that U.S. Healthcare HMO should be held liable under agency and negligence principles. * * * [A] claim about the quality of a benefit received is not a claim * * * ‘to recover benefits due’ * * * under the terms of [the] plan.

We recognize that the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear in situations like this one, where the benefit contracted for is health care services rather than money to pay for such services. There will be cases in which the quality of a patient’s medical care or the skills of the personnel provided to administer that care will be so low that the treatment received simply will not qualify as health care at all. In such a case, it may well be appropriate to conclude that the plan participant or beneficiary has been denied benefits due under the plan. This is not such a case, however; while the * * * complaint alleges that the * * * hospital committed malpractice when it decided not to perform certain blood tests, no one would conclude from that malpractice that [the hospital] was not acting as a health care provider when it made those decisions.

* * [T]he HMO’s argument * * * is at root a contention that the employer and the HMO impliedly contracted that the health care services provided would be of acceptable quality and, accordingly, that these damage suits rest on a failure to provide services of acceptable quality. * * * [W]hile we have no doubt that all concerned expected the medical services arranged for by the HMOs to be of acceptable quality, this seems to us beside the point. The relevant inquiry is not whether there was an

⁴³ *Andrews-Clarke v Travelers Insurance Co.*, 984 F. Supp. 49 (D. Mass. 1997).

⁴⁴ See cases cited in *Law and the American Health Care System*, op. cit., Ch. 3(E).

⁴⁵ 57 F. 3d 350 (3rd Cir. 1995), cert. den. 116 S. Ct. 564 (1995).

expectation of acceptably competent services but rather whether there was an agreement to displace the quality standard found in otherwise applicable law with a contract standard. * * *

The HMO takes heart in [Corcoran]. * * * Although United's decisions in Corcoran were in part medical decisions, United, unlike the HMOs here, did not provide, arrange for, or supervise the doctors who provided the actual medical treatment. Instead, United only performed * * * utilization review. The difference between "utilization review" and arranging for medical treatment is crucial * * * because only in a utilization review role is an entity in a position to deny benefits * * * .

In these cases the defendants HMOs play two roles, not just one * * * . * * * Unlike Corcoran there is no allegation that the HMOs denied anyone any benefits that they were due under the plan. Instead the plaintiffs here are attempting to hold HMOs liable for their role as the arrangers of their decedents' medical treatment. * * *⁴⁶

The *Dukes* quality/coverage distinction was quickly embraced by courts throughout the country who understood the analytic framework as a means of averting the seeming injustice of preempting state remedies for injuries caused by the conduct of managed care companies. Furthermore, classifying the case as a quality case that is governed by state law results in the remand of the case back to the state courts from federal court, thereby freeing the federal courts of having to handle cases that, even if benefit claims, are really battles over the standard of medical care.⁴⁷ Federal courts—particularly courts that are as overwhelmed by cases as is the current federal court system—view medical standards cases as the quintessential province of state courts.

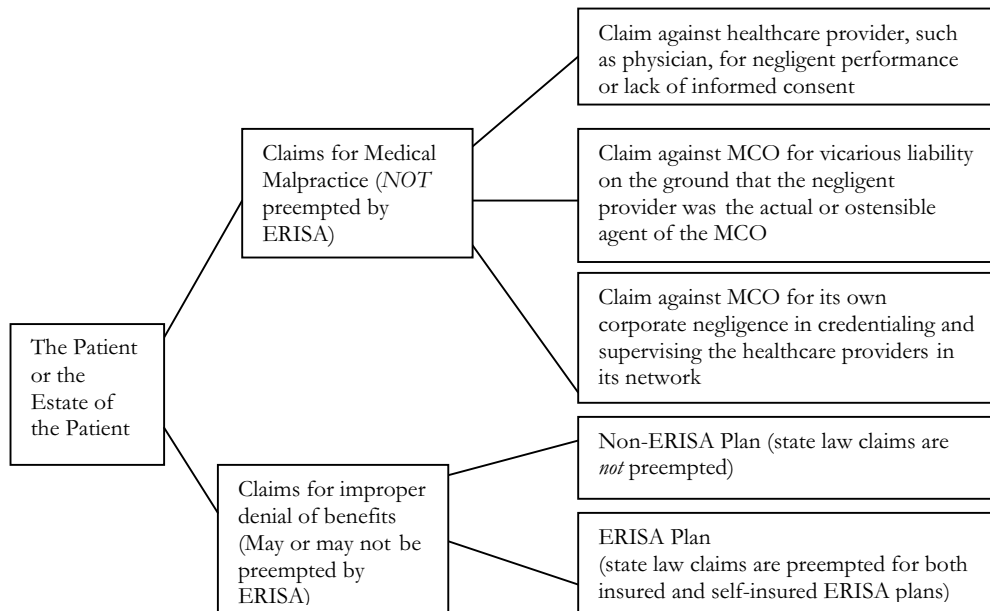
In sum, ERISA preemption applies to claims that are for benefits due under the plan, but not for claims challenging the quality of care. As the *Dukes* court pointed out, HMOs wear two hats: those of insurers and health care providers. When a claim challenges the conduct of an HMO in its utilization management capacity, a preemption holding is nearly inevitable. But to the extent that the claim involves the quality of care, most federal courts will classify the complaint as not preempted and will remand the case to state court for a trial on the merits. This of course does not mean that the plaintiff wins. It may turn out that the real issue in the case is a claim for benefits, in which case the state court must dismiss the action as preempted by ERISA. It may also turn out that the claim of malpractice against the HMO cannot be sustained under either corporate or vicarious negligence theories, for the reasons explored earlier in this Issue Brief. Furthermore, post-*Dukes/Corcoran* cases tend to be a hodgepodge of holdings. In some cases, the court construes the complaint as effectively one for benefits; in others, with strikingly similar facts, a court will view the complaint as one challenging the quality of care.⁴⁸ Nonetheless, the *Dukes* case was viewed as a major victory for plaintiffs because it opened the door to a medical malpractice case against an HMO whose product is supplied to an ERISA plan. ERISA preemption of certain state law claims is summarized in the following figure.

⁴⁶ *Dukes*, 57 F. 3d at 356-61.

⁴⁷ Sara Rosenbaum, David Frankford, Brad Moore, and Phyllis Borzi, "Who Should Determine When Health Care is Medically Necessary?," 340 NEJM 3 (January 21, 1999).

⁴⁸ See *Law and the American Health Care System*, op. cit., Ch. 3(E).

Figure 1. ERISA Preemption of State Law Claims⁴⁹



Part 3. The Further Blurring of the Coverage/Quality Distinction Post-*Dukes*: The *Moscovitch* and *In Re U.S. Healthcare* Cases

Two recent decisions underscore the inclination of the courts to view HMOs in their health care provider capacity when reviewing cases brought by ERISA plan participants.

*Moscovitch v Danbury Hospital*⁵⁰ involved a wrongful death action brought by an ERISA beneficiary following the death of her son. The facts of the case were as follows: The plaintiff was enrolled in a medical plan administered by the PHS company as part of an ERISA-covered benefit plan. The plaintiff's son was admitted to Danbury hospital for serious mental illness and then transferred to Vitam for continued treatment. The day of his arrival at the second provider, the plaintiff committed suicide. The plaintiff's complaint alleged negligence on the part of the hospital, the second provider, and the plan administrator. Specifically, the complaint alleged, among other matters, that both directly and through its agents Danbury and Vitam, PHS was negligent and failed to provide the appropriate standard of care.

The defendants removed the case to federal court and moved for dismissal of the claims as claims for benefits that were preempted by ERISA. The company pointed to the following elements of the complaint as essentially establishing coverage claims: PHS improperly terminated treatment at Danbury and transferred the decedent; PHS made improper determinations regarding the type of treatment the decedent required; and PHS refused to provide inpatient care.

⁴⁹ This flowchart is taken from Dean M. Harris, "Healthcare Law and Ethics: Issues for the Age of Managed Care," Health Administration Press (Chicago, IL, 1999), p. 292.

⁵⁰ 25 F. Supp. 2d 74 (D. Conn. 1998).

In fact, these claims were strikingly like those in the *Corcoran* case, which similarly involved decisions not to hospitalize a patient and instead to order outpatient care. Nonetheless, the court refused to dismiss the claims:

Viewing these allegations in context [of the claims against the treating providers Danbury Hospital and Vitam], however, it is clear that the plaintiff is challenging the appropriateness of the medical and psychiatric decisions of PHS concerning the care given to the decedent. [The complaint] does not assert that PHS was making the wrong decisions about whether certain care would be covered by its plans but instead challenges the decisions made by PHS with respect to the quality and appropriate level of care and treatment. For example [the complaint] alleges that PHS failed to properly diagnose and assess the decedent's psychiatric condition, failed to properly monitor care and treat him, failed to properly oversee his treatment, and failed to prescribe and administer appropriate medication. Such claims do not fall within the scope of ERISA. * * * The plaintiff here, like the plaintiff in *Dukes*, challenges the quality of the medical treatment the decedent allegedly received from PHS and its agents.

The court * * * recognizes that it is often difficult to determine when an entity such as PHS is arranging, supervising, or providing the medical treatment of a plan participant * * * or merely making benefit determinations. * * * It will be the plaintiff's burden [at trial] to show that PHS crossed the line into making such treatment decisions, but he may attempt to do so under state law. * * *

In a 1999 case, the first since it decided the *Dukes* case, the United States Court of Appeals for the Third Circuit extended its earlier holding in what may be an extension of its earlier rationale regarding the “two lives” of HMOs. *In re U.S. Healthcare, Inc.*⁵² involved the death of a two-day-old baby following a 24-hour discharge by the HMO.⁵³ The baby exhibited signs of illness soon after discharge; neither the physician nor the HMO responded to the family's urgent requests for medical care, including home visitation by an HMO nurse under its advertised “L'il Applesseed” program for newborns. The plaintiff, among other matters, directly challenged as negligent the HMO's use of a presumptive 24-hour discharge policy as a general treatment standard and without an individualized decision. In effect, at least one count of the complaint in effect directly challenged the appropriateness of the company's *coverage standards*.

Nonetheless, the court refused to dismiss this claim:

As an administrator overseeing an ERISA plan, an HMO will have administrative responsibilities over the elements of the plan, including determining eligibility for benefits, calculating those benefits, disbursing them to the participant, monitoring available funds, and keeping records. As we held in *Dukes*, claims that fall within the essence of the administrator's activities in this regard fall within [ERISA's civil action provisions] and are completely preempted. In contrast, * * * when the HMO acts under the ERISA plan as a health plan provider, it arranges and provides medical treatment, directly or through contracts with hospitals, doctors or nurses. In performing these activities, the HMO is not acting in its capacity as a plan administrator but as a provider of health care, subject to the prevailing standard of care.⁵⁴

⁵¹ *Moscovitch*, 25 F. Supp. 2d at 80-82.

⁵² 193 F. 3d 151 (3rd Cir. 1999).

⁵³ The facts of this case arose before the 1996 enactment by Congress of the Newborns' and Mothers' Health Protection Act, Pub. L. 104-204, which amends ERISA to prohibit the use of automatic 24-hour discharge policies.

⁵⁴ *In re U. S. Healthcare*, 193 F. 3d at 162.

In re U.S. Healthcare can be seen as the full realization of the import of the modern American medical system in an ERISA context. As a practical matter, the old insurance/health provider distinction no longer exists. Whether loosely or tightly organized, the modern American health care company sells health care; in an ERISA context, it also sells administrative services. But these administrative services assume a subsidiary position in the view of the Third Circuit when the issue is the treatment being provided rather than recordkeeping, eligibility determination, or benefit payment matters. In effect, *In re U.S. Healthcare* makes the coverage/quality distinction moot in a managed care context. Once the facts of a case are grounded in medical treatment, the company's conduct vis-a-vis the plaintiff is integral to treatment, and the proper analytic framework is malpractice, not insurance coverage decision-making.

Conclusion and Implications

Several major conclusions can be drawn from the cases to date.

First, given the strong public opinion in favor of retaining individual rights against managed care companies operating under ERISA plans, as well as the more self-interested desire to avoid cases if possible, it is possible that federal courts around the country may follow the lead of the Third Circuit in its latest ERISA case, just as they did following the *Dukes* decision. In cases involving challenges to the quality of the treatment standards and procedures used by managed care companies, courts increasingly may view these actions as extensions of the company's role as a treating health care provider rather than as a plan administrator that makes coverage decisions. This is particularly the case where the named defendant is the HMO or prime managed care intermediary rather than a utilization management firm, as in *Corcoran*.

Second, where employers self-insure and buy administrative services from HMOs and other managed care entities, the employers may themselves face vicarious liability claims. As with any other vicarious liability claim, the resolution of such a claim against an employer will turn on whether the facts support a conclusion that the employer retained control over the conduct of the company. At least in those cases where self-insuring employers act as their own ERISA fiduciary and thus retain the right to make ultimate decisions regarding whether or not treatment will be furnished, the evidence of control is very strong. Congress could of course choose to limit exposure, even where employers retain control over treatment decisions.

Third, the *Dukes* case, as important as it is, also makes clear that if an employer and an insurer contract for a *certain standard of care*, then courts may in fact be bound to honor such an agreement as consistent with the enormous discretion that employers have under ERISA to design their own benefit plans. In fact, such a case already has occurred. In *Jones v The Kodak Medical Assistance Plan*,⁵⁵ the United States Court of Appeals for the Tenth Circuit dismissed a challenge to denial of appropriate treatment for an addiction disorder on the grounds that even though the application of the plan's treatment standards was, by the admission of the plan's own consultant, inappropriate in the plaintiff's case, the treatment guidelines in use were part of the plan documents themselves and thus completely unreviewable.⁵⁶ In other words, the court found nothing wrong with a company that decided to write possibly substandard treatment guidelines into its plan.⁵⁷

⁵⁵ 169 F. 3d 1289 (10th Cir. 1999).

⁵⁶ According to the court, the guidelines were a matter of *plan design and structure*,

The implications of the *Kodak* case for employee rights are profound. To the extent that managed care companies include their treatment guidelines in their contracts with employers, their treatment decisions could all be “boot-strapped” into the plan itself and thus shielded from review entirely – not just under state law but under ERISA itself. The right to contest a denial of coverage under ERISA applies only for benefits under the plan. As the court in *Dukes* suggested, where a benefit under the plan is not merely care, but *care of a certain standard*, the care in essence becomes unreviewable. It may be that an employer or health care company that contracted for substandard care could in certain circumstances be charged with violation of ERISA’s fiduciary standards, but such a charge would not carry recovery of damages, as the Supreme Court’s decision in *Pilot Life* indicates.

A fourth issue that is still unresolved is what happens in cases in which physicians, hospitals, and other health providers that are members of networks are given the discretion under their capitation agreements to in effect make resource allocation decisions on the company’s behalf. The Third Circuit decisions suggest that regardless of the tasks with which they are charged, providers making treatment decisions should be viewed as providers, not plan administrators. But a major case now pending before the U.S. Supreme Court, *Herdrich v Pegram*,⁵⁸ concerns the situations under which physicians will be regarded as plan fiduciaries under ERISA. Since the essence of a fiduciary’s job under ERISA is to conserve trust benefits for the good of the group, it is not clear whether viewed as fiduciaries, doctors do not acquire a shield from liability for actions that viewed in another light would be considered malpractice.

The final set of implications concerns legislative reform efforts at the federal and state levels. The House-passed managed care quality bill would reinstate state law in the case of liability for managed care coverage decisions.⁵⁹ As such, the bill would in effect overturn the *Pilot Life* case insofar as the Supreme Court held that state law claims are preempted by ERISA when applied to managed care company coverage decisions. In effect, states that enact such laws (and Congress in refraining from preempting such laws) are electing to preserve a distinction that courts may be on the verge of eliminating, at least in a managed care context. How such a decision to retain this distinction will affect the decision by other courts to follow the lead of the Third Circuit in getting rid of it cannot be known.

The bottom line for the time being is that taken together, the evolving line of ERISA coverage/quality cases suggests that courts are increasingly willing to view HMO and managed care conduct in a provider/treatment light. To the extent that employers and companies do not contract for care of a certain quality, this means that companies (and even employers in certain cases) may be

rather than *plan implementation*, and as a result could not be reviewed since courts must enforce a plan “as written” unless it violates a specific ERISA provision. *Id.* (citing *Averhart v U.S. West Management Pension Plan*, 46 F.3d 1480, 1488 (10th Cir. 1994) and *Hein v Federal Deposit Ins. Corp.*, 88 F.3d 210, 215 (3d Cir. 1996)). Because an employer may draft a benefits plan any way it wishes—indeed, ERISA does not mandate that employers provide any particular benefits or even any benefits at all—the employer does not act as a fiduciary when it sets the terms of the plan.

⁵⁷ The court also found that there was no breach of ERISA disclosure requirements even though the guidelines were not revealed to participants.

⁵⁸ 154 F. 3d 362 (7th Cir. 1998), reh. den. 170 F. 3d 683 (7th Cir. 1999), cert. granted 120 S. Ct. 10 (Sept. 28, 1999).

⁵⁹ H.R. 2990 (106th Cong., 1st Sess.). As of April 5, 2000, a joint Senate-House conference committee was still attempting to reach agreement on various components of H.R. 2990 and S.1344, the Senate-passed version of a “Patients’ Bill of Rights”.

liable for damages under malpractice theory when their care falls below the standard of care in a particular area. This makes efforts to develop and refine a proper standard of care -- and to apply it and rigorously oversee it in a managed care context -- of enormous importance.